County of El Dorado

Mental Health Services Act (MHSA)

Fiscal Year 2014-15 Three-Year Plan Update

Covering Fiscal Years 2014-15, 2015-16 and 2016-17

Health and Human Services Agency

Mental Health Division

August 26, 2014

Acknowledgements

The El Dorado County Health and Human Services Agency, Mental Health Division would like to thank the families, community members, service providers and organizations who provide support, care and treatment for the members of our community who have been diagnosed with a mental illness. Your dedication to mental health is greatly appreciated. We would also like to thank the El Dorado County Board of Supervisors and Mental Health Commission for their continued efforts to improve mental health services in our County, and the National Alliance on Mental Illness (NAMI) for providing consumer and family support and community training.

And finally, thank you to all who hosted Mental Health Services Act (MHSA) planning meetings, assisted with the organization of the meetings, and participated in the community planning process. MHSA programs are developed from your ideas and the modifications to existing programs were based upon your input. For those members of our community who have a mental illness or risk factors for mental illness, we hope these MHSA programs will assist with your recovery, resiliency and wellness.

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Part 1. Mental Health Services Act and County Profile

Mental Health Services Act

California voters passed Proposition 63, the Mental Health Services Act (MHSA), in November of 2004, and the MHSA was enacted into law January 1, 2005. The MHSA imposes a one percent (1%) tax on personal income in excess of $1,000,000. These funds are distributed to counties through the State and are intended to transform the mental health system.

The MHSA established five components that address specific goals for priority populations and key community mental health needs:

- Prevention and Early Intervention (PEI)
- Community Services and Supports (CSS)
- Innovation (INN)
- Workforce Education and Training (WET)
- Capital Facilities and Technology Needs (CFTN)

To develop and implement each of these MHSA components, the County of El Dorado (County) holds community planning meetings to gather information from consumers, their families, providers, and community members throughout the County.

MHSA Purpose and Intent

The MHSA, Section 3, states the purpose and intent of the MHSA is:

(a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.

(b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.

(c) To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.

(d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.

(e) To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices

subject to local and state oversight to ensure accountability to taxpayers and to the public.[1]

MHSA General Standards

Services provided under MHSA must integrate the following General Standards:[2]

(1) Community Collaboration: "a process by which clients and/or families receiving services, other community members, agencies, organizations, and businesses work together to share information and resources in order to fulfill a shared vision and goals."[3]

(2) Cultural Competence: "incorporating and working to achieve each of the goals listed below into all aspects of policy-making, program design, administration and service delivery. Each system and program is assessed for the strengths and weaknesses of its proficiency to achieve these goals. The infrastructure of a service, program or system is transformed, and new protocol and procedure are developed, as necessary to achieve these goals.

(1) Equal access to services of equal quality is provided, without disparities among racial/ethnic, cultural, and linguistic populations or communities.

(2) Treatment interventions and outreach services effectively engage and retain individuals of diverse racial/ethnic, cultural, and linguistic populations.

(3) Disparities in services are identified and measured, strategies and programs are developed and implemented, and adjustments are made to existing programs to eliminate these disparities.

(4) An understanding of the diverse belief systems concerning mental illness, health, healing and wellness that exist among different racial/ethnic, cultural, and linguistic groups is incorporated into policy, program planning, and service delivery.

(5) An understanding of the impact historical bias, racism, and other forms of discrimination have upon each racial/ethnic, cultural, and linguistic population or community is incorporated into policy, program planning, and service delivery.

(6) An understanding of the impact bias, racism, and other forms of discrimination have on the mental health of each individual served is incorporated into service delivery.

(7) Services and supports utilize the strengths and forms of healing that are unique to an individual's racial/ethnic, cultural, and linguistic population or community.

(8) Staff, contractors, and other individuals who deliver services are trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural, and/or linguistic population or community that they serve.

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[1] The Mental Health Services Act, Section 3, Purpose and Intent.
[2] California Code of Regulations (CCR), Title 9, Division 1, Chapter 14, Section 3320, General Standards.
[3] CCR, Title 9, Division 1, Chapter 14, Section 3200.060, Community Collaboration.

(9) Strategies are developed and implemented to promote equal opportunities for administrators, service providers, and others involved in service delivery who share the diverse racial/ethnic, cultural, and linguistic characteristics of individuals with serious mental illness/emotional disturbance in the community."[4]

(3) Client Driven: "the client has the primary decision-making role in identifying his/her needs, preferences and strengths and a shared decision-making role in determining the services and supports that are most effective and helpful for him/her. Client driven programs/services use clients' input as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes."[5]

(4) Family Driven: "families of children and youth with serious emotional disturbance have a primary decision-making role in the care of their own children, including the identification of needs, preferences and strengths, and a shared decision-making role in determining the services and supports that would be most effective and helpful for their children. Family driven programs/services use the input of families as the main factor for planning, policies, procedures, service delivery, evaluation and the definition and determination of outcomes."[6]

(5) Wellness, Recovery, and Resilience Focused: "promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination."[7]

(6) Integrated Service Experiences for clients and their families: "the client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive and coordinated manner."[8]

Public Mental Health System

The public mental health system consists of governmental and contracted providers who provide mental health services through local government, state and/or federal funding. The specific nature of the mental health needs and impairments are assessed for each individual to determine their eligibility to receive services through the County's mental health programs. The primary focus of these services is for individuals who are on Medi-Cal or uninsured and meet the specialty mental health/medical necessity criteria.

MHSA provides public education and support for the public mental health system through the development and funding of specific projects, but it is not "the mental health system" nor "the public mental health system". MHSA cannot fund all mental health needs within a county, nor is MHSA designed to fill that role. "The MHSA addresses a broad continuum of prevention, early intervention and service needs and provides funding for the necessary infrastructure,

[4] CCR, Title 9, Division 1, Chapter 14, Section 3200.100, Cultural Competence.
[5] CCR, Title 9, Division 1, Chapter 14, Section 3200.050, Client Driven.
[6] CCR, Title 9, Division 1, Chapter 14, Section 3200.120, Family Driven.
[7] Welfare and Institutions Code (WIC) Section 5813.5(d)(1).
[8] CCR, Title 9, Division 1, Chapter 14, Section 3200.190, Integrated Service Experience.

technology and training elements that will effectively support the local mental health system."[9] The role of primary care physicians and mental health services available through health insurance networks is of utmost importance in also supporting the local mental health needs.

All communities have service priorities, but there is limited funding available. Unfortunately, this means that not all wants and needs can be funded through MHSA. Therefore, even though a service need is identified, it does not mean the project will be able to be funded through MHSA. Rather, the totality of identified needs are considered, weighed against current programs, their outcomes and available funding, and a determination is made based on those factors as to whether a new program should be introduced to the MHSA service array. Similar considerations are made as to whether an existing program should be eliminated, be reduced in funding or be increased in funding.

MHSA Plan Requirements

In August 2013, the Mental Health Services Oversight and Accountability Commission (MHSOAC) issued instructions for the Fiscal Year (FY) 2014-15 MHSA Plans.[10] The instructions summarize MHSA Plan requirements found within the MHSA, the Welfare and Institutions Code (WIC) and the California Code of Regulations (CCR), including the stakeholder process (community planning process), public review, the information to include regarding programs and outcome measures, expenditure plan, compliance and fiscal accountability certifications, and Board of Supervisors adoption. A copy of the instructions can be found as Attachment A.

MHSA Plans are written for a three-year duration, however plans are to be updated annually. This allows for necessary changes to be implemented, such as projects to be added, discontinued or amended, changes in revenues and/or expenditures to be addressed, or other important information to be incorporated.

MHSA Plans may also be amended mid-year, however amendments require the same community planning process as a Plan or Plan Update require, and are generally only undertaken due to extraordinary circumstances or significant revenues/expenditures to be adjusted.

MHSA Terminology

As used within this document, and generally within MHSA:

- "**Component**" refers to the MHSA funding streams of:
  - Prevention and Early Intervention (PEI)
  - Community Services and Supports (CSS)

[9] California Department of Mental Health. Mental Health Services Act Expenditure Report Fiscal Year 2007-2008. http://www.dhcs.ca.gov/services/MH/Documents/MayLegReportFormat4_14_08_V8.pdf.

[10] Mental Health Services Oversight and Accountability Commission, *FY 2014-2015 MHSA Three-Year Program and Expenditure Plan Instructions*. August 2013. http://www.mhsoac.ca.gov/docs/FY14-17_3YrProgExpendPlan_Instructions.pdf.

- Innovation (INN)
- Workforce Education and Training (WET)
- Capital Facilities and Technology Needs (CFTN)

- "**Program**" refers to a grouping of projects under a component designed to achieve a common goal, serve a common demographic, or address a common community need. In the past, "Programs" were referred to as "Workplans".

- "**Project**" refers to a set of targeted activities focusing a specific aspect of a program. One or more projects will be found within each program.

- "**Activities**" are what will occur within each project.

A glossary has been included at the end of this document (before the Plan attachments) to assist with the terminology utilized within this Plan.

Funding Methodology

On August 7, 2013, Department of Health Care Services (DHCS) released MHSD Information Notice 13-15, which identifies the "Methodology for Distributions to Local Mental Health Services Fund".[11] Through application of the methodology described in MHSD Information Notice 13-15, El Dorado County will receive 0.406698% of the total MHSA funding available in FY 2014-15, which is anticipated to be approximately $6,654,552. For more information about how MHSA funding is allocated to specific programs/projects within El Dorado County, please see Part 4 of this Plan.

The State no longer provides counties with specific annual MHSA allocations. Rather, the MHSA funding distributed to each county is based on a percentage of the actual deposits into the State's Mental Health Services fund. Therefore, the amount distributed fluctuates monthly.[12] The estimated revenues identified for each MHSA component is based upon revenues received in prior fiscal years, estimated MHSA revenues identified in the State's budget, and estimates from statewide MHSA organizations and their consultants.

Additional funding, attributed to the MHSA programs as offsets to expenditures, is available from Medi-Cal or other reimbursements for services. Interest on funds already received but not yet expended and Public Safety Realignment 2011 (Assembly Bill [AB] 109) are examples of other revenue sources.

El Dorado County reports the total MHSA revenues and expenditures annually to the State. This report is referred to as the "Revenue and Expenditure Report". The report for FY 2012-13 has not yet been requested by the State, but the FY 2011-12 report is included as Attachment B.

[11] California Department of Health Care Services, MHSD Information Notice 13-15 and Enclosure 1. August 7, 2013. http://www.dhcs.ca.gov/formsandpubs/Pages/MentalHealth-InfoNotices.aspx.
[12] *Ibid.*

Component Funding

The MHSA specifies the percentage of total funding applied to each of its components:

Component	Net % of Annual Allocation
CSS	76%
PEI	19%
INN	5%
WET	0% - Utilizing Fund Balance or Reallocation from CSS
CFTN	0% - Utilizing Fund Balance or Reallocation from CSS

80% of the MHSA funds are allocated to CSS
20% of the MHSA funds are allocated to PEI and from that total, 5% is allocated to INN

The ability to shift funds between components is dictated by the terms of the MHSA. CSS funds may be shifted to WET and CFTN, but may not exceed 20% of the total average amount of funds allocated to that County for the previous five years. Funds may not be transferred into PEI. There is also some flexibility to move funding between projects within the same component, however if services are provided through a contracted vendor, there may be contractual issues, in addition to any required community planning process requirements, to be addressed before funds could be shifted.

County Profile

El Dorado County encompasses a large geographic area (1,708 square miles, of which approximately 51% is U.S. Forest Service land[13]), with two incorporated cities (South Lake Tahoe and Placerville) and twelve unincorporated Census-Designated Places (CDPs)[14].

Demographics

According to the 2010 census, the population within the County is 181,058, which represents a 15.8% increase since the 2000 census.[15] Approximately 33% of the County's population resides toward the western border of the County in the El Dorado Hills and Cameron Park communities, with the Tahoe basin on the eastern border being the second highest region in population.

Eighty-two percent of the County's population resides in unincorporated areas of the County. The communities within the County have developed out of the distinct characteristics of each of these regions and have historically operated quite independently. The rural nature of many unincorporated areas of the County results in challenges to obtaining mental health services

[13] Retrieved from http://www.fs.usda.gov/main/eldorado/about-forest, March 7, 2013.
[14] Retrieved from http://www.dof.ca.gov/research/demographic/state_census_data_center/census_2010/documents/2010Census_DemoProfile1.xls, June 25, 2013.
[15] Unless otherwise noted, all demographic data is retrieved from the 2010 census (http://quickfacts.census.gov/qfd/states/06000.html), March 7 and May 7, 2013.

(e.g., transportation to services, outreach to residents, and public awareness relative to available services).

Location	2010 Census Population[16]	Percent of County	Persons per Square Mile[17]
City of Placerville (incorporated)	10,389	5.7%	1,787.5
City of South Lake Tahoe (incorporated)	21,403	11.8%	2,106.3
Auburn Lake Trails CDP	3,426	1.9%	269.2
Cameron Park CDP	18,228	10.1%	1,641.2
Camino CDP	1,750	1.0%	777.7
Cold Springs CDP	446	0.2%	590.4
Coloma CDP	529	0.3%	157.7
Diamond Springs CDP	11,037	6.1%	663.2
El Dorado Hills CDP	42,108	23.3%	869.0
Georgetown CDP	2,367	1.3%	156.5
Grizzly Flats CDP	1,066	0.6%	160.8
Pollock Pines CDP	6,871	3.8%	866.7
Shingle Springs CDP	4,432	2.4%	539.9
Tahoma CDP	1,191	0.7%	459.2
Remainder of Unincorporated Area	55,815	30.8%	35.9
El Dorado County Total	181,058	100.0%	106.0

The County seat, Placerville, is surrounded by unincorporated, rural areas. South Lake Tahoe (the city and unincorporated areas of the Tahoe Basin) features a resort community, a sizable transient community, and is much more ethnically diverse than the remainder of the County.

The Tahoe Basin is separated from the remainder of the County by the Sierra Nevada Mountains, with Highway 50 providing a mountainous, 60-mile connector route between the two regions. There is no locally operated public transportation between the Tahoe basin and the West Slope of the County, however Amtrak California operates once daily bus service between the two cities. In terms of service provision, the Tahoe basin and the West Slope of the County are essentially two distinct areas.

Gender distribution in the County is nearly equal between men (90,571) and women (90,487).[18] Veterans represent approximately 9.8% of the population.

[16] Retrieved from http://www.dof.ca.gov/research/demographic/state_census_data_center/census_2010/documents/2010Census_DemoProfile1.xls, June 25, 2013.
[17] *Ibid.*
[18] Gender distributions from U.S. Census Bureau data and compiled by Sacramento Area Council of Governments (SACOG).

The race distribution within the County is as follows:

Race	Percent of County
White (not Hispanic)	79.6%
Hispanic or Latino Origin	12.3%
Asian	3.7%
American Indian and Alaska Native	1.4%
Black	0.9%
Native Hawaiian and Other Pacific Islander	0.2%
Persons Reporting Two or More Races	3.3%

The median age in the County is 43.6, distributed as follows:[19]

Age	Total	Percent of County
Under 5	9,513	5.3%
5 to 9	11,126	6.1%
10 to 14	12,506	6.9%
15 to 19	12,522	6.9%
20 to 24	8,958	4.9%
25 to 34	17,244	9.5%
35 to 44	22,203	12.3%

Age	Total	Percent of County
45 to 54	32,346	17.9%
55 to 59	15,146	8.4%
60 to 64	12,970	7.2%
65 to 74	15,437	8.5%
75 to 84	7,969	4.4%
85 and Over	3,118	1.7%

Children 0 to 19 comprise 25.2% of the population and adults age 60 and over comprise 21.8% of the population. The population of adults age 55 and over has increased significantly from 2000. In 2000, this group consisted of 34,691 individuals (22.2% of the total population), whereas in 2010, the same age range consisted of 54,640 individuals (30.2% of the total population).

Income Levels

The median household income in El Dorado County is $68,815.[20] However, economic disparities are evident across the County:

[19] Age distributions from U.S. Census Bureau data and compiled by Sacramento Area Council of Governments (SACOG).
[20] Median household income, U.S. Census Bureau 2007-2011 American Community Survey 5-Year Estimates. http://factfinder2.census.gov/.

Place of Residence within the County	Median Household Income[21]	Percent of Individuals Below the Poverty line[22]
Cameron Park	$72,562	4.3%
El Dorado Hills	$115,121	2.7%
Placerville (city)	$53,385	14.0%
South Lake Tahoe (city)	$41,685	18.4%
Remaining County Unincorporated Areas	Not Available	Not Available
El Dorado County Total	$68,815	8.4%

According to the American Fact Finder, approximately 8.4% of the County's population has been below the poverty level within a 12 month period during the time period of 2007-2011.[23] There are specific areas of the County that experience higher poverty levels. Of the 43 census tracts within El Dorado County, 18 are above the County's average poverty level, representing approximately 44% of the County's population.[24]

Poverty Status in the Past 12 Months
2007-2011 American Community Survey 5-Year Estimates[25]

Includes All or Portion of Area	Includes All or Portion of Zip Code[26]	2007-2011 Population	% Population Below Poverty Level	Population Below Poverty Level
Countywide	--	178,630	8.4%	15,005
South Lake Tahoe	96150	28,887	16.06%	4,639
Camino, Placerville	95667, 95709	11,319	9.83%	1,113
Diamond Springs, El Dorado/Nashville, Placerville	95619, 95623, 95667	11,451	8.80%	1008
El Dorado/Nashville, Placerville	95623, 95667	6,820	14.10%	962
Placerville	95667	6,100	14.30%	872
Camino, Pollock Pines	95709, 95726	4,781	15.20%	727
El Dorado Hills	95762	27,110	2.68%	726

[21] Median household income, U.S. Census Bureau 2007-2011 American Community Survey 5-Year Estimates. http://factfinder2.census.gov/.
[22] People of all ages in poverty - percent, U.S. Census Bureau 2007-2011 American Community Survey 5-Year Estimates. http://factfinder2.census.gov/
[23] American Fact Finder. *Poverty Status in the Past 12 Months.* Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_5YR_S1701&prodType=table. September 29, 2013.
[24] Maps showing the locations of census tracts within El Dorado County are available through the U.S. Census Bureau website at http://www2.census.gov/geo/maps/dc10map/tract/st06_ca/c06017_el_dorado/.
[25] American Fact Finder. *Poverty Status in the Past 12 Months.* Retrieved from http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_11_5YR_S1701&prodType=table. September 29, 2013.
[26] Based on Census Tract Boundaries. Maps showing census tract zip code locations within El Dorado County are available through the El Dorado County Surveyor's Office website at http://edcapps.edcgov.us/maplibrary/html/ImageFiles/gi005667a.pdf.

Includes All or Portion of Area	Includes All or Portion of Zip Code[26]	2007-2011 Population	% Population Below Poverty Level	Population Below Poverty Level
Coloma, Placerville	95613, 95667	4,590	13.00%	597
Cool, Garden Valley, Georgetown, Greenwood, Lotus, Pilot Hill, Placerville	95614, 95633, 95634, 95635, 95651, 95664, 95667	6,381	8.80%	562
Placerville, Pollock Pines	95667, 95726	5,980	8.90%	532
Cameron Park/Shingle Springs, El Dorado Hills	95682, 95762	9,996	5.12%	512
Cool, Greenwood, Pilot Hill	95614, 95635, 95664	4,946	7.30%	361
Cameron Park/Shingle Springs, Rescue	95672, 95682	6,937	5.10%	354
Cameron Park/Shingle Springs	95682	5,427	6.47%	351
Cameron Park/Shingle Springs, Placerville	95667, 95682	4,848	5.90%	286
Garden Valley, Georgetown, Placerville, Pollock Pines, Twin Bridges	95633, 95634, 95667, 95726, 95735	3,208	8.50%	273
Cameron Park/Shingle Springs, El Dorado Hills, Rescue	95672, 95682, 95762	7,356	3.10%	228
Camino, Placerville, Pollock Pines	95667, 95709, 95726	2,192	9.50%	208
El Dorado/Nashville, Grizzly Flats, Mt. Aukum, Placerville, Somerset	95623, 95636, 95656, 95667, 95684	5,015	4.10%	206
Cameron Park/Shingle Springs, Lotus, Placerville	95651, 95667, 95682	2,844	5.40%	154
Cameron Park/Shingle Springs, El Dorado/Nashville, Placerville	95623, 95667, 95682	2,747	5.40%	148
Cameron Park/Shingle Springs, El Dorado Hills, Pilot Hill, Rescue	95664, 95672, 95682, 95762	3,939	3.10%	122
Echo Lake, South Lake Tahoe, Tahoma	95721, 96142, 96150	662	5.10%	34
El Dorado Hills, Rescue	95672, 95762	5,048	0.60%	30
Kyburz, Pollock Pines, Twin Bridges	95720, 95726, 95735	46	0%	0

Languages

The primary language spoken within El Dorado County is English. As of August 2013, California DHCS identified Spanish as the only "threshold language" within El Dorado County.[27] A "threshold language" is the primary language identified by 3,000 or five percent of the Medi-Cal beneficiaries, whichever is lower, in an identified geographic area. MHSA considers threshold languages when determining other languages to be considered in program design and implementation.

According to the U.S. Census, approximately 4% of the population age five and over speaks only Spanish at home.[28] Approximately 65% of this population resides in South Lake Tahoe, 16% resides in Placerville and 7% resides in Cameron Park/Shingle Springs. The remaining 12% is distributed throughout the remainder of the County.[29]

Health Insurance

With the implementation of the Affordable Care Act, the collaboration between insurance providers, health care providers, mental health providers, and specialty mental health care providers in serving the needs of El Dorado County residents is more important than ever.

Enroll America identified that approximately 13% (approximately 19,674) of the residents under the age of 65 in El Dorado County were uninsured prior to the implementation of the Affordable Care Act.[30] With the implementation of the Affordable Care Act, it is anticipated that this number will drop, however more recent estimates of the number of uninsured specifically for El Dorado County are not yet available.

According to DHCS, 20,421 individuals in El Dorado County were receiving Medi-Cal as of October 2011. With the implementation of the Affordable Care Act, this number is anticipated to increase, however those numbers are not yet available from DHCS. Preliminary local data indicates that as of May 2014, approximately 27,168 individuals (both adults and children) receive Medi-Cal in El Dorado County.

The role of health care providers in the provision of mental health services cannot be underestimated. Individuals frequently feel more comfortable addressing mental health concerns with their primary care physician. For those with private insurance, referrals for mental health services would be handled through their insurance networks. For individuals with Medi-Cal, mild to moderate mental health needs are served through their primary care physicians, and individuals with severe mental illness are served through the Mental Health

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[27] California Department of Health Care Services. MHSD Information Notice No.: 13-09, Enclosure 1. http://www.dhcs.ca.gov/formsandpubs/Documents/13-09Encl1.pdf. April 2013.
[28] 2010 U.S. Census. *Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over (Hispanic Or Latino)*.
[29] U.S. Census, PCT011: Language Spoken at Home by Ability to Speak English for the Population 5 Years and Over (Hispanic or Latino).
[30] Enroll America. State Maps & Info, California. http://www.enrollamerica.org/state-maps-and-info/state-profiles/california/. Retrieved April 25, 2014.

Division (MHD) of Health and Human Services Agency (HHSA). Therefore, CSS services are primarily for those with Medi-Cal or those who are uninsured. MHSA programs cannot provide services that are available through private insurance.[31]

Demand for Mental Health Services

A February 2012 report[32] to the California DHCS identified that approximately 4.6% of the population in El Dorado County has a need for mental health services based upon the serious mental illness definition. Within households with income below the 200% poverty level, this rate increases to approximately 8.9%. When a broader definition of mental health needs is utilized, a level which is beyond the scope of the MHSA CSS funding, the percent of population that has a need for mental health services increases to approximately 12.2% of the population, and within households with income levels below the 200% poverty level, the need increases to approximately 19.5%. However, it is important to remember that under most circumstances, participation in mental health services is voluntary in nature.[33]

Mental illness can affect anyone, regardless of their ethnicity, income, housing status, age, or any number of other criteria. The MHSA projects are designed to address the needs of those residents who meet the eligibility criteria of each project. However, research has shown that there is a higher prevalence of mental illness in households that are considered low-income.[34] Per the United States Department of Health and Human Services, "In 2010, adults living below the poverty level were three times more likely to have serious psychological distress as compared to adults [with income] over twice the poverty level."[35]

With a population of 181,058,[36] it would be anticipated that between 8,329 (4.6%) and 16,114 (8.9%) individuals in El Dorado County are in need of services to treat a serious mental illness at any given time. However, since individuals seek treatment through their private insurance, Medi-Cal, Medicare, private payor services, or other treatment options, it is not possible to

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[31] The Mental Health Services Act, Section 3(d), Purpose and Intent. "State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs."

[32] Technical Assistance Collaborative, *California Mental Health and Substance Use System Needs Assessment* (February, 2012) at http://www.dhcs.ca.gov/provgovpart/Pages/BehavioralHealthServicesAssessmentPlan.aspx.

[33] The exception being services in which an individual is legally required to participate.

[34] References include: Mental Health: A report of the Surgeon General. 1999, as referenced by NAMI. http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Annual_Minority_Mental_Healthcare_Symposia/Latino_MH06.pdf.
"The Vicious Cycle of Poverty and Mental Health | World of Psychology." PsychCentral.com. http://psychcentral.com/blog/archives/2011/11/02/the-vicious-cycle-of-poverty-and-mental-health/.
Hudson, C.G. (2005). Socioeconomic Status and Mental Illness: Tests of the Social Causation and Selection Hypotheses. American Journal of Orthopsychiatry, 75, 3-18.
Lancet. (2011). Mental health care—the economic imperative. The Lancet, 378, 1440. doi:10.1016/S0140-6736(11)61633-4.

[35] United States Department of Health and Human Services, Office of Minority Health, http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=3&lvlid=539, referencing the Centers for Disease Control and Prevention, *Health, United States, 2011*, page 38. http://www.cdc.gov/nchs/data/hus/hus11.pdf.

[36] Unless otherwise noted, all demographic data is retrieved from the 2010 census (http://quickfacts.census.gov/qfd/states/06000.html), March 7 and May 7, 2013.

know the actual number of individuals who have been diagnosed with a serious mental illness or who are seeking services for a serious mental illness.

Based on the local data from May 2014, with a Medi-Cal coverage rate of 27,168 individuals, it would be anticipated that between 1,250 (4.6%) and 2,418 (8.9%) individuals on Medi-Cal are in El Dorado County are in need of services to treat a serious mental illness at any given time. According to the electronic health record utilized by the MHD, there were approximately 1,089 individuals are receiving services through the MHD as of April 2014, which includes direct services by MHD staff and contracted providers, or approximately 4% of the Medi-Cal beneficiaries.

Those without insurance may also receive medically-necessary services (as determined by a mental health assessment) through the MHD. However, as previously noted, participation in mental health services is voluntary in nature and individuals may elect to not receive services or receive services through alternate treatment options.

A key element in encouraging individuals to seek mental health treatment is addressing the stigma and discrimination long associated with mental illness. The PEI projects within this MHSA Plan and the Statewide PEI Stigma and Discrimination Reduction program work to reduce the stigma and discrimination associated with mental illness. Once mental illness becomes more understood by the general public as a medical issue and the historical stigma is reduced, those in need of services will hopefully become more willing to seek services.

Suicide Rate

Data from the California Department of Public Health reflects that from 2006 through 2012, El Dorado County experienced 220 deaths due to suicide. Each year since 2009, suicide accounts for 3% of the total deaths in El Dorado County. [37]

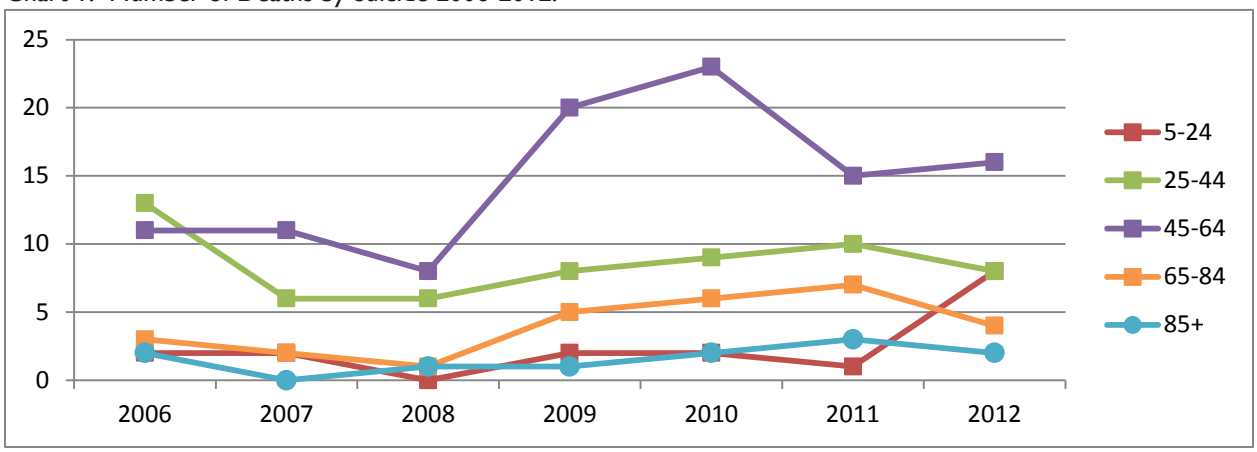
Age	Total	% of Total
5-14	1	<1%
15-24	16	7%
25-34	21	10%
35-44	39	18%
45-54	62	28%

Age	Total	% of Total
55-64	42	19%
65-74	16	7%
75-84	12	5%
85+	11	5%
TOTAL	220	

The annual data is reflected for age range blocks in Chart 1.

[37] California Department of Public Health, Health Information and Strategic Planning, Vital Statistics Query System. http://www.apps.cdph.ca.gov/vsq/default.asp. The data for 2013 is not yet available.

Chart 1. Number of Deaths by Suicide 2006-2012.



This MHSA Plan includes a suicide prevention program that will be awarded through a competitive procurement process.

As noted above, a key element in encouraging individuals to seek mental health treatment, including treatment for those who may have suicidal thoughts, is addressing the stigma long associated with mental illness.

Part 2. Needs Assessments and Community Planning Process

Needs Assessments

Populations

The original MHSA Plans developed for El Dorado County identified specific areas of need for mental health services within our County. The initial assessments identified underserved populations within the Latino and Native American populations. From this, the PEI Health Disparities program developed. These two groups continue to be underserved, and in the April 2014 external quality review, concern was expressed for the penetration rate of services for the Medi-Cal Hispanic population within El Dorado County.

In more recent years, including during the community planning process for this FY 2014-15 MHSA Plan, additional populations have drawn the focus of the community, including transitional age youth, older adults, homeless/soon to be homeless[38], school-aged children and low-income individuals/families. Children under the age of five were also a focus of the FY 2013-14 community planning process and programs for those populations were included in the FY 2013-14 MHSA Plan.

Workforce Needs

Within WET, the 2008 Workforce Needs Assessment identified the hard-to-fill positions of psychiatrists, nurses and Marriage and Family Therapist Interns. It also identified a need for bilingual (Spanish) staff in the public mental health system workforce. The workforce has changed since this initial Workforce Needs Assessment, and a new assessment will be performed in FY 2014-15, the results of which will be published on the MHSA web page and included in the next FY 2015-16 MHSA Plan. Although it had been anticipated that the Workforce Needs Assessment would be performed in FY 2013-14, staffing levels within the MHD precluded that from occurring. Current staffing trends identify challenges in staffing psychiatrists, nurses, psychiatric technicians, mental health clinicians (licensed and pre-licensed), licensed clinical social workers (licensed and pre-licensed); bilingual/bicultural staff; and all positions that work evenings, weekends, and part-time and/or on-call.

Previous MHSA Plans detailing the early community planning processes, needs assessments and origins of the MHSA programs may be found on the County's MHSA web page.[39]

Barton Health Community Health Needs Assessment

Barton Health completed its Community Health Needs Assessment (CHNA) Report for the South Lake Tahoe and surrounding communities in 2012. Barton Health's CHNA identified "Mental Health & Mental Disorders" as one of the health priorities for the Barton Health

[38] Throughout this document, the terms "homeless" or "soon to be homeless" are utilized to identify any resident of El Dorado County who does not have housing or stable housing as defined by McKinney Vento (https://www.onecpd.info/resources/documents/homelessassistanceactamendedbyhearth.pdf).
[39] El Dorado County, MHSA Plans Archive. http://www.edcgov.us/MentalHealth/MHSA_Plans.aspx.

service area, and "Mental Health" was identified as the top community health concern among community key informants.[40] The main issues discussed included shortage of psychiatrists and treatment facility options, stress management, stigma associated with mental illness, and individuals living with disabilities.[41] More information about the Barton Health CHNA, along with the complete report, can be accessed from http://www.bartonhealth.org/main/community-health.aspx.

In January 2014, Barton Foundation hosted a Mental Health Forum, bringing together a wide-cross section of the community to discuss mental health strengths, barriers and needs in the South Lake Tahoe region. Barton will utilize the information obtained during the meeting to implement strategies to address identified needs. The information discussed at this meeting is considered to be part of the community planning process for the purposes of developing the MHSA Plan.

Discussion identified some strengths within the mental health system in the South Lake Tahoe region, such as:

- Law enforcement Crisis Intervention Training/Team (CIT);
- Intensive Case Management (ICM) program;
- Use of tele-health;
- Treating mental health as a true medical emergency; and
- Training/assessment on mental health patients in the Emergency Department.

There were also some weaknesses/needs identified, including:

- Stigma and understanding of mental illness;
- Need for mental health training;
- Limited resources (staffing, psychiatry, therapy) and delay in access to service;
- Patients' ability to identify their illness, the importance of attending appointments regularly, and education on their benefits;
- Transportation barriers (personal and ambulance transport out of the area);
- Lack of service integration/coordinated care, including barriers resulting from confidentiality/HIPAA requirements;
- Under-insured gap/access and affordability;
- Medicare services;
- Homeless patients and mental illness; and
- Substance abuse/dual diagnosis.[42]

Since the Forum, these needs are being discussed and some solutions have been identified through collaborative efforts. For example, one solution for the ambulance transport issue has been identified and implemented, allowing transport to appropriate mental health hospitals in

[40] Professional Research Consultants, Inc. for Barton Health. *2012 PRC Community Health Needs Assessment Report.* 2012, pp. 12-13.
[41] *Ibid.* p. 41.
[42] Barton Foundation, Community Advisory Committee, Mental Health Forum Minutes.

Nevada, which results in consumers being closer to their home and a much shorter duration that an ambulance is away from the South Lake Tahoe area.

Marshall Medical Center Community Health Needs Assessment

Marshall Medical Center published its CHNA in October 2013.[43] Priority health needs for the Marshall Medical Center hospital service area included:

- limited mental health services/lack of access to mental health services;
- lack of access to inpatient and outpatient substance abuse treatment;
- limited transportation options; and
- perceptions of limited cultural competence in health care and related systems.

A map of the communities of concern can be found on page 4 of the CHNA, which includes the areas in and surrounding Diamond Springs, El Dorado, Georgetown, Placerville, and Pollock Pines. In the Marshall Medical Center Annual Report and Plan for Community Benefit, limited mental health services/lack of access to mental health services was identified in the top three needs.[44] Marshall Medical Center developed a work plan to address this need.[45] More information about the Marshall Medical Center CHNA and Plan for Community Benefit, along with the complete reports, can be accessed from http://www.marshallmedical.org/communitybenefit.

On March 17, 2014, Marshall hosted a community resource meeting, bringing together a wide-cross section of the West Slope community to discuss mental health, substance abuse treatment, and chronic pain management needs on the West Slope. Marshall will utilize the information obtained during the meeting to implement strategies to address the identified needs. The information discussed at this meeting is considered to be part of the community planning process for the purposes of developing the MHSA Plan. Key discussion areas related to mental health needs included:

- access to services;
- affordable housing;
- transportation;
- services for transitional age youth;
- specialty Medicare services;
- services for the uninsured;
- services for those with mild to moderate mental illness;
- in-county specialty services (e.g., in-patient rehabilitation facilities, board and care facilities for those with a mental illness);
- medication costs;
- availability of psychiatrists; and
- knowledge of available resources.

[43] Valley Vision, Inc. for Marshall Medical Center. A Community Health Needs Assessment of the Marshall Medical Center Hospital Service Area. 2013, p 5.
[44] Marshall Medical Center Annual Report and Plan for Community Benefit. Fiscal Year 2014, p. 10.
[45] *Ibid.* pp. 17-18.

California Healthy Kids Survey

Every two years, high schools in El Dorado County administer the California Healthy Kids Survey for grades 9 and 11 (some schools elect to administer the survey on an annual basis and/or for grades 9-12). The California Healthy Kids Survey is a statewide survey of resiliency, protective factors, and risk behaviors in school-aged youth.[46]

Two specific questions on the Healthy Kids survey address mental health:

- "During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more that you stopped doing some usual activities?"
- "During the past 12 months, did you ever seriously consider attempting suicide?"

Survey results from every high school for the most recent year administered is not available from the website, however summary information is available for previous years regarding feelings of sadness or hopelessness:

Depression-Related Feelings, by Grade Level for 2008-2010 (All Years)[47]

El Dorado County	Percent	
	Yes	No
9th Grade	28.8%	71.2%
11th Grade	30.2%	69.8%
Non-Traditional	41.4%	58.6%

California	Percent	
	Yes	No
9th Grade	30.6%	69.4%
11th Grade	32.1%	67.9%
Non-Traditional	37.2%	62.8%

The survey also indicates that the highest level of depression-related feelings is by those with feelings of low connectedness to school:[48]

El Dorado County	Percent					
	Yes			No		
	2004-2006	2006-2008	2008-2010	2004-2006	2006-2008	2008-2010
High Connectedness	18.5%	17.4%	19.8%	81.5%	82.6%	80.2%
Medium Connectedness	33.3%	31.1%	37.4%	66.7%	68.9%	62.6%
Low Connectedness	50.1%	45.0%	45.1%	49.9%	55.0%	54.9%

[46] California Healthy Kids Survey, California Department of Education (Safe and Healthy Kids Program Office) and WestEd (Health and Human Development Department). https://chks.wested.org/.

[47] Percentage of students in grades 9, 11, and non-traditional students, reporting whether in the past 12 months, they had felt so sad or hopeless almost every day for two weeks or more that they stopped doing some usual activities. California Healthy Kids Survey, California Department of Education (Safe and Healthy Kids Program Office) and WestEd (Health and Human Development Department). https://chks.wested.org/indicators/emotional-and-behavioral-health/emotional-mental-health/depression-related-feelings/by-grade-level. 2008-2010 is the most recent consolidated data for El Dorado County available on the website. Some individual school data is available online for more recent years.

[48] California Healthy Kids Survey, California Department of Education (Safe and Healthy Kids Program Office) and WestEd (Health and Human Development Department). https://chks.wested.org/indicators/emotional-and-behavioral-health/emotional-mental-health/depression-related-feelings/by-level-of-connectedness-to-school. 2008-2010 is the most recent consolidated data for El Dorado County available on the website. Some individual school data is available for school year 2011-12 or 2012-13.

MHSA staff requested the Healthy Kids Survey data from each high school, and based on the data provided, approximately 29.1% of the 9th graders and 30.7% of the 11th graders have felt so sad or hopeless almost every day for two weeks or more during the last 12 months that they stopped doing some usual activities (excludes the non-traditional high schools as their data is not broken down by 9th and 11th grade). Within non-traditional schools, this increases to approximately 50% of the students.

Current data for the question "During the past 12 months, did you ever seriously consider attempting suicide?" reflects that approximately 20.3% of 9th graders and 20.5% of 11th graders have considered attempting suicide (excludes the non-traditional high schools as their data is not broken down by 9th and 11th grade). Within non-traditional schools, this percent is significantly higher.

Community Planning Process

The general public and stakeholders were invited to participate in MHSA planning opportunities in 2014 to contribute to the development of the County's FY 2014-15 MHSA Plan. Plan progress, anticipated changes, budget allocations, program planning and objectives, mental health policy, plan implementation, and outcome measures/monitoring/program evaluation and quality improvement were discussed at various points during the community planning process. MHSA updates and program planning have also taken place as part of the Mental Health Commission meetings. Informational documents and forms were available in English and in Spanish at the meetings and on the community planning process web page at http://www.edcgov.us/MentalHealth/MHSA_Meetings/2014/MHSA_Community_Meetings_Scheduled.aspx.

Additional information about the FY 2014-15 community planning process can be found online.

Stakeholder Representation

The MHSA project team maintains an email distribution list for individuals who have expressed an interest in MHSA activities. Members of this distribution list include:

- adults and seniors with severe mental illness;
- families of children, adults and seniors with severe mental illness;
- providers of services;
- law enforcement agencies;
- education;
- social services agencies;
- veterans;
- representatives from veterans organizations;
- providers of alcohol and drug services;
- health care organizations; and
- other interested individuals.

During this community planning process, there were approximately 600 individuals on the email distribution list who received notifications regarding the community planning process and

MHSA updates. In total, over 250 individuals attended public meetings, were provided with comment forms and other information about MHSA, participated in one-on-one/small group meetings, or participated in discussions that were heard by Mental Health staff. All input received is considered in the development of this plan, whether through a formal public meeting or informal discussions.

Input from stakeholders was sought during the community planning process. The majority of the participants at the public meetings were families of consumers, education representatives, and providers of services (primarily mental health and alcohol and drug service providers).

MHSA Public Meetings / One-on-One and Small Group Meetings

A press release was issued on February 14, 2014 regarding the MHSA public meetings, and distributed to local media contacts, including the Mountain Democrat, Tahoe Daily Tribune, El Dorado Hills Telegraph, Life Newspapers, Georgetown Gazette and Sacramento Bee. The press release was also posted on the County's News and Hot Topics web page, the HHSA web page, and the MHD's web page. A web page was created specifically for the community planning process (http://www.edcgov.us/MentalHealth/MHSA_Meetings/2014/MHSA_Community_Meetings_Scheduled.aspx). An email was distributed to the MHSA distribution list on February 14, 2014, listing meeting dates, locations and times, and referring recipients to the community planning web page for additional information and handouts.

A new approach implemented this year was inviting local organizations to host a MHSA planning meeting for their staff, clients and/or members. Four organizations elected to host meetings and the turnout for the public meetings was highest at these hosted events.

During last year's community planning process, input was received that the times of the public meetings were not convenient. Therefore, the MHSA project team released a survey to determine the days of the weeks and the time of days that are most convenient for public meetings. The results of that survey are included in Attachment C. Although the number of responses to the survey were low, the most popular days of the week were Tuesday, Wednesday and Thursday and the most popular times of the day were 10:00 am and 6:00 pm. Meetings in El Dorado Hills, Placerville and South Lake Tahoe were offered at both 10:00 am and 6:00 pm, and meetings in other locations were either offered when the host scheduled them or as noted below, with the time of the meeting frequently based on availability of facilities.

Turnout at the FY 2014-15 public meetings was higher than the last two years. The total number of unique participants at the FY 2014-15 public MHSA community planning meetings was 96, and the total attendance was 108. The MHSA project team will continue to work towards increasing participation at the public community planning meetings.

Date	Host	Location	Time	Attendees
1/23/14	El Dorado Hills Vision Coalition	El Dorado Hills	3:00 pm*	27
2/4/14	National Alliance on Mental Illness (NAMI)	Placerville	5:30 pm*	12
2/5/14	Drug-Free Divide	Georgetown	5:00 pm*	6

Date	Host	Location	Time	Attendees
2/13/14	South Lake Tahoe Family Resource Center[49]	South Lake Tahoe	6:00 pm*	21
2/19/14	MHD	Somerset	6:00 pm	0
2/25/14	MHD	Cool	6:00 pm	5
2/27/14	MHD	Placerville	6:00 pm	6
3/4/14	MHD	South Lake Tahoe	10:00 am	8
3/4/14	MHD	Garden Valley	6:00 pm	7
3/5/14	MHD	Placerville	10:00 am	2
3/11/14	MHD	El Dorado Hills	6:00 pm	4
3/12/14	MHD	Pollock Pines	6:00 pm*	5
3/13/14	MHD	Georgetown	6:00 pm	1
3/19/14	MHD	El Dorado Hills	10:00 am	4

*Date, time and location selected by host/site organizer.

During the meetings, attendees were provided with an overview of MHSA, the planning process, current projects, and funding. Attendees could ask questions and receive answers about MHSA and the County's MHSA Plan, provide input on existing programs and expenditures, identify needs, identify barriers to obtaining mental health services, and identify potential solutions to address the needs and barriers. Attendees were also provided with pre-meeting quiz containing true/false statements about MHSA activities. The quiz was reviewed at the end of each meeting to assist the attendees in increasing their knowledge about MHSA. Input from the public meetings is available in Attachment D.

One-on-one and/or small group meetings were also held to discuss MHSA, and include meetings with church representatives, local non-profits, and education.

Additional Meeting and Opportunities for Raising Awareness about the MHSA Community Planning Process and MHSA Plan

During the FY 2014-15 community planning process, MHSA staff attended several meetings related specifically to mental health issues.

Date	Host / Location	Topic
1/10/14	Barton Foundation Mental Health Forum South Tahoe High School, South Lake Tahoe Number of Participants: Approximately 58 Adults	Mental health services in the South Lake Tahoe region
3/17/14	Marshall Foundation Community Resources Federated Church, Placerville Number of Participants: Approximately 25 Adults	Mental health, substance abuse and chronic pain management service needs

[49] Provided in English and Spanish.

Date	Host / Location	Topic
3/21/14	Foothill Indian Education Alliance Number of Participants: Approximately 21 Adults and Youth	MHSA overview, how to provide input, the needs of the Native American community, outcomes of the Wennem Wadati project
4/7/14	Ending the Stigma of Mental Illness - Community Forum Somerset Number of Participants: 6 Adults	Screening of "A New State of Mind: Ending the Stigma of Mental Illness", input about MHSA funding, discussion of ending stigma in our community
4/8/14	Ending the Stigma of Mental Illness - Community Forum Placerville Number of Participants: 74 Adults	Screening of "A New State of Mind: Ending the Stigma of Mental Illness", panel of mental health professionals, discussion of ending stigma in our community
5/6/14	Ending the Stigma of Mental Illness - Community Forum Placerville Number of Participants: 17 Adults	Screening of "A New State of Mind: Ending the Stigma of Mental Illness", panel of mental health professionals, discussion of ending stigma in our community

Mental Health staff attend other many meetings not specifically related to MHSA and/or the mental health needs within our County, but which provide an opportunity to raise awareness about mental health and MHSA, discuss how to become involved in the planning process, and/or learn about the general needs of the community. Some of these meetings include:

- Chronic Disease Coalition
- Community Strengthening/Ready by 5
- Diamond Springs/El Dorado Community Advisory Committee
- Drug Free Divide
- El Dorado County Commission on Aging
- El Dorado County Veteran Commission
- El Dorado Hills Vision Coalition
- Health Connections Advisory Board
- Lake Tahoe Collaborative
- Multidisciplinary Adult Services Team (MAST)

When in line with the structure of these non-MHSA-specific meetings, attendees may be provided with comment forms and flyers about how to become involved in the MHSA planning process. During this community planning process through meetings such as these, over 100 individuals received comments forms and information about how to get involved.

In FY 2014-15, MHSA staff anticipate increasing similar participation with service organizations, professional organizations, Chambers of Commerce, and/or organizations established for specific interests (e.g., hobbies).

Other Methods of Input

The public was also invited to provide input through a comment form, via email or via regular mail. The number of comment forms and letters received exceeds the number received during last year's community planning process.

The comment form asked for basic demographic information, and included the following six comment areas:

- Mental Health Service Gaps / Needs
- Recommendation(s) / What is Needed
- What's Working
- What's Not Working
- Any Other Comments about MHSA or mental health needs and services?
- Did this meeting meet your expectations; if no, why not, and any other comments about the meeting (when the comment form was completed after attending one of the MHSA meetings)

The responses received via comment forms are summarized in Attachment D.

Outcomes of Community Planning Process

The following issues were of primary concern to the planning participants:

- Transportation;
- Housing;
- Locally provided services;
- Services provided on school sites;
- Parental involvement;
- Underlying causes of and issues related to mental illness;
- Stigma reduction;
- After crisis care;
- Dual diagnosis/co-occurring disorders;
- Getting the word out about programs and resources;
- Training / education / staff development and
- Services for those with mild to moderate mental illness.

Priority populations were identified as:

- Middle and High School Age Youth;
- Transitional Age Youth;
- Older Adults; and
- Homeless.

Please see Attachment D for the input received and more specific discussion topics. Below is a discussion about activities under development or in process to address these key topics:

Transportation

Both Medi-Cal managed care plans in El Dorado County (California Health and Wellness and Anthem Blue Cross) offer Medi-Cal clients transportation assistance to medical appointments (physical health and mental health) that may be in the form of gas reimbursement, bus script or direct transport. The type of transportation available depends upon the individual situations of each client and the advance notice requirements depends on the type of transportation assistance provided. Individuals in need of transportation assistance should contact their Medi-Cal provider to discuss transportation options and make arrangements (some options require doctor approval in advance or a form to be signed the day of the appointment). MHD clients may request assistance from staff to help with these arrangements. This information has been emailed to all MHD staff so they may discuss this information with their clients. (Program addressing this concern: Medi-Cal service from the managed care plans.)

The MHD also operates a scheduled van shuttle that provides individuals with the opportunity to be picked up and dropped off at specific locations three times each weekday, to and from the West Slope Mental Health outpatient clinic in Diamond Springs. This van shuttle has proved to be very successful and serves approximately 40-60 individuals per week. The MHD will continue to explore how transportation can be expanded to more rural areas, either through its transportation services or in partnership with Medi-Cal providers. (Program addressing this concern: CSS Project 4a: Outreach and Engagement Services.)

Housing

On May 13, 2014, the MHD received approval from the Board of Supervisors to contract with Summitview Child and Family Services for an in-county Adult Residential Facility (ARF). The facility would provide six beds for a Full Service Partnership program, which would be available for clients who are not yet ready for transitional housing or independent housing, and assist them with gaining the necessary independent living skills.

In the spring of 2014, the MHD received approval to proceed with securing master leases on housing for Full Service Partnership (FSP) clients, and the master lease template is under development. Rather than entering into a lease agreement with individual clients, the landlords will lease to the County, which in turn will lease directly to the clients. Clients will continue to pay their share of housing costs, however clients who are in the FSP program will be eligible for housing assistance, and other supportive services, if needed. Potential housing opportunities are being explored on both the West Slope and in the South Lake Tahoe.

Mental Health is applying for Projects for Assistance in Transition from Homelessness (PATH) grant funds, which will provide outreach, linkage to services and benefits, and housing assistance for individuals who are homeless or soon to be homeless and have a mental health issue. If awarded, approximately $6,000 will be available to assist with housing costs and $25,000 will be available for staffing (there are required matching funds as well), along with limited administrative funding. This grant will be contracted to a community-based organization through a competitive procurement process (Request for Proposals [RFP]). More information about the PATH grant is available at http://www.dhcs.ca.gov/services/MH/Pages/PATH.aspx.

The MHD continues to explore other in-county housing options that will benefit our clients.

(Programs addressing this concern: CSS Project 2b: Adult Full Service Partnership; CSS Project 3a: Transitional Age Youth (TAY) Engagement, Wellness and Recovery Services; CSS Project 4a: Outreach and Engagement Services.)

Locally Provided Services

As was the case in the FY 2013-14 community planning process, the participants expressed the importance of locally-provided services. In El Dorado County, as with many rural counties, there are centralized points of service due to the locations of the businesses that provide services. In El Dorado County, those service locations have historically centered around Placerville and South Lake Tahoe.

Activities within MHSA projects can occur in a variety of locations. For example, one of the benefits of the CSS FSP programs is that services can, and are, provided in locations which clients have identified as their preference, such as in the home or other community-based locations. FSP programs utilize a "whatever it takes" approach to the provision of services.

As noted in Part 4, Community Services and Supports programs include:

- 61% of the CSS funding is allocated to projects that are performed in various locations throughout the County based on client preference and/or location:
  - Project 1a: Youth and Family Full Service Partnership
  - Project 1c: Foster Care Enhanced Services
  - Project 2b: Adult Full Service Partnership
  - Project 2c: Older Adults Program (Partner program to PEI Older Adults Program)
  - Project 3a: TAY Engagement, Wellness and Recovery Services
  - Future Potential Project 2d: Assisted Outpatient Treatment
- 24% of the CSS funding is allocated to projects that serve eligible populations in the County, but the services must be provided at a specific location due to facilities/equipment limitations:
  - Project 1b: Family Strengthening Academy
  - Project 2a: Wellness Centers
- 2% of the CSS funding is allocated to projects offered in locations in the community:
  - Project 4b: Community-Based Mental Health Services
- 13% of the CSS funding is allocated to outreach and engagement and resource management, which may be performed through the outpatient clinics or in various locations in the community:
  - Project 4a: Outreach and Engagement Services
  - Project 4c: Resource Management Services

All CSS programs are offered on both the West Slope and in the Tahoe Basin.

Similarly, PEI programs may be provided in the community at various locations, or they may be restricted to specific geographic locations due to responses to RFPs or facility needs.

As noted in Part 4, Prevention and Early Intervention, of the total PEI funding for projects (excluding administrative costs), approximately:

- 29% is allocated to projects that are performed in various locations throughout the County, including schools, community centers, and/or churches:
  - Project 1b: Mentoring for 3-5 Year Olds
  - Project 1f: Prevention and Early Intervention for Youth in Schools
  - Project 2a: Mental Health First Aid
  - Project 2e: Suicide Prevention and Stigma Reduction
  - Project 4b: Senior Peer Counseling
  - Project 4c: Older Adult Program
  - Project 5a: Community-Based Mental Health Services
  - Project 5b: Community Health Outreach Worker
- 37% is allocated to projects offered in a specific location(s) as a result of a competitive procurement process:
  - Project 1c: Parenting Skills (formerly Incredible Years)
  - Project 1d: Primary Intervention Project (PIP)
  - Project 2f: Foster Care Continuum Training
  - Project 3a: Wennem Wadati - A Native Path to Healing
  - Project 3b: Latino Outreach
- 16% is allocated to projects that serve eligible populations in the County, but the services must be provided at a specific location due to necessary facilities/equipment; and
  - Project 1a: Children 0-5 and Their Families
  - Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness
- 18% is allocated to projects that provide information/activities in all schools, educational classes, and/or information Countywide based on internet access, newspaper distribution or other posted materials:
  - Project 1e: SAMHSA Model Programs
  - Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education
  - Project 2d: Community Information Access
  - Project 2g: Community Outreach and Resources

Not all CSS and PEI projects identified in the FY 2013-14 MHSA Plan have been fully implemented (due to reasons such as contract development time, competitive procurement processes, and/or MHD staffing levels), but once they are, the array of services throughout the County should expand.

Programs provided through Traditional funding are outside the scope of the MHSA Plan, have significant funding limitations, and frequently provide services to individuals with a lower acuity level. Therefore, mental health services provided through Traditional funding are, and will remain, limited in service locations.

Stigma Reduction

The stigma of mental illness is prevalent throughout society, regardless of age, race, religion or other identifiable groups. In FY 2013-14, a proposed PEI program specifically to address stigma reduction was unable to be funded. That continues to be the case in FY 2014-15. However, within each PEI project, one of the required elements is stigma and discrimination reduction, and it is a specific activity under PEI Project 2e: Suicide Prevention and Stigma Reduction.

In FY 2013-14, the Community Resource Center was awarded a grant through the Statewide California Mental Health Services Authority (CalMHSA) Stigma and Discrimination Reduction

program to host community dialogue events centering around the documentary "A New State of Mind: Ending the Stigma of Mental Illness." Community events such as these, outreach opportunities, and PEI programs encourage individuals to talk about the importance of mental health. MHSA programs themselves cannot make a change – it takes the people in a community to bring about a change in perception.

But sometimes, it also takes a change in the vocabulary to bring about change. "Mental illness" or "mental health" have historically negative connotations and perhaps the focus should be on "behavioral health", "mental wellness" or other words or phrases that aren't already tainted by negative stereotypes. Any words or phrases used when talking about mental health need to support the message that seeking treatment for mental health is a positive action for one's self and one's family, that when a person is diagnosed with mental illness it is a medical diagnosis and does not define who the individual is, and that mental illness is another malady that the human body/mind may experience, similar to diabetes or heart disease. (Programs addressing this concern: All PEI programs, schools, community partners such as NAMI.)

After Crisis Care

After an individual experiences a mental health crisis episode, the follow-up care that may be received is very important to an individual's continued wellness. The MHD has been working on several areas to help individuals receive the care they need. If an individual has private insurance, they will be encouraged to seek treatment through their insurance network. If an individual has Medi-Cal or is uninsured, they will be encouraged to seek treatment either through their primary care physician or through the MHD, depending upon the severity of their illness. There are several options for engaging clients in services through the MHD:

- In-Patient Hospitalizations: In the event an individual needs to be hospitalized due to a psychiatric emergency, the County's Psychiatric Emergency Services staff connect the individual to the appropriate in-patient facility based on the individual's needs and insurance. If an individual has private insurance, their care is turned over to the in-patient facility and insurance network once they are transported to the facility from the hospital. For those on Medi-Cal or uninsured, they are admitted to the in-County Psychiatric Health Facility (PHF), where discharge planning begins at admission. The MHD has refined its discharge planning process to ensure that clients discharged from the PHF are engaged in out-patient services, which may include scheduling out-patient appointments and follow-up telephone calls from out-patient staff. However, it is important to remember that once an individual is discharged from the PHF, absent any other court-ordered mental health services, an individual has the right to decline to participate in mental health treatment.

- CIT Outreach and Follow-Up: The El Dorado County Sheriff's Office maintains a CIT team, the members of which receive CIT training and specialize in working with individuals who may have law enforcement interaction and a mental illness. Through a grant received by the Sheriff's Office, CIT staff perform post-crisis follow-up with individuals who experience a mental health crisis episode which results in a law enforcement response. Additionally, the CIT multi-disciplinary team is a partnership of County departments, such as the Sheriff's Office and the MHD, where the mental health needs of consumers in our community can be addressed.

(Programs addressing this concern: CSS Project 4a: Outreach and Engagement Services; WET Program 7: Crisis Intervention Team Training.)

Dual Diagnosis/Co-Occurring Disorders

The MHD is expanding its services for individuals with both mental health and substance abuse issues. The HHSA Alcohol and Drug Programs (ADP) are now part of the MHD and staff are co-located with Mental Health staff. New co-occurring disorder groups have been started, at both the outpatient clinics and the PHF. Challenges in communication between the programs do exist due to HIPAA requirements that each program (Alcohol and Drug Programs and Mental Health) maintain a high level of confidentiality, but the MHD is exploring how we can work toward becoming more integrated in service delivery. (Programs addressing this concern: ADP programs; CSS Project 2a: Wellness Centers; CSS Project 3a: TAY Engagement, Wellness and Recovery Services.)

Services Provided on School Sites

With the realignment of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) funding from Mental Health to the schools through the 2011-12 Budget Act, a significant shift in funding for school-based mental health services occurred. All educationally-related mental health services are now provided through the schools, either directly by school employees or through the use of contracted providers.[50]

However, there continues to be concern expressed within the community that more resources are needed to address the mental health needs of our youth. MHSA cannot provide all mental health services for children, youth and families in our County, but some supportive services can be provided. Children/youth meeting the criteria for educationally-related mental health services, or other school-based programs funded through the schools, will continue to be provided with those services through the educational system. Children/youth meeting the criteria for specialty mental health services continue to receive services through traditional funded programs or through CSS funded programs, depending upon the child's needs. WET funding will be assisting education staff to identify early warning signs of mental illness and suicide. PEI funding can be utilized for prevention and early intervention activities.

Proposals for a new PEI program for school-aged youth (middle and high school ages) were submitted, and this FY 2014-15 MHSA Plan includes a new program to provide a school-based program for youth. Please see the PEI section under Part 4 of this plan, and the new PEI Project 1f: Prevention and Early Intervention for Youth in Schools. In the FY 2013-14 MHSA Plan, of the non-administrative PEI funding, 47% went to programs specifically designed to address the needs of children and families. This percentage has increased in the FY 2014-15 MHSA Plan to 58% with the inclusion of the new Project 1f: Prevention and Early Intervention for Youth in Schools.

(Programs addressing this concern: PEI Project 1d: Primary Intervention Project (PIP); PEI Project 1e: SAMHSA Model Programs; PEI Project 1f: Prevention and Early Intervention for

[50] For more information about this change, please see the California Department of Education's website at http://www.cde.ca.gov/sp/se/ac/mhsfaq.asp.

Youth in Schools; PEI Project 2a: Mental Health First Aid; PEI Project 2e: Suicide Prevention and Stigma Reduction; PEI Project 3a: Wennem Wadati - A Native Path to Healing.)

Parental Involvement

The participants in the community planning process identified the importance of parental involvement in the early identification and treatment of mental health needs of our youth. Parents are an integral part of a child's mental health, and their support of their child, understanding their role in treatment for mental illness related issues, and how they obtain services for their child is of utmost importance. There are times when a parent's actions may contribute to a child's anxiety (e.g., school performance expectations) or trauma (e.g., domestic violence), but in those instances it is hoped that parents can be reached as a part of a child's treatment for those issues.

The new PEI program for school-aged youth includes a parent component. Through this new PEI program, and other existing PEI programs such as Youth Mental Health First Aid, it is hoped that parents will begin to gain a greater understanding in how they can positively contribute to their child's mental wellness and learn the signs of early mental illness. (Programs addressing this concern: PEI Program 1: Youth and Children's Services; PEI Program 2: Community Education Project; PEI Project 1f: Prevention and Early Intervention for Youth in Schools; CSS Program 1: Youth and Family Strengthening Program; CSS Program 3: TAY Engagement, Wellness and Recovery Services.)

Underlying Causes of and Issues Related to Mental Illness

During the community planning process, there was discussion about some of the underlying causes of mental health issues that arise. Whether a mental illness occurs due to a traumatic event, bullying, peer/family pressure, biological basis, poverty, or any other number of risk factors, early identification of a potential mental illness and treatment for those concerns is important. But it is also important to recognize the cause(s) of a mental illness and address the underlying causes, not just the symptoms. When those causes can be addressed directly, either through public campaigns (e.g., stigma and discrimination reduction), groups (e.g., peer support), classes (e.g., stress management), or other methods, those underlying causes need to be addressed. For example, when an individual is diagnosed with a heart disease, the doctors do not just address the patient's symptoms, rather they encourage lifestyle change and depending upon the cause, larger campaigns may be started to address the issue, such as national smoking cessation campaigns or nutrition campaigns to address obesity. We need to explore these underlying causes for those who have been diagnosed with a mental illness as well and identify potential family or community causes that can be addressed. (Programs addressing this concern: PEI programs, especially those with an educational component.)

Getting the Word out About Programs and Resources

Concern continues to be expressed regarding how to get the word out about the available mental health services. There are many different reference guides available within El Dorado County, generally published through community-based organizations, coalitions and/or collaboratives. In FY 2014-15, the MHD will continue to expand its outreach efforts to distribute brochures and its resource guide developed through the Training, Technical Assistance and Capacity Building (TTACB) program (TTACB is no longer funded through State

MHSA). (Programs addressing this concern: PEI Project 2g: Community Outreach and Resources; PEI Project 5a: Community-Based Mental Health Service; PEI Project 5b: Community Health Outreach Worker; CSS Project 4a: Outreach and Engagement Services.)

Training / Education / Staff Development

Participants in the community planning process expressed the need for more educational opportunities, including training/education for parents, new parents, students, teachers, shelter volunteers, schools, law enforcement, health care providers, emergency room staff, and business owners. These educational opportunities could occur through the schools, at libraries, at scheduled training events, on schools' professional development days, and should include follow-up check-in/refresher training. Topics may include items such as, but not limited to, how to access services, diagnosis, treatments, medications, and/or co-occurring disorders. This training expands beyond those working in the public mental health system to general community awareness and understanding, and thus these educational opportunities would be presented through PEI (training for those in the public mental health system is provided through the WET component).

The majority of the general community education services occur through the PEI Program 2: Community Education Project. However, as was pointed out during the community planning process, attendance at mental health-related educational opportunities is often low. Similar to the messaging within stigma reduction, key to the success of encouraging attendance at mental health events is perhaps changing the message. For example, for parents of high school students, the event title may not be "Mental Health and Your Child", but rather "Helping Your Child Succeed", or for older adults the event title may be "Helping Your Family, Friends and Yourself". (Programs addressing this concern: PEI Program 2: Community Education Project; schools, community partners such as NAMI.)

Additional educational opportunities are available through other PEI programs, but may be of a more focused nature. For example, Project 1e: SAMHSA Model Programs is aimed at a school setting, and for school personnel, there are two WET programs designed to improve understanding of early indicators of mental health and suicide prevention.

(Programs addressing this concern: All PEI programs, especially PEI Program 2: Community Education Project; WET Program 2: Workforce Development; WET Program 4: Early Indicators of Mental Health Issues; WET Program 5: Suicide Education and Training; WET Program 7: Crisis Intervention Team Training.)

Services for Those with Mild to Moderate Mental Illness

Those with private insurance have mental health services included in their health care plans, and if not, their insurance should soon be modifying its benefits to comply with the Mental Health Parity and Addiction Equity Act, as amended.[51]

One of the challenges faced by those with Medi-Cal has been how to obtain mental health services for mild to moderate mental illness. In December 2013, the California DHCS issued

[51] For more information about the Mental Health Parity and Addiction Equity Act, see http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html.

an all-county letter delineating the responsibilities of Medi-Cal managed care plans regarding provision of mental health services.[52] Under this new requirement, Medi-Cal managed care plans must provide medically necessary outpatient mental health services to adults and children diagnosed with a mental health disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) that results in mild to moderate distress or impairment of mental, emotional, or behavioral functioning. Arrangements for these services should be made through the primary care physician or the managed care plan directly (for El Dorado County, those are Anthem Blue Cross and California Health and Wellness). Specialty mental health services continue to be provided through County Mental Health Departments/Divisions.

This issue also exists for those who are uninsured, however the barrier most often faced by this group is lack of funding to pay for mental health services. This continues to be a challenging area, but with the implementation of the Affordable Care Act, it would be anticipated that there are fewer uninsured individuals facing this challenge.

Some early intervention services are provided through PEI projects, however the PEI cannot provide the full range of services for those with a mild to moderate mental illness. Therefore, individuals with mild to moderate mental illness should first speak with their primary care physicians, and if they meet eligibility for one or more of the PEI early intervention programs, they may receive some services through those programs. However, MHSA is not designed to replace other available resources that may exist.

(Programs addressing this concern: primary health care providers; PEI early intervention projects.)

Middle and High School Aged Youth

Please see the discussion above under "Services Provided on School Sites" and below under "School-Based Mental Health Services".

Transitional Age Youth (TAY)

Staff from both outpatient clinics have been engaging transitional age youth in services, including individual therapy, psychiatry, groups, and development of independent living skills. Services for TAY are also provided at the alternative high school in South Lake Tahoe in collaboration with ADP staff. Youth emerging from the juvenile justice system are also being engaged in the TAY program, and discussions are occurring to explore how greater collaboration between schools and Child Welfare Services may enhance the services provided and encourage continued engagement in services. Additionally, the West Slope outpatient clinic has been working with an intern from Folsom Lake College–El Dorado Center to engage the TAY population at the college level and in the community. (Programs addressing this concern: CSS Project 3a: TAY Engagement, Wellness and Recovery Services.)

[52] Department of Health Care Services, *Medi-Cal Managed Care Plan Responsibilities for Outpatient Mental Health Services*, All-County Letter 13-021. December 13, 2013. http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2013/APL13-021.pdf

Older Adults

Several challenges were identified for older adults experiencing a mental health need. First and foremost, is the stigma associated with mental illness that older adults face, not only due to their own beliefs about mental illness, but also stigma from their peers. However, there are other barriers to service that this age group face, including not knowing how to access services, lack of or cost of transportation, cost of services and lack of Medicare providers. Older adults are frequently willing to go to primary care physicians for health care, and through those offices, the issue of mental health may more comfortably be raised. One CSS and two PEI projects have been developed specifically for older adults. While the stigma associated with mental health may be difficult to change within this generation, it is hoped that through these MHSA projects, and improved relationships with primary care physicians and the MHD, that the needs of older adults will begin to be addressed by removing barriers to service. (Programs addressing this concern: PEI Project 4b: Senior Peer Counseling; PEI Project 4c: Older Adult Program; CSS Project 2c: Older Adults Program.)

Homeless

HHSA has developed a strong working relationship with homeless advocates and law enforcement in El Dorado County. HHSA is a member of a work group to address homeless issues in the County, and the MHD has participated in outreach activities to the homeless populations, is a regular attendee of the Crisis Intervention Team Multi-Disciplinary Team, and has scheduled inreach events for homeless individuals/families ("inreach" occurs when staff are placed in a site frequented by homeless people, such as a shelter or community resource center, and direct, face-to-face interactions occur at that site).

As discussed above, the PATH grant provides outreach, linkage to services and benefits, and housing assistance for individuals who are homeless or soon to be homeless and have a mental health issue. If awarded, approximately $25,000 will be available for staffing (there are required matching funds as well), along with limited housing assistance and administrative funding. This grant will be contracted to a community-based organization through a competitive procurement process (RFP).

It is recognized that stable housing is beneficial to the treatment of mental health services. As discussed under the Housing section above, the MHD is increasing efforts to obtain affordable housing for FSP clients, and this would include those transitioning from homelessness to stable housing. However, one of the key successes of this transition is having a regular monthly income to continue to be able to afford housing costs, and through the PATH grant and FSP services, it is hoped that more individuals eligible for SSI will be able to obtain those benefits to assist with the cost of housing.

(Programs addressing this concern: CSS Project 2b: Adult Full Service Partnership; CSS Future Potential Project 2d: Assisted Outpatient Treatment; CSS Project 3a: TAY Engagement, Wellness and Recovery Services; CSS Project 4a: Outreach and Engagement Services.)

Proposals Received

There were several direct proposals for new programs submitted during the community planning process:

- **School-Based Mental Health Services:** Three proposals were received for school-based PEI services. The proposals encouraged inclusion of a PEI project to provide services on school campuses for youth at risk for or experiencing mild to moderate mental health issues. The purposes of the proposals were to provide additional services and supports for students who may have mild to moderate mental health needs (under PEI) and provide a higher level of services for those who may have more serious mental health needs (under CSS). These youth would be identified and referred (or self-referred) to the project for school-based prevention and early intervention services, including education, action planning, groups, short-term individual and/or family counseling, case management, and as needed referred to private insurance, County MHD, emergency personnel, and/or others for more serious issues.

  Youth face many issues that are risk factors for mental illness, including the peer/family pressure, bullying, trauma, use of alcohol and/or other drugs, witnessing domestic violence, parental abandonment, suicidal ideation, involvement in the juvenile justice system, poverty, and child abuse or neglect. Although most middle and high schools have school counselors, many students may not seek services or the counselors have a very high case load and are unable to provide mental health services or address the complex nature of some of the mental health issues that arise. At current staffing levels, school teachers, counselors and administrators are unable to address all counseling needs of the student populations.

  The three proposals were incorporated into one new PEI project called "PEI Project 1f: Prevention and Early Intervention for Youth in Schools." The new PEI project will be highly coordinated for maximum impact and effectiveness, thus connecting students and families with the appropriate level of services and interventions as efficient and seamless as possible, and it will link with a current CSS project (CSS Project 1b: Family Strengthening Academy). There will be a strong focus on case management and community connectedness, designed to promote academic success and personal growth through addressing social, emotional or behavioral problems. Services provided through this PEI project and its linked CSS project will provide students and their families with a continuity of services.

  This program does not negate the importance of parental involvement in their child's mental health needs, whether those needs are addressed on a school campus, through their primary care physician or through a specialty mental health service (through private pay, an insurance network, or Medi-Cal). Therefore, parent involvement will be a key component of the PEI program.

  The new project (PEI Project 1f: Prevention and Early Intervention for Youth in Schools) is funded at $75,000 for FY 2014-15 and $100,000 for FY 2015-16 and FY 2016-17, and will be awarded through a competitive procurement process to one vendor Countywide. For a full description of the new project and how it links with CSS Project 1B: Family Strengthening Academy, please see the full project description in Part 4 of this Plan.

- **CASA:** A proposal was received for funding for CASA to help ensure that all children in the Child Welfare System who are receiving mental health services through CSS

Project 1c (Foster Care Enhanced Services) have an assigned CASA. Research indicates that children in the Child Welfare System who are assigned a CASA spend less time in foster care and are less likely to return to foster care. Approximately 85% to 90% of the children enrolled in Project 1c: Foster Care Enhanced Services have an assigned CASA.

This proposal is included in the CSS Project 1c: Foster Care Enhanced Services at approximately $20,000 annually as a sole source contract to CASA, providing the provision of such funding is not determined in conflict with the roles of an agency providing the children with services and CASA.

- **Mental Health Professionals Stationed on the Divide:** A proposal was submitted to have a mental health professional stationed on the Divide on a regular schedule to provide services to adults and older adults, as well as outreach, engagement and educational services. One of the challenges on the Divide, and many other outlying areas within El Dorado County, is lack of public transportation that is needed to access centrally located services. Historically, this has made it difficult, if not impossible, for clients of the MHD to travel to the central services areas. Additionally, there are other factors affecting travel between the central service areas and the outlying areas, including cost of private transportation and weather-related limitations (i.e., snow).

  This proposal is included in the CSS Project 4b: Community-Based Mental Health Services, which is the project designed for these types of services and originally included in the FY 2013-14 MHSA Plan. Successful implementation of this project depends upon many factors, including sufficient staffing levels to be able to have staff stationed on the Divide on a regular schedule, consolidation of consumers who live on the Divide to a single case manager, the identification of an appropriate location from which these services can be provided, and a sufficient number of clients to warrant a regular schedule. These issues will be researched in FY 2014-15 and if determined feasible, implemented as appropriate based on the outcomes of the research.

  CSS Project 4b: Community-Based Mental Health Services also applies to other outlying areas of the County, with similar considerations to be researched to determine viability of each proposed location.

  No changes to CSS Project 4b: Community-Based Mental Health Services are required as a result of this proposal.

- **Wellness Workers:** A proposal was submitted for "Wellness Workers" to assist the public with navigation of the mental health system, education, conducting support groups and activities, creating an awareness of mental wellness and assistance identifying resources.

  Insufficient funding exists to develop an entirely new Wellness Worker project under either CSS or PEI, however these type of services are included under several MHSA projects:

  - PEI Project 2g: Community Outreach and Resources: Provide printed information related to mental health, services and supports available, reference materials and resources.

- PEI Project 2d: Community Information Access: Provide a free, web-based community education and information resource center for consumers of mental health services, family members and community stakeholders.
- PEI Project 3a: Wennem Wadati - A Native Path to Healing: Uses various outreach, prevention and early intervention strategies to address all age groups in the Native American community.
- PEI Project 3b: Latino Outreach: Using a Promotora model of outreach and engagement to Spanish-speaking or limited English-speaking Latino community members that utilizes non-professional Latino peers to provide community-based outreach and engagement to the various geographically-spread communities.
- PEI Project 5a: Community-Based Mental Health Services: The MHD staff will provide outreach, mental health awareness, resources, linkage and education to local communities to increase the dialogue about mental wellness.
- PEI Project 5b: Community Health Outreach Worker: Provides a point of contact for general mental health information coordination and community resources.
- CSS Project 4a: Outreach and Engagement Services: To engage individuals with a serious mental illness in mental health services and to continue to keep clients engaged in services by addressing barriers to service. This project includes outreach to various populations, such as those who are homeless.

No changes to the PEI or CSS projects are needed to implement this proposal, however, in FY 2014-15, an increased focus will be placed on education, outreach and engagement, raising awareness about available services, and coordination between the various projects that have an outreach component.

- **Needs Assessment:** A proposal was submitted to develop a community mental wellness assessment for adults and older adults utilizing the services matrix under development by the MHD, with particular attention to transportation and housing. This proposal contains elements of CSS, PEI and WET.

  CSS: Housing and transportation issues are included under CSS. Please see the discussion about relating to both these topics and what steps are being taken to address the needs of consumers.

  PEI: Through the PEI Project 2g: Community Outreach and Resources, the resource list (under development in FY 2013-14 through the PEI-TTACB program) will continue to be maintained, updated and published for public access. This list will strive to identify resources in all regions of the County. Where gaps are identified and those gaps are related to mental health issues, the MHSA team will continue to work to identify how those gaps can be filled through MHSA projects.

  WET: The MHD will be performing a workforce needs assessment, which will capture staffing and service needs within our County. This will be cross-referenced with the known available resources to determine where gaps in service may exist.

  No changes to the CSS, PEI or WET projects are needed to implement this proposal.

- **Transportation Assistance:** Please see the section above related to Transportation. Transportation in the outlying areas of the County continues to be a challenge. Local transit providers do not have regular routes scheduled to outlying areas, such as the Divide or El Dorado Hills, and those with a serious mental illness frequently do not drive. These services will be funded through the Medi-Cal providers directly (Anthem Blue Cross and California Health and Wellness) and through CSS Project 4a (Outreach and Engagement).

- **Family Liaison:** A proposal was received to have an individual within the MHD identified as the Family Liaison whose responsibilities would include working with the families to explain the processes involved with mental health services (in-patient and out-patient as appropriate), HIPAA requirements, and client-specific information to extent allowed by law.

  When an individual experiences a crisis episode or is being treated for a severe mental illness, the family frequently provides a high level of support to the consumer. However, when a family member has questions, they often do not know who to contact or are unable to receive the information they are requesting. By having an family liaison within the MHD, family members will have a designated point person for requesting assistance.

  These services will be funded through CSS Project 4a (Outreach and Engagement) and the project description has been updated to reflect the role of the "family liaison". Successful implementation of this project depends upon many factors, including sufficient staffing levels to be able to have an assigned staff member fill this role and available funding.

Notification of the Draft FY 2014-15 MHSA Plan

HHSA provided notification of the Draft FY 2014-15 Plan publication as follows:

- **FY 2014-15 Plan 30-Day Comment Period:** The Draft FY 2014-15 MHSA Plan was posted on the County's website on June 9, 2014 for a 30-day review period. Emails were sent on June 9, 2014 to the MHSA distribution list, the Mental Health Commission members, the Chief Administrative Office (CAO), the Board of Supervisors' offices, and the HHSA staff advising recipients that the Draft FY 2014-15 MHSA Plan was posted and available for public comment for 30 days. A press release was distributed on June 10, 2014, to the Tahoe Daily Tribune, Mountain Democrat, Georgetown Gazette, Sacramento Bee, Life Newspaper (Village Life) and El Dorado Hills Telegraph.

- **FY 2014-15 Plan Public Hearing:** The Mental Health Commission held a public hearing on July 16, 2014 at 5:30 p.m. The hearing was noticed on the Mental Health Commission's web page (www.edcgov.us/MentalHealth/Mental_Health_Commission_Meetings.aspx), the MHSA web page (www.edcgov.us/mentalhealth/mhsa.aspx), and sent out to the individuals on the MHSA email distribution list. If you wish to join the MHSA email distribution list, please send an email to MHSA@edcgov.us with the subject of "Subscribe".

- **El Dorado County Board of Supervisors:** This Plan will be presented to the El Dorado County Board of Supervisors for adoption on August 26, 2014. Notification of the date was posted on the MHSA web page[53] and included on the Board of Supervisors agenda.
- **California Mental Health Services Oversight and Accountability Commission (MHSOAC):** Within 30 days of the Board of Supervisors' approval of the FY 2014-15 MHSA Plan, a copy of the Plan will be provided to the MHSOAC as required by the MHSA.

Substantive Comments/Recommendations

Substantive comments received during the comment period and public hearing process, responses to those comments, and a description of any substantive changes made to the MHSA Plan are summarized below:

General	
1.	*Note:* Throughout the document, references to the Plan Update being a "draft" or projects being "proposed" have been changed to reflect their status after adoption of the Plan Update. Other grammatical and non-substantive wording issues have been corrected.
2.	*Comment:* Some individuals don't have internet access and therefore cannot access information online. It would be helpful to mental health information, calendars of events, etc. in coffee shops and other public venues.
	Response: Thank you for this input. We are striving to make information more accessible to the community, and will add coffee shops and other public venues to the list of potential access points. Other locations identified in the community planning process identified: libraries, doctor offices, grocery stores, central information points, community service districts, chambers of commerce, service organizations, schools, churches, community resource center, social media, wellness events, and teen centers.

[53] http://www.edcgov.us/MentalHealth/MHSA.aspx.

3.	*Comment:* It is recommended that the MHSA staff consider meeting needs in population centers such as El Dorado Hills, Cameron Park, and portions of Rescue that have been expressly communicated by members of the public at Mental Health Commission Meetings and local community input meetings, especially related to PEI programs. It is recommended that higher population centers be a priority for services.
	Response: The FY 2014-15 Three-Year Plan Update includes services for residents who may meet project criteria, including residents in El Dorado Hills, Cameron Park, Rescue and all other areas of the County. MHSA does not fund projects based on County-wide population dispersal rates. MHSA projects are based upon participation eligibility. Residents of El Dorado County may access services through projects in which they meet eligibility criteria. Where the services are delivered for eligible participants depends upon the project. Where projects are limited in service delivery, those limitations result from: • equipment/facility requirements (e.g., Wellness Centers in South Lake Tahoe and Diamond Springs); • limited service delivery area by slope vetted during the community planning process (e.g., Senior Peer Counseling on the west slope only); • public demand (e.g., Mental Health First Aid); or • results of a competitive procurement process (e.g., PIP only in certain schools in the El Dorado Hills area, the Georgetown Divide area, and South Lake Tahoe).
Proposals Received	
4.	*Comment:* Regarding the Mental Health Professionals Stationed on the Divide proposal, the response is not specific about a worker for the Divide area. Does it mean the proposal can be implemented when staff/clients are identified? Are there plans to identify people on the Divide? Why not have one worker to travel to the various outlying districts of the County?
	Response: Successful implementation of this project depends upon many factors, including sufficient staffing levels to be able to have staff stationed on the Divide on a regular schedule, consolidation of consumers who live on the Divide to a single case manager, the identification of an appropriate location from which these services can be provided, and a sufficient number of clients to warrant a regular schedule. The goal would be to have a single clinician serving the Divide area, or other areas of the County. However, at this time, clients from the Divide area are assigned to various clinicians and it would not be cost effective or achieve the proposal goals to have different clinicians rotate to the Divide. The most effective solution would be that clients on the Divide are assigned to a single clinician. However, there are reasons why an individual may wish to remain with his/her current clinician or why it may not be beneficial to a client's treatment plan to change clinicians with whom a client has an established relationship. If these factors are determined feasible, then further exploration is needed regarding issues such as location, frequency, and appropriate staffing levels.

MHSA Funding	
5.	*Comment:* How can the MHSA revenues change from month to month without the Mental Health Division knowing how much will be received?
	Response: When MHSA Plans had to be approved by the State (prior to FY 2012-13), the State provided each county with total annual revenue allocations, but not how much would be received each month. Starting in FY 2012-13, the State no longer approves all MHSA Plans nor provides the counties with the annual allocations. Rather, the State is required to disburse monthly to the counties all funds in the State's Mental Health Fund (received as MHSA tax revenues). El Dorado County receives 0.406698% of the funding in the State's Mental Health Fund, but since the State's tax revenues vary from month-to-month the County does not know how much the MHSA revenues will be each month (or annually) until they are received. Therefore, the budget for the MHSA is based upon anticipated revenues and are reconciled after the close of the fiscal year.
6.	*Comment:* If funding levels drop lower than anticipated in FY 2014-15, will project funding be cut?
	Response: The County does not anticipate lower than expected funding levels in FY 2014-15, however the total amount of MHSA funding received will not be known until the end of FY 2014-15. As discussed in Part 3 under "MHSA Funding", fund balance will be utilized to the extent possible. However the Plan has been clarified to also allow for a reduction in services if the revenues are too low. If such a circumstance were to arise, the public would be engaged in discussions about this issue.
7.	*Comment:* The funding percentages for various populations and geographic locations under PEI do not add up to 100%.
	Response: Thank you for this correction. The percentages have been updated to reflect: **Population Served** — **% of MHSA PEI Funding** Children (from birth through age 18) or children and their families ..... 58% Older adults (age 60+) ..... 6% All adults (age 18+; includes older adults)[54] ..... 9% Health disparities, which include services for children, adults and families ..... 19% Education programs ..... 10% Community-based programs ..... 4% **Geographic Locations** — **% of MHSA PEI Funding** Various locations throughout the County ..... 29% Specific locations due to competitive procurement process ..... 37% Specific locations due to facility/equipment needs ..... 16% Schools, internet access, newspaper distribution or other posted materials 18%

[54] Due to the inclusion of older adults along with adults, the total percentage adds up to 106%.

8.	*Comment:* Only 6% of the total funding is dedicated to Prevention and Early Intervention programs. Why is that?
	Response: The reason <u>new</u> PEI revenues are only about 6% of the total available MHSA funding because there are large fund balance in CSS (as well as fund balances in the other components). Total PEI funding comes from two sources: 1) Fund Balance - unspent funds from previous years. The MHD has been working, and will continue to work, to reduce the fund balance. 2) New Annual Revenues - these are the new funds the MHD receives each year for MHSA from the State. Details about the MHSA budget are provided in the section "MHSA Funding", below. Total available PEI funding in FY 2014-15 is anticipated to be $2,695,760, of which $1,251,689 is anticipated new revenues (equal to 19% of the total anticipated new revenues) and $1,444,071 is the estimated fund balance (revenues left over at the end of FY 2013-14). As new MHSA funds are received, they are allocated at the following percentages as required by the Mental Health Services Act: • net 76% to CSS • net 19% to PEI • net 5% to Innovation However, since there are fund balances in all components, the total amount of available funding is higher than just the annual revenues. MHSA does not allow us to pool the fund balances and re-allocate them per the above percentages. Because fund balances remain from prior fiscal years, the total funding available by component is:

Component	Total Funding	Percent of Total
PEI	$2,695,760	16%
CSS	$12,163,626	71%
Innovation[55]	$1,648,033	10%
WET	$186,437	1%
CFTN	$428,398	3%
Total	$17,122,254	100%

[55] Subject to any potential reversion.

PEI – General	
9.	*Comment:* PEI funding is mandated at 19% of the MHSA revenues, but is there mandate as to the age levels served?
	Response: Yes (for medium and large counties) and no (for small counties, which are those with a population under 200,000). The 2008 PEI guidelines state: "Counties should develop PEI projects and select programs based on the requirements that PEI county components must reflect programs that address all age groups and a minimum of 51 percent of their overall PEI component budget must be dedicated to individuals who are between the ages of 0 to 25. Small counties are excluded from the requirements to address all age groups and dedicate a minimum of 51 percent of their overall PEI component budget to individuals who are between the ages of 0 and 25." El Dorado County is a small county, so MHSA does not mandate any specific amount be dedicated to certain age groups. Therefore, the PEI programs are guided by the input received through the community planning process, from which there has been strong support for PEI programs to address the needs of children, transitional aged youth, and older adults.
10.	*Comment:* Does the Mental Health Division have hard copies of the MHSA Plan for those without internet access?
	Response: Yes, copies of the Draft FY 2014-15 MHSA Plan Update were placed in the lobbies of the Mental Health Out-Patient Clinics during the week of 6/16/14 for viewing onsite. Additionally, individuals may request a copy of the Plan, or a copy of specific sections of the plan, by calling (530) 621-6315 or in person at one of the Mental Health Out-Patient Clinics. The MHSA Plans are printed on an as-requested basis and there may be a short wait while the MHSA Plan is being printed.
PEI – 1c: Parenting Skills (previously Incredible Years)	
11.	*Comment:* Will the current contract for Incredible Years programs cease when the FY 2014-15 MHSA Plan Update is adopted?
	Response: No. The current contract will remain in effect until it can be amended to reflect the new project criteria. The project description has been updated to reflect this information.
PEI – 1d: Primary Intervention Program (PIP)	
12.	*Comment:* The "Budget" section for the PIP project description states "Up to $106,350 through December 31, 2014 (current contracts)." The total of the calendar year contracts for PIP is actually $212,700.
	Response: Thank you for this correction. The text has been updated to reflect "Up to $212,700 through December 31, 2014 (current contracts for calendar year 2014)."

13.	*Comment:* Recommended to allow PIP funds to be able to be used at sites beginning in the fall of 2014 (October 2014), rather than delaying until January 2015, so that services are not interrupted.
	Response: In calendar year 2014, $212,700 was allocated to PIP to provide two semesters of services, which equals approximately $106,350 per semester (although providers are not held to that amount each semester as there may be higher start-up costs or participation rates in one semester or the other). The PIP project is being extended through June 30, 2015 at the same level. The funding is based on providing services during two semesters annually, and it would be anticipated that a school semester ends in the December timeframe. Therefore, the contracts for PIP services for the extended project period will be established to begin services at the end of the fall 2014 semester.
PEI – 1f: Prevention and Early Intervention for Youth in Schools	
14.	*Comment:* School counselors would be able to implement the case management services and other PEI services required in this project. If the school counselor is licensed, they may also be able to provide the direct treatment interventions. According to the American School Counselor Association and American Counseling Association, school counselors are qualified to provide school-based individual and group counseling as well as crisis intervention conflict management, etc. Not only is a school counselor qualified to provide the appropriate level of intervention for this program, but a school counselor is also trained in home-school relations and can navigate the school system as a whole, including facilitating Individualized Education Program (IEP) meetings as well as Student Study Teams (SST). With the purpose of both of these meetings to bring the student and family, teachers and administrators together to devise a plan as to what appropriate level of intervention is suitable for that particular student. I understand that this is not a school counseling program, nor am I requesting for it to be, I am merely suggesting that the education and training a school counselor receives, leaves them qualified to provide the intervention services in the proposed PEI program.
	Response: A review of the requirements for a credentialed School Counselors indicates that the training and services required for that position would allow those individuals to provide the necessary services and case management services for the PEI portion of this project. The project description has been updated to include credentialed School Counselors. However, for the CSS linkage portion of this project (with the Family Strengthening Academy), those services must be performed by individuals eligible to provide billable Medi-Cal services. The requirements for Medi-Cal are too extensive to list within this document, and referral is made to the Medi-Cal regulations for more detail.

PEI – 2e: Suicide Prevention and Stigma Reduction Project	
15.	*Note:* On June 9, 2014, the MHSOAC released the Proposed Prevention and Early Intervention Regulations for a 45-day comment period ending July 24, 2014. The majority of the proposed changes have not been incorporated into the FY 2014-15 MHSA Plan Update because the regulations are not yet final. However, one of the requirements in the proposed PEI regulations has been directly incorporated into PEI Project 2e: Suicide Prevention and Stigma Reduction. The new PEI regulations, if passed as currently written, require suicide prevention projects to utilize a "validated method to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness that are applicable to the specific program/approach." (Section 3750(f).) Since the RFP for the Suicide Prevention and Stigma Reduction project has not been issued yet, and changing an evaluation method mid-project would be difficult, the project has been changed as follows: Measurement 3: This project shall use a validated method to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness that are applicable to the specific prevention program/approach implemented.
PEI – 4c: Older Adult Program	
16.	*Comment:* I would recommend having transportation costs included in this program. This would help to ensure older adults are able to get to their appointments, their isolation would be decreased, and they are more able to connect with medical professionals. If people cannot access the services, the prevention efforts cannot begin. Transportation is critical to prevention and early intervention of mental health issues.
	Response: Transportation was identified by individuals who completed the Older Adults Survey as part of the FY 2013-14 MHSA Plan as the main barrier to service. Transportation assistance, as available, will be included in the project description for this project.

CSS – Budget

17. *Comment:* The Mental Health Commission is concerned for the level of spending anticipated within CSS over the next three years. While CSS projects are valuable in the treatment of mental illness, the cost of the projects has increased since the FY 2013-14 MHSA Plan. Therefore, the Mental Health Commission is submitting a proposal to reduce the costs of the CSS projects minimally in FY 2014-15 and more substantially in future fiscal years and would like to explore the projects in more detail to determine appropriate funding levels in FY 2015-16 and thereafter.

	FY 2014-15	FY 2015-16	FY 2016-17
Available Revenue	**$12,163,626**	**$9,257,164**	**$6,759,605**
Program 1: Youth and Family Strengthening Program			
Project 1a: Youth and Family Full Service Partnership	$425,000	$430,000	$430,000
Project 1b: Family Strengthening Academy	$100,000	$52,000	$52,000
Project 1c: Foster Care Enhanced Services	$825,766	$827,969	$827,969
Program 2: Wellness and Recovery Services			
Project 2a: Wellness Centers	$2,100,000	$2,205,000	$2,205,000
Project 2b: Adult Full Service Partnership	$3,846,189	$3,202,500	$3,202,500
Project 2c: Older Adults Program (Partner program to PEI Older Adults Program)	$50,500	$50,500	$50,500
Program 3: Transitional Age Youth (TAY) Services			
Project 3a: TAY Engagement, Wellness and Recovery Services	$350,000	$367,500	$367,500
Program 4: Community System of Care			
Project 4a: Outreach and Engagement Services	$1,076,567	$840,000	$840,000
Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)	$150,000	$157,500	$157,500
Project 4c: Resource Management Services	$175,000	$183,750	$183,750
Administrative Costs			
Per Department of Mental Health Information Notice 10-01	$208,425	$215,010	$215,010
Total CSS Program Expenditures	$9,307,447	$8,531,729	$8,531,729
Reallocation to WET	$35,361	$166,000	$156,000
Reallocation to CFTN	$0	$136,176	$232,473
Contribution to the Prudent Reserve	$0	$0	$0
Total Reallocation of CSS	$35,361	$302,176	$388,473
Total CSS Expenditures	**$9,342,808**	**$8,833,905**	**$8,920,202**
Anticipated Year-End Fund Balance	$2,820,818	$423,259	($2,160,597)

Future Potential Project:				
Project 2d: Assisted Outpatient Treatment		$125,000	$225,000	$175,000
Total CSS Expenditures (including Future Potential Project)		**$9,467,808**	**$9,058,905**	**$9,095,202**
Anticipated Year-End Fund Balance (including Future Potential Project)		$2,695,818	$198,259	($2,335,597)

Response: As noted in Part 4 of this Plan under the CSS budget discussion, the Mental Health Division is also concerned about the CSS budget and we appreciate the input from and partnership with the Mental Health Commission. The recommendations of the Mental Health Commission have been incorporated into the CSS budget, with minor modifications after reviewing the Mental Health Division's budget (the budgets for certain projects could not be aligned to match the proposal exactly due to staffing costs, but the total projected CSS expenditures match the Mental Health Commission's proposal). This will continue to allow a full range of CSS services in FY 2014-15, during which time more intensive discussions can occur regarding CSS expenditures. The Mental Health Division will continue to discuss this topic with the public and the Mental Health Commission, and will continue to monitor project budgets and implementation goals.

CSS – 2c: Older Adult Program

18. *Comment:* I would recommend having transportation costs included in this program. This would help to ensure older adults are able to get to their appointments, their isolation would be decreased, and they are more able to connect with medical professionals. If people cannot access the services, the prevention efforts cannot begin. Transportation is critical to prevention and early intervention of mental health issues.

Response: Transportation was identified by individuals who completed the Older Adults Survey as part of the FY 2013-14 MHSA Plan as the main barrier to service. Transportation assistance, as available, will be included in the project description for this project.

CSS – 4a: Outreach and Engagement

19. *Comment:* More outreach with the local Veteran Affairs Department should be done to reach Veterans in our community.

Response: HHSA has been working with the Veteran Affairs Department this past year to develop stronger working relationships between the two Departments. HHSA has identified the areas from which Veterans receive services on a regular basis, such as through Employment Services, and those areas where the request for services from Veterans is minimal. Mental Health is one of the areas that serves very few, if any, Veterans because most Veterans receive mental health services through the Veterans Health Administration (VA).

However, the MHSA staff have been attending the Veteran Affairs Commission meetings to provide updates to the Commission and the Veteran Affairs Department related to services that are available locally to Veterans through MHSA and the Mental Health

	Division (such as Psychiatric Emergency Services). Additionally, the Mental Health First Aid project has been working with the chair of the Veteran Affairs Commission and the Military Family Support Group to schedule trainings, and it is hoped that through additional community outreach in FY 2014-15 more Veterans will become aware of the importance of seeking treatment for mental health concerns. There are two PEI programs that have a specific component for Veterans: Mental Health First Aid and the Community Information Access. The military module for Mental Health First Aid is relatively new and the description for Mental Health First Aid in the Draft Update did not include this new training module. The military module training materials are available and the description of the Mental Health First Aid project has been updated accordingly. Additionally, transportation assistance for Veterans was also identified under CSS Outreach and Engagement in the FY 2013-14 MHSA Plan as a result of the community planning process. The procedures to access that assistance are being drafted.
WET – 4: Early Indicators of Mental Health Issues	
20.	*Comment:* Measurement 4 identifies "Referrals from schools to the MHD". Since the schools are now referring directly to providers through the use of EHRMS funding, it seems a more accurate measurement would be "Referrals from schools to mental health professionals."
	Response: Agreed. Measurement 4 has been updated to reflect "Referrals from schools to mental health professionals."
21.	*Comment:* This program would likely be more effective if a consistent message is provided across the County or district rather than changing the programs from school to school. Should this program be implemented on a wider level, such as County-wide or district-wide rather than school-by-school?
	Response: Agreed. Consistent messaging and education is key to success of this project. The project has been modified to allow for County-wide and district-wide implementation.
WET – 5: Suicide Education and Training	
22.	*Comment:* This program would likely be more effective if a consistent message is provided across the County or district rather than changing the programs from school to school. Should this program be implemented on a wider level, such as County-wide or district-wide rather than school-by-school?
	Response: Agreed. Consistent messaging and education is key to success of this project. The project has been modified to allow for County-wide and district-wide implementation.

Part 3. Program Outcomes and Changes; MHSA Funding

Program Outcomes and Changes

Outcomes for the FY 2012-13 MHSA Plan Update were reported in the FY 2013-14 MHSA Plan, adopted by the Board of Supervisors in December 2013. The full report of outcomes for FY 2013-14 will occur in the FY 2015-16 MHSA Plan. Interim outcome data, as available, is provided below.

Funding level changes and other program changes incorporated into this FY 2014-15 MHSA Plan Update are also identified.

Prevention and Early Intervention (PEI)

Program 1: Youth and Children's Services	
Project 1a: Children 0-5 and Their Families	
Vendor:	Infant-Parent Center
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Contract Amount:	$375,000 through June 30, 2016; program extension through June 30, 2017 will be for an additional $125,000
Service Locations:	Cameron Park, but residents from any part of the County meeting eligibility criteria may participate
Outcomes:	Contract executed March 25, 2014. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Clarification that services are available to anyone meeting eligibility requirements, not just those living on the West Slope. However, eligible participants must be willing to travel to Cameron Park for services. Clarification that children meeting the criteria for specialty mental health are referred to the MHD.
Project 1b: Mentoring for 3-5 Year Olds	
West Slope:	
Vendor:	Big Brothers Big Sisters
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Contract Amount:	$150,000 through June 30, 2016; program extension through June 30, 2017 will be for an additional $50,000
Service Locations:	Various locations on the West Slope based on available facilities and location of volunteers
Outcomes:	The contract was executed effective June 10, 2014. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Clarified service delivery sites are not strictly limited to Ken Lowry Center and Head Start School Sites on the West Slope.

Tahoe Basin:	
Vendor:	To Be Determined
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Project Amount:	$25,000 annually through June 30, 2017
Service Locations:	Various locations in the Tahoe Basin based on available facilities and location of volunteers
Outcomes:	The Request for Proposals has not yet been published. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Clarification that program processes will be similar in the Tahoe Basin and on the West Slope.
Project 1c: Parenting Skills (was previously called "Incredible Years")	
Vendor:	New Morning Youth and Family Services
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Contract Amount:	$150,000* through June 30, 2016; program extension through June 30, 2017 will be for an additional $50,000 *The contract was inadvertently executed with the total not-to-exceed amount of $50,000, which is equal to only one fiscal year of service. The contract will be amended in 2014 to reflect the full three-year funding of $150,000.
Service Locations:	Based on demand in the following locations: North County (e.g., Georgetown Divide, Cool, and surrounding areas); South County (e.g., Grizzly Flats, Somerset, Fairplay, and surrounding areas); West County (e.g., El Dorado Hills, Cameron Park, Rescue, Shingle Springs, and surrounding areas); Mid-County (e.g., Pollock Pines, Camino, and surrounding areas); South Lake Tahoe area (e.g., Meyers, South Lake Tahoe, and surrounding areas); and Placerville area (e.g., Placerville, Diamond Springs, and surrounding areas).
Outcomes:	The contract was executed February 13, 2014. Classes have started in the Placerville area and are being scheduled for other locations. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Expand program to include other evidence-based parenting programs, such as Parent Project, and allow for the adjustment of these programs so that they can be offered in condensed periods of time. Modify payment method to be based upon participant attendance rather than an hourly rate per facilitator. It is anticipated the same number of individuals will receive services. Classes will continue to be required in the six regions of the County, one in each region per calendar year. In the event demand for a class in a region is lower than necessary to host a class in that region, the service provider may request hosting one additional class in a high-demand region within a one year time frame. The current contract with New Morning Youth and Family Services reflecting the scope of the Incredible Years project will

	remain active until the new contract reflecting the revised contract amount and scope and compensation format of the Parenting Skills project is executed. The vendor for this project was selected through a competitive procurement process in FY 2013-14.
Project 1d: Primary Intervention Project (PIP)	
Vendor:	Black Oak Mine Unified School District
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Contract Amount:	$61,478 through December 31, 2014; increase FY 2014-15 by $30,739 and add $61,478 for FY 2015-16
Service Locations:	Black Oak Mine Unified School District
Outcomes:	Contract was executed on February 13, 2014 and the project has started within the schools. Outcomes will be reported in the FY 2015-16 MHSA Plan.
Vendor:	El Dorado Hills Community Vision
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Contract Amount:	$63,236 through December 31, 2014; increase FY 2014-15 by $31,618 and add $63,236 for FY 2015-16
Service Locations:	Buckeye Unified School District
Outcomes:	Contract was executed on February 13, 2014 and the project has started within the schools. Outcomes will be reported in the FY 2015-16 MHSA Plan.
Vendor:	Tahoe Youth and Family Services
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Contract Amount:	$87,986 through December 31, 2014; increase FY 2014-15 by $43,993 and add $87,986 for FY 2015-16
Service Locations:	Lake Tahoe Unified School District
Outcomes:	Contract was executed on February 20, 2014 and the project has started within the schools. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Increase expenditures by $319,050 to extend program through June 30, 2016, and adjust contract amounts based on current percent of total budget (amounts noted above, equal to 28.9% to Black Oak Mine Unified School District, 29.7% to El Dorado Hills Community Vision, and 41.4% to Tahoe Youth and Family Services). No new RFP will be issued; current contracts will be extended if vendor wishes to continue to provide services. Clarification that the contracts for PIP services for the extended project period will be established to begin services at the end of the fall 2014 semester.

Project 1e: SAMHSA Model Programs	
Vendor:	El Dorado County Office of Education
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Contract Amount:	$392,500 through June 30, 2016
Service Locations:	Countywide in schools; at least one program in each school
Outcomes:	The contract was executed on June 24, 2014. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Project runs through FY 2015-16.
Program 2: Community Education Project	
Project 2a: Mental Health First Aid	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	Approximately $120,000 annually
Service Locations:	Countywide based on requests and facility and staffing availability.
Outcomes:	From July 2013 through March 2014, 13 Mental Health First Aid classes have been offered, with 245 attendees. Additional classes are scheduled in April through June 2014. Participants have included pastors, pastoral staff, health ministry members, registered nurses, teachers, school administrators, high school peer advocates, health academy students, foster parents and other interested community members. Feedback from the participants have indicated they would recommend Mental Health First Aid to others. In FY 2013-14, two bilingual County staff became certified instructors of Youth Mental Health First Aid through the MHSA regional training program. Both individuals are pursuing certification as bilingual instructors in both the Youth and Adult Mental Health First Aid programs. One staff member from El Dorado County Office of Education (EDCOE) also became a certified instructor of Youth Mental Health First Aid through the MHSA regional training program. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	The demand for Mental Health First Aid continues to increase and individuals who took the class in 2011 or earlier are due for renewal certification. The program cost has increased due to the number of classes offered throughout the County, salary increases approved by the Board of Supervisors in FY 2013-14, class materials and a true-up to the FY 2014-15 HHSA budget. Anticipated number of classes estimated at twelve or more per year.

Project 2b: National Alliance on Mental Illness (NAMI) Training	
Vendor:	NAMI
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Outcomes:	NAMI has requested that this contract not be pursued, therefore this project is discontinued effective July 1, 2014. NAMI will continue to provide community training through alternate funding.
FY 14-15 Changes:	Program discontinued at the request of NAMI.
Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education	
Vendor:	Purchases through PFLAG by HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	Approximately $5,000 annually
Service Locations:	Countywide based on requests for materials.
Outcomes:	The following booklets were ordered in FY 2013-14: "Be Yourself" (40 copies), "Faith in our Families" (100 copies), "Our Daughters and Sons" (100 English copies and 50 Spanish copies), and "Welcoming our Trans Family and Friends" (30 copies). Three cultural competency discussions were provided in FY 2013-14 for foster parents and CASA staff and volunteers.
FY 14-15 Changes:	None.
Project 2d: Community Information Access	
Vendor:	Relias Learning
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Contract Amount:	$31,731.10 through December 31, 2016; program extension through December 31, 2017 will be for an additional $16,000 (approximately)
Service Locations:	Countywide via the internet
Outcomes:	Relias Learning is unable to provide the total number of web page "hits", and therefore other sources for this information are being explored. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	None.

Project 2e: Suicide Prevention and Stigma Reduction	
Vendor:	To Be Determined
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Project Amount:	Up to $30,000 annually
Service Locations:	Countywide
Outcomes:	The Request for Proposals has not yet been published. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Clarification that the MHD staff may also provide some Suicide Prevention activities in certain circumstances under this project. Added Measurement 3: This project shall use a validated method to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness that are applicable to the specific prevention program/approach implemented.
Project 2f: Foster Care Continuum Training	
Vendor:	To Be Determined
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Contract Amount:	Up to $50,000 annually
Service Locations:	County-wide based on demand and results of competitive procurement process
Outcomes:	The Request for Proposals has not yet been published. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Expanded to include participation in this project by support network members, including but not limited to extended family members, friends, child care providers, and respite care providers. Foster families often need support from their extended networks to successfully care for the children in their custody. Including the support network members in training will allow for consistent messaging within the foster family and their support networks.
Project 2g: Community Outreach and Resources	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	Approximately $20,000 in FY 2014-15 and approximately $10,000 annually in FY 2015-16 and FY 2016-17
Service Locations:	Countywide based on demand.
Outcomes:	As of May 15, 2014: **Measurement 1: Number of people accessing web-based information:** Based on Google Analytics data, the main MHSA web page (http://www.edcgov.us/MentalHealth/MHSA.aspx) received 1,300 page views from January 1 through April 15, 2014. The MHSA community planning process web page (http://www.edcgov.us/ MentalHealth/MHSA_Meetings/2014/ MHSA_Community_Meetings_Scheduled.aspx) received 596 page views and the press release regarding the community planning process (http://www.edcgov.us/MentalHealth/Press_Releases/

	Public_Input_Sought_on_Mental_Health_Services_Act_(MHSA)_Plan.aspx) received 501 page views. These page views will provide the baseline for future web-based information access data. **Measurement 2: Number of brochures and other reference materials distributed:** In December 2013, the MHD updated its brochure. Distribution of these materials occurred at public outreach events, at the Mental Health office and via direct provision to community organizations. Once the South Lake Tahoe office moves to its new location, the brochure for the South Lake Tahoe office will be updated and distributed. **Measurement 3: Number of individuals involved in future MHSA planning activities:** In FY 2013-14, 56 individuals participated in the MHSA community planning process or were provided with an introduction to MHSA. In FY 2014-15, 96 individuals attended public MHSA community planning meetings and over 100 individuals attended other MHSA meetings or were provided with an introduction to MHSA through brief presentations. These numbers will provide the baseline for future participation rates. **Other activities:** The MHD staff participated in three community forums, hosted by the Community Resource Center through a grant received from CalMHSA. The community forums were designed to open discussions about stigma and discrimination within our County.
FY 14-15 Changes:	Clarification that costs also include signage.
Program 3: Health Disparities Program	
Project 3a: Wennem Wadati - A Native Path to Healing	
Vendor:	Foothill Indian Education Alliance
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Contract Amount:	Up to $125,725 annually
Service Locations:	Schools, Foothill Indian Education Alliance's office in Placerville, and other community-based sites that are accessible to the Native American population on the West Slope, including the provision of Talking Circles in schools or other locations.
Outcomes:	The Wennem Wadati program provided services to 189 unique individuals in the first quarter of FY 2013-14 and 157 unique individuals in the second quarter of FY 2013-14. The annual unduplicated count of individuals served will be provided in the FY 2015-16 MHSA Plan. The program is hoping to add a Talking Circle at Blue Oaks school in Cameron Park starting in FY 2015-16.
FY 14-15 Changes:	Clarification that Talking Circles may be made available to any age group.

Project 3b: Latino Outreach	
Vendor:	South Lake Tahoe Family Resource Center
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Contract Amount:	Up to $135,128 annually
Service Locations:	South Lake Tahoe
Outcomes:	In the first and second quarters of FY 2013-14, services were provided to over 180 unduplicated individuals each quarter. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Clarification that not all services provided by the Family Resource Center are funded through MHSA, however should funding for other programs decrease or be lost, MHSA funding may also be utilized for the other programs provided by the Family Resource Center.
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	Approximately $11,000 in FY 2013-14 (interim services)
Service Locations:	West Slope
Outcomes:	County staff provided interim services under the Latino Outreach program while a new contractor was being selected. Outreach to all regions of the West Slope were performed, and included contact with apartment complex managers, churches, the Food Bank, and clothing/food distribution centers. Linkage with mental health services, primary health care, education, employment and public benefits was provided. During this time period, staff connected with approximately 75 individuals, and provided referrals and linkage to services for issues related to mental health, medical care, dental care, employment, education, legal, food, housing, and domestic violence.
Vendor:	New Morning Youth and Family Services
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Contract Amount:	Up to $85,000 in FY 2013-14; up to $96,000 annually starting in FY 2014-15
Service Locations:	West Slope
Outcomes:	The contract was executed December 18, 2013 and services were transitioned to New Morning Youth and Family Services from the MHD in January 2014. In the first quarter of calendar year 2014 (January through March), approximately 149 individuals contacted, received outreach, or received linkage/services through the West Slope Latino Outreach program. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Clarification that the target population for this program is Spanish-speaking or limited English-speaking Latino individuals and families.

Program 4: Wellness Outreach Program for Vulnerable Adults	
Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	Approximately $50,000 annually
Service Locations:	South Lake Tahoe, Placerville (through October 25, 2013) and Diamond Springs (starting October 28, 2013)
Outcomes:	The Wellness Centers provide a wide range of services from drop in classes, resource referrals, and food education. Attendance data for FY 2013-14 will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	None.
Project 4b: Senior Peer Counseling	
Vendor:	EDCA Lifeskills as the fiscal and administrative contractor on behalf of Senior Peer Counseling
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Contract Amount:	$135,000 through June 30, 2017
Service Locations:	Placerville office, clients' homes and other community meeting places on the West Slope; future plans include exploring how services may be expanded to or developed in the Tahoe Basin
Outcomes:	The contract is scheduled to go to the Board of Supervisors for approval in August 2014. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	None.
Project 4c: Older Adult Program	
Vendor:	To Be Determined
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Contract Amount:	Up to $80,000 in FY 2014-15, up to $85,000 in FY 2015-16, and up to $90,000 in FY 2016-17
Service Locations:	Countywide
Outcomes:	The Request for Proposals has not yet been published. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Transportation assistance, as available, will be included in the project

Program 5: Community-Based Services	
Project 5a: Community-Based Mental Health Services	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	Approximately $29,338 in FY 2014-15 and $30,262 in FY 2015-16 and FY 2016-17
Service Locations:	County-wide based on demand
Outcomes:	Due to low staffing levels and the late adoption of the FY 2013-14 MHSA Plan, the MHD has not been able to fully implement this program in FY 2013-14. However, staff have participated in community events to provide support for attendees (such as the "Ending the Stigma of Mental Illness - Community Forums").
FY 14-15 Changes:	Reduced funding level to $29,338 in FY 2014-15 (from $75,000) is a true-up to anticipated expenditures reflected in HHSA's budget, with the difference directed to Project 2a: Mental Health First Aid.
Project 5b: Community Health Outreach Worker	
Vendor:	To Be Determined
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Contract Amount:	Up to $35,000 annually
Service Locations:	County-wide based on demand and results of competitive procurement process
Outcomes:	The Request for Proposals has not yet been published. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	None.
Administrative Costs	
Vendor:	HHSA, MHD
Project Amount:	$175,000 in FY 2014-15, and $185,500 annually in FY 2015-16 and FY 2016-17
FY 14-15 Changes:	Adjusted funding level to reflect anticipated costs.
PEI-TTACB	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	$0 in FY 2014-15
Service Locations:	County-wide based on demand
Outcomes:	An initial resource list has been compiled and is being reviewed and converted to web-based format for posting online.
FY 14-15 Changes:	This program is being discontinued effective in FY 2014-15 as State-provided TTACB funding has ended. Maintenance of the resource list will be performed under Project 2g: Community Outreach and Resources.

Community Services and Supports (CSS)

Program 1: Youth and Family Strengthening Program	
Project 1a: Youth and Family Full Service Partnership	
Vendor:	Sierra Child and Family Services
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Project Amount:	Approximately $350,000 annually
Service Locations:	Countywide based on clients' location and needs
Vendor:	Summitview Child and Family Services
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Project Amount:	Approximately $75,000 annually
Service Locations:	Countywide based on clients' location and needs
Project Funding:	$425,000 in FY 2014-15, and $430,000 in FY 2015-16 and FY 2016-17, which includes the above-referenced contracts and MHD staff time
Outcomes:	As of May 2014, there are 21 children enrolled in this project. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Allows for procurement of services through an open and/or competitive procurement process. Decreased budget from FY 2013-14 due to a true-up to actual expenditures in past years.
Project 1b: Family Strengthening Academy	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	$100,000 in FY 2014-15; $52,000 in FY 2015-16 and FY 2016-17.
Service Locations:	Countywide based on clients' location and needs, service provider location, and available facilities
Outcomes:	Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Reduce funds to $100,000 in FY 2014-15 due to lower than anticipated enrollment. Reduce funds to $52,000 in FY 2015-16 and FY 2016-17 due to lower than anticipated enrollment and shift in project focus. Allows for procurement of services through an open and/or competitive procurement process. Includes a contracted vendor which will also be providing services through PEI Project 1f: Prevention and Early Intervention for Youth in Schools in an amount not to exceed $50,000 annually.

Project 1c: Foster Care Enhanced Services	
Vendor:	Sierra Child and Family Services
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Project Amount:	$101,000 in FY 2013-14; increase to $250,000 in FY 2014-15
Service Locations:	Based on clients' location and needs
Outcomes:	As of May 2014, there are approximately 30 children enrolled in the program with Sierra Child and Family Services. Outcomes will be reported in the FY 2015-16 MHSA Plan.
Vendor:	Summitview Child and Family Services
Contract Status:	☐ Pending ☒ Active ☐ Not Applicable
Project Amount:	$75,000 in FY 2013-14; increase to $200,000 in FY 2014-15
Service Locations:	Based on clients' location and needs
Outcomes:	As of May 2014, there are approximately 3 children enrolled in the program with Summitview Child and Family Services. Outcomes will be reported in the FY 2015-16 MHSA Plan.
Vendor:	CASA
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Project Amount:	$20,000 annually
Service Locations:	Based on clients' location and needs
Outcomes:	Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Anticipated program costs of $825,766 in FY 2014-15, which includes the above-referenced contracts. Increased costs for the program implementation have been included in the FY 2014-15 MHSA Plan due to increasing demand for services, additional staffing and salary and other cost increases. Based upon implementation guidance from the State received in FY 2013-14 and the screening of current and new children placed into foster homes, the number of children meeting criteria for this project has exceeded the FY 2013/14 anticipated demand. Therefore, the anticipated number of children served through this program has been increased. Allows for procurement of services through an open and/or competitive procurement process. Funding in the amount of $20,000 to CASA as a sole source contract to help ensure that all children receiving services in this project have an assigned CASA.

Program 2: Wellness and Recovery Services	
Project 2a: Wellness Centers	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	Approximately $2,120,769 in FY 2014-15 and $2,205,000 in FY 2015-16 and FY 2016-17
Service Locations:	South Lake Tahoe and Diamond Springs
Outcomes:	Since relocating to the Diamond Springs location, the West Slope Outpatient Wellness Center has seen an increase in daily attendance. This trend is anticipated to continue. The South Lake Tahoe Wellness Center is anticipated to relocate in mid- to late-2014 and it is anticipated a similar trend will occur once it is settled into its new location.
FY 14-15 Changes:	Increased cost due to increasing demand for services, lease costs, additional staffing, and salary and other cost increases.
Project 2b: Adult Full Service Partnership	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	Approximately $3,846,189 in FY 2014-15
Service Locations:	Countywide based on clients' location and needs
Outcomes:	In FY 2013-14, FSP services were expanded to the Tahoe Basin. The MHD has received approval to proceed with securing master leases on housing for FSP clients. Rather than entering into a lease agreement with individual clients, the landlords will lease to the County, which in turn will lease directly to the clients. Clients will continue to pay their share of housing costs, however clients who are in the FSP program will be eligible for housing assistance, and other supportive services, if needed. Potential housing opportunities are being explored on both the West Slope and in the South Lake Tahoe area.

	Vendor:	Summitview Child and Family Services
	Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
	Project Amount:	Approximately $709,800 annually (offset by Medi-Cal reimbursement). Estimated contract of $3,678,600 for a term effective upon final execution by the parties through June 30, 2019; one-time cost of $129,600 in FY 2014-15 for facility start-up costs
	Service Locations:	West Slope
	Outcomes:	On May 13, 2014, the Board of Supervisors approved a contract with Summitview Child and Family Services for the establishment of an ARF with six beds on the West Slope to provide Full Service Partnership services for individuals released from a higher level of care facility but who are not quite ready for living in transitional housing or independent housing. Outcomes will be reported in the FY 2015-16 MHSA Plan.
	FY 14-15 Changes:	Increased costs for the program implementation have been included as a result of increasing demand for services, opening of an in-county ARF, additional staffing, and salary and other cost increases. Clarification that the costs may also include vehicle purchases (including 4WD vehicles for accessing remote areas and driving in winter weather conditions) by the MHD. Two new contracted vendor has been identified (Summitview Child and Family Services and A Helping Hand). Allows for procurement of services through an open and/or competitive procurement process.

Project 2c: Older Adults Program (Partner program to PEI Older Adults Program)	
Vendor:	To Be Determined
Contract Status:	☒ Pending ☐ Active ☐ Not Applicable
Project Amount:	Approximately $50,500 annually
Service Locations:	Countywide based on clients' location and needs
Outcomes:	The Request for Proposals has not yet been published. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Change in service provider and procurement method (from contracted vendor and a competitive procurement process) to provision of services through County staff and volunteers and contracted vendors for specific activities (e.g., groups or classes). In the event operations of this project are transitioned to a contracted vendor in whole or in part, the vendor(s) will be selected through an open and/or competitive procurement process. Contracts for specific activities, groups or classes will be done through an open and/or competitive procurement process Reduction in budget for this project are a result of a true-up to the HHSA budget and anticipated number of clients to be served. Transportation assistance, as available, will be included in the project.
Future Potential Project 2d: Assisted Outpatient Treatment	
Vendor:	None selected – potential future project
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	Estimated at approximately $125,000 in Year 1 of implementation (based on 6 months of service), $225,000 in Year 2 of implementation and $175,000 in Year 3 of implementation
Service Locations:	To be determined
Outcomes:	The Mental Health Commission and HHSA continue exploration of this project.
FY 14-15 Changes:	None. The project is still under review and cannot yet be implemented; it is identified as a potential future project.

Program 3: Transitional Age Youth (TAY) Services	
Project 3a: TAY Engagement, Wellness and Recovery Services	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	Approximately $342,387 in FY 2014-15 and $367,500 in FY 2015-16 and FY 2016-17
Service Locations:	Countywide based on clients' location and needs
Outcomes:	Staff from both outpatient clinics have been engaging transitional age youth in services. These services include therapy, psychiatry, groups, and development of independent living skills. Additionally, the West Slope outpatient clinic has been working with an intern from the Folsom Lake College – El Dorado Center to engage transitional age youth. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Allows for procurement of services through an open and/or competitive procurement process. This program partners in part with the Prevention and Early Intervention (PEI) Project 1f: Prevention and Early Intervention for Youth in Schools. Despite increasing demand for services, additional staffing, and salary and other cost increases, the budget for this project has decreased slightly due to limitations on CSS expenditures. This project will continue to be monitored for demand and outcomes and the funding adjusted as needed and as available in the future.
Program 4: Community System of Care	
Project 4a: Outreach and Engagement Services	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	Approximately $1,055,798 in FY 2014-15
Service Locations:	Countywide
Outcomes:	In FY 2013-14, the MHD has increased its outreach and engagement activities to not only reach individuals with serious mental illness who are homeless, in the jails, receiving primary care services, and who require outreach to their homes, but with the relocation of the West Slope Outpatient Clinic to Diamond Springs, engagement efforts have increased to encourage continued participation in mental health services. A scheduled van shuttle provides individuals with the opportunity to be picked up and dropped off at established locations three times each day. The MHD has participated with local law enforcement to perform outreach to the homeless populations, is a regular attendees on the Crisis Intervention Team Multi-Disciplinary Team, and has scheduled inreach events for homeless individuals/families ("inreach" occurs when staff are placed in a site frequented by

	homeless people, such as a shelter or community resource center, and direct, face-to-face interactions occur at that site). Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Recognizes that peer counselors may not always be available to assist with outreach and engagement efforts. Includes the role of a "family liaison" to assist family members with information about the processes involved with mental health services (in-patient and out-patient as appropriate), HIPAA requirements, and client-specific information to extent allowed by law. Includes Projects for Assistance in Transition from Homelessness (PATH) funds, which will be subcontracted to a community-based organization through a competitive procurement process, for outreach, case management, benefit applications, training, linkage to services and housing assistance. These funds are designed to help individuals/families who are homeless or soon to be homeless and who have a mental health issue (or a mental health issue and a substance abuse issue) receive necessary services, apply for public assistance/benefits (including SSI/SSDI), and assistance in obtaining housing or remaining in housing. Clarification that outreach and engagement efforts also including partnering with law enforcement and their Crisis Intervention Teams. Increased costs due to increasing demand for services, expanded services, additional staffing and salary increases.
Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	Approximately $157,613 in FY 2014-15
Service Locations:	Countywide based on clients' location and needs
Outcomes:	Due to low staffing levels and the late adoption of the FY 2013-14 MHSA Plan, the MHD has not been able to implement this program in FY 2013-14.
FY 14-15 Changes:	The reduced cost is a true-up to budget to reflect the actual number of staff that are anticipated to be working in this project. More focused efforts for community-based mental health services are being provided through Full Service Partnership projects.

Project 4c: Resource Management Services	
Vendor:	HHSA, MHD
Contract Status:	☐ Pending ☐ Active ☒ Not Applicable
Project Amount:	Approximately $175,000 in FY 2014-15
Service Locations:	Countywide
Outcomes:	MHD staff have been working with community providers to improve collaboration and service provision. Internally, the MHD has been working to improve access and service delivery, as well as access for primary care physicians to psychiatric consultations.
FY 14-15 Changes:	Increased cost from FY 2013-14 due to increased focus on resource management and associated staffing, and salary and other cost increases.
CSS-Housing	
Trailside Terrace	
Location:	Shingle Springs
Number of Units:	40
MHSA Units:	5
Status:	All MHSA units are leased.
FY 14-15 Changes:	None.
The Aspens at South Lake	
Location:	South Lake Tahoe
Number of Units:	48
MHSA Units:	6
Status:	All MHSA units are leased.
FY 14-15 Changes:	None.

Workforce Education and Training (WET)

Program 1: Workforce Education and Training (WET) Coordinator	
Project Amount:	Approximately $11,037 in FY 2014-15
Outcomes:	Measurement 1: Increase the number of training opportunities for the mental health workforce: The WET Coordinator has signed up for a variety of distribution lists to be notified of upcoming trainings. Information about upcoming trainings applicable to mental health is distributed to managers and supervisors, and when possible, to the MHSA email distribution list. Notices received regarding trainings applicable to other disciplines (e.g., Child Welfare Services, Public Health) is also distributed when possible. Measurement 2: Increased number of bilingual / bicultural mental health workforce employed within the public mental health system: As of April 2014, the MHD has hired two new bilingual/bicultural Mental Health Clinicians and one Mental Health Worker in FY 2013-14. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	The reduced project amount reflects a true-up to the FY 2014-15 HHSA budget.
Program 2: Workforce Development	
Project Amount:	Approximately $49,825 in FY 2014-15
Outcomes:	Measurement 1: Increase the number of training opportunities for the public mental health system workforce, including staff, contractors, volunteers and consumers: Additional trainings have been identified in FY 2013-14. Some trainings have been provided to MHD staff, and in FY 2014-15, additional focus will be on bringing training to the entire public mental health system. Measurement 2: Increased number of bilingual / bicultural public mental health workforce system staff in the County: As of April 2014, the MHD has hired two new bilingual/bicultural Mental Health Clinicians and one Mental Health Worker in FY 2013-14. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Addition of Psychiatric Rehabilitation Training (previously WET Program 3) and clarification that County staff and/or volunteers may provide and/or attend training. Decreased costs for the program implementation are a result of a true-up to the HHSA budget. Staff will primarily charge their time for attending Workforce Development trainings to "indirect" rather than to this project.

Program 3: Psychiatric Rehabilitation Training	
Project Amount:	$0
Outcomes:	None at this time.
FY 14-15 Changes:	These materials have been purchased and implementation of the program requires staff to access the materials as a training program; therefore this program will be rolled under Program 2: Workforce Development effective with the implementation of the FY 2014-15 MHSA Plan.
Program 4: Early Indicators of Mental Health Issues	
Provider:	EDCOE
Project Amount:	Up to $50,000 in FY 2014-15, $45,000 in FY 2015-16 and $40,000 in FY 2016-17.
Outcomes:	The contract has not yet been executed. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Identified an end date of June 30, 2017 for this program. Removed incorrect reference to the selected programs will primarily focus on anti-bullying, reducing substance abuse, and positive behaviors. Rather, the selected programs will assist those working with youth to identify early signs and symptoms of mental illness in alignment with the project title. Corrected reference to this program utilizing PEI funds; now properly reflects that the program will utilize WET funds. Clarified that these programs may be made available to other educators and community partners working with children and youth subject to licensing requirements and provided that there is no additional costs incurred to do so. Identified Teachers/Education as the primary target audience for this program and Public Mental Health System Employees, Contractors and Volunteers as secondary target audiences for this program. Changed focus to be County-wide and district-wide, rather than focusing on school-by-school topics. Clarification of the budget to match the WET Programs matrix and that costs may be used for web site development and video production costs.

Program 5: Suicide Education and Training	
Project Amount:	Up to $50,000 in FY 2014-15, $45,000 in FY 2015-16 and $40,000 in FY 2016-17 on a reimbursement basis.
Outcomes:	The contract has not yet been executed. Outcomes will be reported in the FY 2015-16 MHSA Plan.
FY 14-15 Changes:	Identified an end date of June 30, 2017 for this program. Correct funding in the program description to reflect the same information as the WET Budget worksheet. Clarified that these programs may be made available to other educators and community partners working with children and youth subject to licensing requirements and provided that there is no additional costs incurred to do so. Added Teachers/Education as the primary target audience for this program and Public Mental Health System Employees, Contractors and Volunteers as secondary target audiences for this program. Modification of the budget to the same funding level as Program 4: Early Indicators of Mental Health Issues. Corrected reference from "train-the-trainer" to "trainer." Clarified that the focus is to be County-wide and district-wide. Clarified that staff training will include dissemination of information and/or training annually. Clarification of the budget to match the WET Programs matrix and for which activities/costs the funding may be utilized.
Program 6: Consumer Leadership Academy	
Project Amount:	Approximately $600 in FY 2014-15
Outcomes:	Due to low staffing levels and the late adoption of the FY 2013-14 MHSA Plan, the MHD has not been able to fully implement this program in FY 2013-14.
FY 14-15 Changes:	Increased maximum number of participants in the Consumer Leadership Academy to 10 participants per academy session. Provided clarification regarding the intent of the program to provide clients with assistance in locating potential work and/or volunteer opportunities in the public mental health system, as well as on-going vocational support for a period of up to two years. Staff will primarily charge their time for to the appropriate CSS project when working with clients in the Consumer Leadership Academy rather than to this project.

Program 7: Crisis Intervention Team Training	
Project Amount:	$20,000
Outcomes:	No MHSA funding has been utilized for Crisis Intervention Team Training in FY 2013-14.
FY 14-15 Changes:	Change in how funds are utilized to be up to $20,000 for the term of the MHSA Plan. Funds may be utilized in whole or in part in any fiscal year. Once funding is utilized in whole or in part, additional funding may be added through the MHSA community planning process if funding is available. Clarification that County staff may provide support for this program (e.g., administrative activities, program analysis).

Capital Facilities and Technology (CFTN)

Program 1: Electronic Health Record System Implementation	
Project 1a: Avatar Clinical Workstation	
Project Amount:	Approximately $180,686 in FY 2014-15
Outcomes:	Measurement 1: Implementation of EHR [electronic health record] throughout the MHD. – *Completed May 2013.* Measurement 2: Ability to provide centralized, electronic appointment scheduling. – *Completed May 2013.* Measurement 3: Updated and standardized business procedures and assessments, resulting in practices that are more efficient. – *Ongoing.* Measurement 4: Improved reporting capabilities (to audit charts and provide information relevant to program development). – *Ongoing.* Measurement 5: Successful maintenance of the EHR and continued training. – *Ongoing.*
FY 14-15 Changes:	Uses of funds include but are not limited to the examples provided in the program description. Decreased costs due to true-up to FY 2014-15 HHSA budget.
Project 1b: Electronic Outcome Measurement Tools	
Project Amount:	Approximately $5,000 annually
Outcomes:	The electronic health record system is in the process of being updated to include the information from the Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA) forms.
FY 14-15 Changes:	Uses of funds include but are not limited to the examples provided in the program description.

Program 2: Telehealth (formerly Telemedicine)	
Project Amount:	Approximately $129,000 in FY 2014-15 and $25,000 in FY 2015-16 and FY 2016-17.
Outcomes:	The current video-conferencing system utilized at the outpatient clinic in Diamond Springs is outdated equipment, and the microphone no longer works and cannot be replaced due to the age of the equipment. A procurement process is underway to install a new system in Diamond Springs. When the South Lake Tahoe office relocates to its new facility, a similar procurement process will occur.
FY 14-15 Changes:	Uses of funds include but are not limited to the examples provided in the program description. Removed reference to the County being a Health Professional Shortage Area.
Program 3: Electronic Care Pathways	
Project Amount:	Approximately $5,900 annually.
Outcomes:	The MHD has been reviewing its internal processes in regards to referrals and is working on improving the process. Because provider electronic health records do not all communicate directly with each other, referral forms are printed from the electronic health record system and faxed to the office receiving the referral.
FY 14-15 Changes:	The Adult Mental Health Care Pathway will not be developed. Clarification that $900 is for iReach system support and $5,000 is for program evaluation by MHD staff.

MHSA Funding

In the FY 2013-14 MHSA Plan, revenues were anticipated to be consistent with or slightly higher than in FY 2012-13. However, as of the end of July, 2014, actual MHSA revenues for FY 2013-14 were approximately 78% of FY 2012-13 levels.

Annual MHSA revenues in FY 2014-15 are projected to be consistent with or slightly higher than in FY 2013-14, potentially equal to the revenues in FY 2012-13.

The revenue and expenditure data contained in this Plan is based upon projections for FY 2014-15, and are inclusive of a one-time-only adjustment for FY 2012-13. In the event the actual revenues are higher than anticipated, the additional funding may be utilized to support the projects identified in this Plan or rolled into the FY 2015-16 fund balance to be utilized on projects identified in the FY 2015-16 Plan. In the event the actual revenues are lower than anticipated, the County will access fund balances remaining from previous years at a higher than anticipated rate and/or reduce funding levels.

This MHSA Plan includes shifting funds from CSS to WET in FY 2014-15, FY 2015-16 and FY 2016-17 and shifting funds from CSS to CFTN in FY 2015-16 and FY 2016-17.

Budgeted Revenues and Expenditures by Component

In addition to the FY 2014-15 revenues, the El Dorado County MHSA programs have fund balances accrued from previous fiscal years that may be accessed during the term of this Plan. There is a planned usage of fund balances, which is discussed in greater detail under each component.

In FY 2014-15, El Dorado County will receive approximately $800,000 more than what was identified in the Governor's budget as a one-time-only adjustment to FY 2012-13 revenues. This increase in funding is not expected to occur on an annual basis and therefore the funds cannot be utilized to sustain programs on a long-term basis.

It is important to note that MHSA funds have historically been underspent from what has been budgeted in the MHSA Plan. Based on this historical pattern, the expenditures in this Plan may appear high. However, it is anticipated that expenditures may come in lower than anticipated. There are sufficient revenues and fund balance for all FY 2014-15 planned expenditures; however, unless revenues are higher than anticipated, the FY 2014-15 budget is not sustainable in future years. If expenditures need to be modified due to actual expenditures meeting projected budgeted expenditures, this will be addressed in the FY 2015-16 MHSA Plan.

FY 2014-15 Revenues	**CSS**[56]	**PEI**	**INN**	**WET**	**CFTN**
Starting Fund Balance	$5,509,074	$1,444,071	$1,318,641[57]	$151,076	$428,398
MHSA	$5,006,756	$1,251,689	$329,392	-	-
Public Safety Realignment 2011 (AB 109)	$110,000	-	-	-	-
Private Payor/Other Insurance	$8,400	-	-	-	
Reallocation from CSS	-	-	-	$35,361	-
Offsetting Expenditures (e.g., Medi-Cal reimbursement)	$1,529,396	-	-	-	-
Available Revenues	$12,163,626	$2,695,760	$1,648,033	$186,437	$428,398

[56] Does not include the CSS-Housing sub-component as those funds have already been transferred to CalHFA.
[57] Subject to any potential reversion.

FY 2014-15 Expenditures	CSS	PEI	INN[58]	WET	CFTN
MHSA Programs	$9,307,447	$2,016,841	$22,000	$186,437	$332,101
Reallocation from CSS	$35,361	-	-	-	-
Potential Future Project	$125,000	-	-	-	-
Contribution to Prudent Reserve	-	-	-	-	-
Total Expenditures	9,467,808	$2,016,841	$22,000	$186,437	$332,101

* MHSA revenues also include interest on funds previously received but not yet spent and Medi-Cal administration revenues in an amount of approximately $40,750. These funds are budgeted under MHSA administration and allocated across MHSA components when the fiscal year is reconciled. Due to the minimal amount, these funds are not included in the above components.

Given the above estimated revenues and expenditures, there remains a potential fund balance at the end of FY 2014-15 as follows:

FY 2014-15	CSS	PEI	INN	WET	CFTN
Estimated Ending Fund Balance	$2,695,818	$678,919	$1,626,033[57]	$0	$96,297

For additional information regarding MHSA allocations and expenditures, please see the individual components and Attachment E.

MHSA Fund Allocation

Within El Dorado County, MHSA funds are allocated by target populations through individual projects, and is not based solely on overall population rates of a geographic area. The target population for each project is identified based through the community planning process. Residents meeting the criteria for the projects are eligible for services regardless of where they reside.

Costs Included

In addition to direct service expenditures, component costs include administrative costs, which include general MHSA program planning and implementation costs and other departmental expenses, including County and Department costs that are spread across programs based on a methodology utilized by HHSA. The total administrative costs are included in the expenditures identified above.

In FY 2013-14, the Board of Supervisors approved salary increases of 5% to staff, management and unrepresented management. In FY 2014-15 and FY 2015-16, there will be an additional 5% increase in each fiscal year. Those additional staffing costs, along with other program changes that impact the costs of the project, are included in the cost for each project.

[58] A separate planning process will occur for Innovation. The current anticipated expenditures are for the costs associated with those planning sessions and writing the Innovation plan.

Prudent Reserve

The County is required to maintain a Prudent Reserve of MHSA funding to provide MHSA services during years in which MHSA revenues fall below recent averages and in which the MHSA allocations are insufficient to continue to serve the same number of individuals as the County had been serving in the previous fiscal year. Previously, legislation required counties to maintain a prudent reserve totaling 50% of the total CSS allocation; however, this requirement was recently eliminated and the amount of the prudent reserve is determined by each county.

The balance of the County's Prudent Reserve in at the start of FY 2013-14 was $1,898,284. The FY 2013-14 MHSA Plan identified a contribution of $601,716 into the Prudent Reserve from CSS funds, which would result in a Prudent Reserve of $2,500,000. However, as of June 2014, this contribution has not yet been transferred and a review of anticipated expenditures in FY 2014-15 leads the MHD to recommend that these funds not be transferred into the Prudent Reserve and remain available for CSS expenditures. Therefore, the Prudent Reserve balance in FY 2014-15 will remain at $1,898,284. All references in this Plan to "fund balance" exclude the Prudent Reserve.

MHSA revenues can fluctuate from year to year, yet it is crucial to be able to maintain existing levels of service for mental health clients for the long term. The maintenance of a Prudent Reserve ensures that County programs will continue to be able to serve those children, adults, and seniors currently being served should future MHSA revenues drop below prior years funding levels. Most counties set aside Prudent Reserve funds annually to ensure that established services will not need to be cut if there is a funding shortfall.

The County does not intend to transfer any funding to the Prudent Reserve in FY 2014-15.

Transfer of Funds Between Components

WIC §5892(b) allows counties to use a portion of their CSS funds for WET, CFTN, and the Prudent Reserve. The total amount of CSS funding used for this purpose may not exceed 20% of the total average amount of funds allocated to that County for the previous five years. El Dorado County will transfer funds to the WET component starting in FY 2014-15 and transfer funds to the CFTN component starting in FY 2015-16. More detail about these transfers is provided in subsequent component sections of this Plan.

Reversion

Unspent MHSA funding may be carried forward as a fund balance to the next fiscal year for a limited duration of time. Funds that are not used within the reversion period must be returned to the State. CSS, PEI and INN funds will revert to the State if they are not utilized within three years. WET and CFTN funds that are not fully expended within 10 years from the year of allocation will revert to the State. The County's WET and CFTN funds were allocated in FY 2006-07 through FY 2008-09, and reversion of those funds would being in approximately 2016 should the funds not be fully utilized. More discussion about reversion can be found within the budget discussion for each component.

Rolling of Project Budgets

Recognizing that new projects may take time to become fully established and may have higher costs within the first year of operation, which may be further compounded by the adoption date of the MHSA Plan, funds allocated but unspent in first year of operations for any new projects will roll from the first full or partial year of operations into second year of operations. Starting in the third year of operations, projects will maintain an annual budget amount without any rollover.

For example, if a new project has the following annual budget:

Year 1	$75,000
Year 2	$80,000
Year 3	$85,000

As a new project, this funding will be allowed as follows:

Year 1 and Year 2	$155,000 (with Year 1 not to exceed $75,000)
Year 3	$85,000

Any project subject to these rolling project budgets will be eligible to utilize Year 1 funds that were not expended in Year 1 during Year 2 of operations. For programs/projects that were new in the FY 2013-14 MHSA Plan, the actual expenditures for Year 1 of operations are not yet known and therefore the budget amounts for FY 2014-15 (Year 2 of operations) is an estimate based on potential program expenditures in FY 2013-14.

Additional Information

Procurement of Services

All procurement processes identified in this Plan will be done in compliance with the Board of Supervisors Policy C-17, Procurement Policy.[59]

Although this Plan identifies service providers as of the date of publication, there may be a change in service providers that occurs during the term of this Plan due to unforeseen circumstances. In such situations, services will be obtained through the procurement method identified under each project. When there are no providers contracted for the services, the MHD may utilize its staff to provide the services or acquire the necessary materials via its purchasing process on an interim basis.

In addition to the method of procurement identified for each program/project, additional services may be procured through sole-source contracts based on the needs of the clients. These services would not be for program/project operations, but rather specific supportive

[59] El Dorado County Board of Supervisors Policy Manual. http://www.edcgov.us/Government/BOS/Policies/Policy_Manual.aspx

services for the clients. Contracted vendors for client needs are not specifically identified as utilization of specific vendors may change on a regular basis based upon the needs of the clients.

Staffing Levels

Key to success of this Plan is adequate staffing levels, both within the HHSA MHD and through our contracted service providers. Projects and activities will be implemented to the extent that adequate staffing is available. Adequate staffing levels within the public mental health system is key to a strong mental health system.

Staff retention continues to be an area of focus for HHSA, and HHSA continues to recruit critical staff to provide services.

In the months that have passed since adoption of the FY 2013-14 MHSA Plan, the MHD has focused on bringing staffing levels up to the maximum allocations allowed under the FY 2013-14 adopted County budget, which would provide staffing to implement the programs in the FY 2013-14 MHSA Plan, and newly hired staff are currently in their training period. It is hoped that in FY 2014-15, all MHSA programs will be able to be implemented as designed.

Part 4. MHSA Programs

MHSA Programs

The MHSA established five components that address specific goals for priority populations and key community mental health needs. Within each component, programs have been developed based upon community input as to local needs and priorities and available MHSA funding.

The remainder of this document discusses the individual components and the projects under each component.

Component Name

- Component Definition
- Component Budget
- Projects to be Included in this Plan
- Projects Discontinued from Previous Plan, if any
- Projects Moved to Other Components, if any

Sub-Component Name (if any)

- Sub-Component Definition
- Sub-Component Budget
- Sub-Component Projects to be Included in this Plan
- Sub-Component Projects Discontinued from Previous Plan

As used within this document, and generally within MHSA:

- "**Component**" refers to the MHSA funding streams of:
  - Prevention and Early Intervention (PEI)
  - Community Services and Supports (CSS)
  - Innovation (INN)
  - Workforce Education and Training (WET)
  - Capital Facilities and Technology Needs (CFTN)
- "**Program**" refers to a grouping of projects under a component designed to achieve a common goal, serve a common demographic, or address a common community need. In the past, "Programs" were referred to as "Workplans".
- "**Project**" refers to a set of targeted activities focusing a specific aspect of a program. One or more projects will be found within each program.
- "**Activities**" are what will occur within each project.

Prevention and Early Intervention (PEI)

Component Definition

"Prevention and Early Intervention" refers to programs designed to prevent mental illnesses from becoming severe and disabling. PEI programs emphasize improving timely access to services for underserved populations and include the following service components:

- outreach to recognize early signs of potentially severe and disabling mental illnesses;
- access and linkage to medically necessary care;
- reduction in stigma associated with diagnosis of a mental illness or seeking mental health services; and
- reduction in discrimination against people with mental illness.

The PEI programs are to emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:

- suicide;
- incarceration;
- school failure or dropout;
- unemployment;
- prolonged suffering;
- homelessness; and/or
- removal of children from their homes.

PEI funds may be used to broaden the provision of community-based mental health services. [60]

Purposes of PEI Programs

- To prevent mental illnesses from becoming severe and disabling.
- To provide early detection and increased access to screening, assessment, and early intervention for depression and suicide.
- To prevent the onset of major depression, to reduce the negative outcomes of untreated depression, and to prevent the tragic consequences of suicide.
- To reduce the risk of institutionalization and homelessness among transitional age youth and adults.
- To provide linkage to the appropriate level (least restrictive) of mental health and other needed services.
- To provide training, knowledge and skills related to mental health for clients, family members, and the broader community, thereby promoting mental health and independent living.

[60] WIC §5840.

- To provide these services in a proactive (outreach) and community-based model thereby reducing disparities in service access.

Fundamental Goals of PEI

- To provide early detection and increased access to screening, assessment, and early intervention for depression and suicide.
- To prevent the onset of major depression, to reduce the negative outcomes of untreated depression, and to prevent the tragic consequences of suicide.
- To reduce the risk of institutionalization and homelessness among adults.
- To provide linkage to the appropriate level (least restrictive) of mental health and other needed services.
- To provide training, knowledge and skills related to mental health for clients, family members, and the broader community, thereby promoting mental health and independent living.
- To provide these services in a proactive (outreach) and community (home-based) model thereby reducing disparities in service access for older, vulnerable, and isolated adults.

Future PEI Regulations

The MHSOAC is in the process of developing regulations for PEI.[61] The proposed regulations have several steps to complete prior to adoption and implementation.[62] The above requirements for PEI will change in the future to align with the new regulations, but the impacts to PEI projects that will be in existence as of the effective date of the PEI regulations is not yet known. According to the MHSOAC, the essential principles of the new regulations will be that they are:

- consistent with Administrative Procedures Act;
- based on the MHSA;
- outcomes-focused; and
- flexible: supports county/community priorities and wisdom.[63]

The next steps are publication of the proposed PEI regulations and receiving of public comment by the MHSOAC. More information about this process and other MHSOAC activities may be found on their website (http://mhsoac.ca.gov/).

[61] The proposed PEI regulations, as of May 14, 2014, can be found at http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2014/May/OAC_052214_7A_ProposedPEIRegs.pdf.
[62] For more information about the regular rulemaking (regulation) process, see http://www.oal.ca.gov/Regular_Rulemaking_Process.htm.
[63] MHSOAC. *PEI/INN Regulations.* September 26, 2013. http://www.mhsoac.ca.gov/Meetings/docs/Meetings/2013/OAC_092613_Tab4_PEIandINNRegsPPT.pdf

PEI Budget

Of the total MHSA funding received by the County, a net 19% must be allocated to PEI per the MHSA. PEI funds must be expended within three years or the funds are subject to reversion to the State. It is not anticipated that any PEI funding will revert to the State in FY 2014-15.

PEI receives only MHSA funds (i.e., there are no Medi-Cal reimbursements for PEI). Total anticipated annual revenues for PEI in FY 2014-15 are $1,251,689, which includes a one-time-only adjustment for FY 2012-13. The future level of MHSA funding is unknown, therefore this Plan will anticipated the same revenues annually as was received in FY 2012-13 ($1,228,387) for the remaining term of this Plan, and will adjust revenues in future Plan Updates as needed.

As of the beginning of FY 2014-15, the remaining PEI fund balance from previous fiscal years is anticipated to be $1,444,071. For PEI, this fund balance is considered one-time-only funding and cannot be utilized to sustain programs on an ongoing basis. The fund balance will be utilized for limited-term programs or for planned one-time-only start-up costs or other expenses.

Based on current revenue and expenditure projections, and current approved projects, the PEI budget is not sustainable beyond FY 2016-17. As a result, unless funding increases, a reduction in PEI services should be anticipated prior to or in FY 2016-17.

For additional information regarding MHSA allocations and expenditures, please see Attachment E.

Funding by Age

Children's programs receive the highest level of PEI funding, which is an age group identified as a priority through the community planning process. However, other age groups were identified as in need of services, including older adults and transitional aged youth. There was also a need expressed for more education relative to mental illness, suicide prevention, stigma reduction and available resources through PEI funding.

Of the total PEI funding for projects (excluding administrative costs), approximately:

- 58% is allocated to projects addressing the needs of children (from birth through age 18) or children and their families:
  - Project 1a: Children 0-5 and Their Families
  - Project 1b: Mentoring for 3-5 Year Olds
  - Project 1c: Parenting Skills (formerly Incredible Years)
  - Project 1d: Primary Intervention Project (PIP)
  - Project 1e: SAMHSA Model Programs
  - Project 2f: Foster Care Continuum Training
  - Project 1f: Prevention and Early Intervention for Youth in Schools
- 6% is allocated to projects specifically designed to address the needs of older adults (age 60+):
  - Project 4b: Senior Peer Counseling
  - Project 4c: Older Adult Program
- 9% is allocated to projects to address the needs of all adults (age 18+; includes older adults):
  - Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness

- Project 4b: Senior Peer Counseling
- Project 4c: Older Adult Program

- 19% is allocated to programs to address health disparities, which include services for children, adults and families:
  - Project 3a: Wennem Wadati - A Native Path to Healing
  - Project 3b: Latino Outreach
- 10% is allocated to projects to education programs:
  - Project 2a: Mental Health First Aid
  - Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education
  - Project 2d: Community Information Access
  - Project 2e: Suicide Prevention and Stigma Reduction
  - Project 2g: Community Outreach and Resources
- 4% is allocated to community-based projects:
  - Project 5a: Community-Based Mental Health Services
  - Project 5b: Community Health Outreach Worker

Funding by Geographic Location

Of the total PEI funding for projects (excluding administrative costs), approximately:

- 29% is allocated to projects that are performed in various locations throughout the County, including schools:
  - Project 1b: Mentoring for 3-5 Year Olds
  - Project 2a: Mental Health First Aid
  - Project 2e: Suicide Prevention and Stigma Reduction
  - Project 4b: Senior Peer Counseling
  - Project 4c: Older Adult Program
  - Project 5a: Community-Based Mental Health Services
  - Project 5b: Community Health Outreach Worker
  - Project 1f: Prevention and Early Intervention for Youth in Schools
- 37% is allocated to projects offered in a specific location(s) as a result of a competitive procurement process:
  - Project 1c: Parenting Skills (formerly Incredible Years)
  - Project 1d: Primary Intervention Project (PIP)
  - Project 2f: Foster Care Continuum Training
  - Project 3a: Wennem Wadati - A Native Path to Healing
  - Project 3b: Latino Outreach
- 16% is allocated to projects that serve eligible populations in the County, but the services must be provided at a specific location due to necessary facilities/equipment; and
  - Project 1a: Children 0-5 and Their Families
  - Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness
- 18% is allocated to projects that provide information/activities in all schools, educational classes, and/or information Countywide based on internet access, newspaper distribution or other posted materials:
  - Project 1e: SAMHSA Model Programs
  - Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education

- Project 2d: Community Information Access
- Project 2g: Community Outreach and Resources

PEI Programs

Program/Project	FY 14-15 Expenditures	FY 15-16 Expenditures	FY 16-17 Expenditures	FY 14-15 % of Expenditures	0-5	Elementary School	Middle School	High School	Adults	Older Adults	Families	All Ages
Revenues:												
Fund Balance	$1,444,071	$678,919	$242,991									
Revenues	$1,251,689	$1,228,387	$1,228,387									
Available Revenues	$2,695,760	$1,907,306	$1,471,378									
Expenditures:												
Program 1: Youth and Children's Services												
Project 1a: Children 0-5 and Their Families[64]	$125,000 (+$117,500)	$125,000	$125,000	12%	✓						✓	
Project 1b: Mentoring for 3-5 Year Olds[64]	$75,000 (+$50,000)	$75,000	$75,000	6%	✓ 3-5						✓	
Project 1c: Parenting Skills (formerly Incredible Years)	$50,000	$50,000	$50,000	2%	✓ 2-5	✓ <12					✓	
Project 1d: Primary Intervention Project (PIP)[65]	$212,700 (+$21,350)	$212,700	TBD	12%		✓ K-3						

[64] The amount shown in parenthesis is the potential rollover balance from FY 2013-14. As a new program in FY 2013-14, this program was eligible to roll unused FY 2013-14 funding into FY 2014-15. The amount of rollover funding is an estimate based on invoices received as of May 1, 2014. The actual amount available in FY 2014-15 will be based on the final FY 2013-14 expenditures.

[65] One year contracts for the term ending December 31, 2014 for a total of $212,700. Expenditures in FY 2014-15 are an estimate based on invoices received as of May 1, 2014. Actual amount for the entire term of the contracts will not exceed $212,700.

Program/Project	FY 14-15 Expenditures	FY 15-16 Expenditures	FY 16-17 Expenditures	FY 14-15 % of Expenditures	0-5	Elementary School	Middle School	High School	Adults	Older Adults	Families	All Ages
Project 1e: SAMHSA Model Programs[64]	$100,000 (+$192,100)	$100,000	$0	14%		✓	✓	✓				
NEW Project 1f: Prevention and Early Intervention for Youth in Schools	$75,000	$100,000	$100,000	4%			✓	✓	✓	✓	✓	
Program 2: Community Education Project												
Project 2a: Mental Health First Aid	$120,000	$105,000	$105,000	6%				✓ 16+	✓	✓		
Project 2b: National Alliance on Mental Illness Training	Discontinued	Discontinued	Discontinued	0%					✓	✓		
Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education	$5,000	$5,000	$5,000	<1%			✓	✓	✓	✓		
Project 2d: Community Information Access	$12,000	$14,000	$16,000	<1%				✓	✓	✓		
Project 2e: Suicide Prevention and Stigma Reduction[66]	$30,000	$30,000	$30,000	1%								✓
Project 2f: Foster Care Continuum Training	$50,000	$50,000	$50,000	2%			✓	✓	✓	✓	✓	
Project 2g: Community Outreach and Resources	$20,000	$10,000	$10,000	1%								✓
Program 3: Health Disparities Program												
Project 3a: Wennem Wadati - A Native Path to Healing	$125,725	$125,725	$125,725	6%								✓

[66] Partners with a Workforce Education and Training (WET) program.

Program/Project	FY 14-15 Expenditures	FY 15-16 Expenditures	FY 16-17 Expenditures	FY 14-15 % of Expenditures	0-5	Elementary School	Middle School	High School	Adults	Older Adults	Families	All Ages
Project 3b: Latino Outreach	$231,128	$231,128	$231,128	11%								✓
Program 4: Wellness Outreach Program for Vulnerable Adults												
Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness[67]	$50,000	$50,000	$50,000	2%					✓	✓		
Project 4b: Senior Peer Counseling	$35,000	$45,000	$55,000	2%						✓		
Project 4c: Older Adult Program[67]	$80,000	$85,000	$90,000	4%						✓		
Program 5: Community-Based Services												
Project 5a: Community-Based Mental Health Services[67]	$29,338	$30,262	$30,262	1%								✓
Project 5b: Community Health Outreach Worker	$35,000	$35,000	$35,000	2%								✓
Administrative Costs												
Per Department of Mental Health Information Notice 10-01[68]	$175,000	$185,500	$185,500	9%								
Total PEI Program Expenditures	$2,016,841	$1,664,315	$1,368,615									
Anticipated Year-End Fund Balance	$678,919	$242,991	$102,763									

[67] Partners with a Community Services and Supports (CSS) program.

[68] California Department of Mental Health, Information Notice 10-01, *Proposed Guidelines for the Mental Health Services Act (MHSA) Fiscal Year 2010/11 Annual Update to the Three-Year Program and Expenditure Plan*, January 19, 2010. http://www.dhcs.ca.gov/formsandpubs/Pages/MIH-InfoNotices-Archive2010.aspx.

Project Name: Children 0-5 and Their Families 1a

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☐ Incarcerations ☒ School Failure or Dropout ☐ Unemployment	☒ Prolonged Suffering ☐ Homelessness ☒ Removal of Children from Their Homes
Objective	To provide early prevention and intervention services to children age 0-5 and their families.	
Target Population(s)	☒ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☒ Adults ☒ Older Adults ☐ All Ages
	Families living in El Dorado County with children in the 0-5 age range (perinatal to five years)	
Service Location(s)	Vendor's Cameron Park office, but services may be provided to all eligible families who wish to be seen in Cameron Park.	
Project Duration	Ongoing	
Activities Performed	**Outreach** – Includes phone and in-person contact with target population, representatives of area agencies, medical/health care providers, educational programs, and other agencies designed to: • Remove barriers to treatment • Assist other providers to recognize early signs of poor coping/stress/mental illness in our target population • Improve agency cooperation • Engage families with very young children who may be living in poverty or isolation • Engagement with target population and offering Spanish language materials • Continuous development of practitioners cultural sensitivity, awareness, knowledge and skills • Honor every family's own personal culture and values and understand cultural factors that may influence clients **Access and Linkage to Medically Necessary Care** - To identify/evaluate needs, risk factors and strengths. Standardized assessment tools include Parent Stress Index, Beck's Depression and Anxiety Scale, Post-Partum Depression Scale, Ages and Stages and Marshak Interactive Method Assessment also includes consultation and enhancement with pre-school	

	and kindergarten programs. Referrals will be based on the identified needs of the family, such as referrals to: Immigration support agency/provider, English as a Second Language (ESL) programs, Early Head Start/Head Start, Infant Development Program, Public Health, Mental Health, First 5 Commission, community-based mental service providers, hospitals, community health and faith based services. Children meeting the criteria for specialty mental health are referred to the MHD. **Stigma and Discrimination Reduction:** Discuss mental illness with parents to help recognize signs, reduce stigma, and discrimination. This program will also be linked with other stigma and discrimination reduction activities. **Activities:** A plan of care will be developed by service provider in concert with family and other community collaborators as appropriate to address the family's specific needs and goals. Treatments may include: • Infant-parent psychotherapy • Individual, couple, family sessions • Home visitation • Parenting support and guidance for fathers, mothers and couples • Infant massage • Pregnancy and post-partum support • Psychological parenting information and support for foster, grandparents and adoptive caregivers • Educational support to address colic, feeding and sleep issues • Circle of Security - evidence based approach to parenting that is focused on infancy and toddlers. • Theraplay - A relationship based approach that uses play to engage children in interactions that lead to competence, self-regulation, self-esteem, and trust • Trauma-Focused Cognitive Behavioral Therapy (CBT) • Eye Movement Desensitization Reprocessing (EMDR)
Services Provided By	☒ Contracted Vendor ☐ Volunteers ☒ County Staff Support[69]
Procurement Method	Sole source to the Infant-Parent Center.

[69] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: Children 0-5 and Their Families 1a

Short-Term Goals	• Increased number of families within the target population who are accessing prevention/wellness/intervention services • Strengthened pipeline among area agencies to facilitate appropriate and seamless referrals between agencies in El Dorado County • Increased awareness of services available among families, health care providers, educators and others who may have access to target population • Emotional and physical stabilization of at-risk families (increasing trust) • Improved infant/child wellness (physical and mental health) • Improved coping/parenting abilities for young parents • Increase awareness and education of Domestic Violence and how it impacts families and young children • Enhancement of programs serving children 0-5
Long-Term Goals	• Decreased number of children removed from the home • Decreased incidence of prolonged suffering of children/families • Child abuse prevention • Suicide prevention • Increased cooperation and referrals between agencies • Reduced stigma of mental health/counseling interventions among target population • Improved trust of services as evidenced by an increase in self-referral by target group families • Decreased cost of 5150 and hospitalizations by providing services in outpatient setting
Outcome Measures	**Measurement 1:** Success will be measured on pre/post testing based on assessment tools, Parent Stress Index, Beck's Depression Beck's Depression and Anxiety Scale, Post-Partum Depression Scale, Ages and Stages, and Marshak Interaction Method **Measurement 2:** Client satisfaction questionnaires, other provider questionnaires **Measurement 3:** Statistics provided by Child Welfare Services related to incidence of child abuse/neglect/placement in target population **Measurement 4:** Informal feedback from area educators in improvement of school readiness and achievement **Measurement 5:** Tracking of self-referred clients **Measurement 6:** Decreased incidents of shaken baby syndrome **Measurement 7:** Reduction of hospital emergency department visits **Measurement 8:** Decreased incidents of domestic violence

Project Name: Children 0-5 and Their Families 1a

Number of Services / Quantity of Service	1,400 client contact hours annually.
Budget	Budgeted up to $125,000 annually on a reimbursement basis. As a new project in FY 2013-14, any budgeted funds that were not utilized in FY 2013-14 are eligible to be utilized in FY 2014-15 and are in addition to the annual funds budgeted for FY 2014-15. Costs include staff, administration, overhead, training and continued education, fees and licensing, and supervision.

Project Name: Mentoring for 3-5 Year Olds by Adults and Older Adults — 1b

Project Type:	☒ Prevention	☐ Early Intervention
Negative Outcome(s) Addressed:	☐ Suicide ☐ Incarcerations ☒ School Failure or Dropout ☐ Unemployment	☒ Prolonged Suffering ☐ Homelessness ☒ Removal of Children from Their Homes
Objective	Recruit, screen and train adults and older adults to mentor at-risk, unserved, and underserved children at different child development sites in El Dorado County.	
Target Population(s)	☒ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☒ Adults ☒ Older Adults ☐ All Ages
	Primary focus would be children age 3-5, mentored by adults and older adults Program could be expanded to mentor children older than 5 years of age	
Service Location(s)	West Slope - Ken Lowry Center and Head Start School Sites; other sites as may be determined by service provider. Tahoe Basin - To be identified	
Project Duration	Ongoing	
Activities Performed	**Outreach:** Collaborate with EDCOE Child Development Department **Access and Linkage to Medically Necessary Care:** Mentors link parents / guardians to other needed services, and through inter-county / community-based organization collaborations, can often get services faster thus preventing future mental health issues. **Stigma and Discrimination Reduction:** Conduct parent workshop on need of mentors for young children to help recognize signs, reduce stigma, and discrimination. This program will also be linked with other stigma and discrimination reduction activities. **Activities:** • To help reduce parental stress and increase parent child interaction, as well as parent teacher interaction. • On the West Slope, develop child case plan using Big Brothers Big Sisters nationally recognized evidence-based program with parent, teacher, and mentor to target activities that meet the child's individual needs; child case plan development requirements will also	

Project Name: Mentoring for 3-5 Year Olds by Adults and Older Adults — 1b

	be implemented in the Tahoe Basin. • On the West Slope, each individual match (adult / older adult and child) case managed by a Big Brothers Big Sisters professional staff; similar matching processes will be implemented in the Tahoe Basin. • Peer support between mentor, teacher and parent / guardian. • Mentor will teach child coping mechanisms to deal with day-to-day stressors and any mental health symptoms. • Provider staff meets with parents and teachers to review child case plan and ensure collaboration and cultural competency. • Tahoe Basin model to be identified based on responses to competitive procurement process, but program will be similar in nature to the West Slope model.
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Support[70] West Slope: Big Brothers Big Sisters, and its volunteers Tahoe Basin: To be determined
Procurement Method	West Slope: Sole source to Big Brothers Big Sisters Tahoe Basin: Competitive procurement process
Short-Term Goals	• Determine if child or family has organically or environmentally induced mental illness concerns. • Develop a case plan for child. • Conduct parent workshop. • Through skill building activities, mentors will develop coping mechanisms with the child.
Long-Term Goals	• Through education and training, mentors normalize mental health conditions helping reduce stigma • Mentors reduce the effects of parental mental health issues affecting the child • Child will utilize skills learned to increase social and emotional development, increase academic performance, and increase socialization skills in school and public • Prevention of adult/ senior depression and other mental health concerns.

[70] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: Mentoring for 3-5 Year Olds by Adults and Older Adults — 1b

Outcome Measures	Measurement 1: Pre/post surveys Measurement 2: Evaluations Measurement 3: Behavioral evaluation Measurement 4: Documented skill building Measurement 5: Rating sheet Measurement 6: West Slope: Big Brothers Big Sisters Youth Outcomes Survey and Strength of Relationship survey; similar outcome measurement for the Tahoe Basin Measurement 7: Recommended adult surveys and evaluations tools Measurement 8: Testimonials
Number of Services / Quantity of Service	Once program is established, approximately 125 children annually Countywide, with the average cost per child approximately $600.
Budget	Up to $75,000 annually on a reimbursement basis, approximately $50,000 for the West Slope and $25,000 for the South Lake Tahoe area. For the West Slope: As a new project in FY 2013-14, any budgeted funds that were not utilized in FY 2013-14 are eligible to be utilized in FY 2014-15 and are in addition to the annual funds budgeted for FY 2014-15. For the Tahoe Basin: As a new project in FY 2013-14 that is not being implemented until FY 2014-15, any budgeted funds that are not utilized in FY 2014-15 are eligible to be utilized in FY 2015-16 and are in addition to the annual funds budgeted for FY 2015-16.

Project Name: Parenting Skills 1c

Project Type:	☒ Prevention	☐ Early Intervention
Negative Outcome(s) Addressed:	☐ Suicide ☐ Incarcerations ☒ School Failure or Dropout ☐ Unemployment	☐ Prolonged Suffering ☐ Homelessness ☒ Removal of Children from Their Homes
Objective	Parenting classes are programs that offer parenting-skills classes to promote emotional and social capability, and reduce and treat behavioral and emotional problems in children ages two to twelve.	
Target Population(s)	☒ 0-5 Years ☒ Elementary School ☒ Middle School ☒ High School	☒ Adults (parenting) ☒ Older Adults (parenting) ☐ All Ages
Service Location(s)	Countywide	
Project Duration	Ongoing	
Activities Performed	**Outreach:** Outreach will be accomplished through direct consumer contact, publications, flyers, web-based content and/or other media outlets. **Access and Linkage to Medically Necessary Care:** Participants would receive linkage to medically necessary care through individual referrals and increased awareness about risk factors leading to self-referrals. **Stigma and Discrimination Reduction:** Client participation in this program will serve to break down barriers, reduce stigma and reduce discrimination through a more thorough understanding of mental illness. **Activities:** Parenting classes are a set of comprehensive, multi-faceted, and developmentally-based curricula targeting parents whose children would benefit from the parent involvement in these classes. These programs addresses the role of multiple interacting risk and protective factors in the development of conduct disorders, serves as a violence prevention strategy, promotes emotional and social competence, and prevents, reduces and treats behavioral and emotional problems in children. Parenting classes include, but are not limited to, Incredible Years, Parenting Wisely, Celebrating Families!, Triple P-Positive Parenting Program, among other parenting classes that are listed on Substance Abuse and Mental Health Services Administration's (SAMHSA) National Registry of Evidence-Based Programs and Practices	

Project Name: Parenting Skills 1c

	(www.nrepp.samhsa.gov). These classes may be held therapeutic and non-therapeutic locations, such as community centers, libraries, schools and churches. For classes that span many weeks, attendance at the beginning is generally higher than attendance at the end of the class. Therefore, these classes may be condensed to a shorter time period to encourage continued participation.
Services Provided By	☒ Contracted Vendor ☐ Volunteers ☒ County Staff Support[71] Contractor: New Morning Youth and Family Services
Procurement Method	Competitive procurement process
Short-Term Goals	• Increase positive and nurturing parents • Increase child positive behaviors, social competence, and school readiness skills • Increase parent bonding and involvement with teachers/school
Long-Term Goals	• Decrease harsh, coercive and negative parenting • Increase family stability • Increase emotional and social capabilities • Reduce behavioral and emotional problems in children
Outcome Measures	Measurement 1: Pre- and post-class survey.
Number of Services / Quantity of Service	At least six community-based classes per year, to be held in local communities (e.g., West County, North County, South County, Pollock Pines area, South Lake Tahoe area, Placerville area) as necessitated by demand. In the event demand for a class in a region is lower than necessary to host a class in that region, the service provider may request hosting one additional class in a high-demand region within a one year time frame. The average cost per class is $8,334.
Budget	Up to $50,000 annually on a reimbursement basis. The current contract with New Morning Youth and Family Services reflecting the scope of the Incredible Years project will remain active until the new contract reflecting the revised contract amount and scope and compensation format of the Parenting Skills project is executed.

[71] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: Primary Intervention Project 1d

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☐ Suicide ☐ Incarcerations ☒ School Failure or Dropout ☐ Unemployment	☐ Prolonged Suffering ☐ Homelessness ☐ Removal of Children from Their Homes
Objective	The Primary Intervention Project (PIP) (also referred to as the Primary Project (formerly the Primary Mental Health Project, or PMHP)) is an evidence-based practice that offers short-term individual, non-directive play services with a trained school aide to students in kindergarten through third grade who are at risk of developing emotional problems. The school-based screening team determines those children who are at risk of developing emotional problems based on indications of difficulties experienced with adjustments in school.	
Target Population(s)	☐ 0-5 Years ☒ Elementary School ☐ Middle School ☐ High School	☐ Adults ☐ Older Adults ☐ All Ages
	Kindergarten through Third Grade (approximately 4-9 years of age)	
Service Location(s)	• Black Oak Mine Unified School District • Buckeye Unified School District • Lake Tahoe Unified School District	
Project Duration	PIP was originally identified as a short-term "pilot" program. It has continued to operation. PIP will be extended to operate through June 30, 2015. The project will again be evaluated during the FY 2015-16 MHSA Community Planning Process to determine whether it will be continued.	
Activities Performed	**Outreach:** Outreach will be accomplished by identifying young children who are "at risk" of developing emotional problems and increasing awareness of mental health issues to parents, teachers and school administrators. **Access and Linkage to Medically Necessary Care:** PIP aides are informed regarding referral and access to County Mental Health Services and linkage to other community resources and providers. **Stigma and Discrimination Reduction:** Increasing the dialogue about mental wellness in a non-stigmatized school setting in an effort to reduce stigma and discrimination.	

Project Name: Primary Intervention Project 1d

	Activities: • Serve students in kindergarten through third grade in three public school districts experiencing mild to moderate school adjustment difficulties. Supervised and trained child aides provide weekly non-directive play sessions with the selected students. • Ensure that students are selected for program participation through a selection process that includes completion of standardized assessments and input from the school-based mental health professionals and teachers. • Encourage the involvement of parents/guardians and teaching staff to build alliances to promote student's mental health and social and emotional development. Parental consent is required for student participation. • Have a core team consisting of school-based, credentialed mental health professionals, local mental health professionals (from a cooperating mental health entity) and child aides. • Ensure that credentialed school-based mental health professionals provide ongoing supervision/training of child aides. • Provide ongoing monitoring and evaluation of program services.
Services Provided By	☒ Contracted Vendor ☐ Volunteers ☒ County Staff Support[72]
Procurement Method	No new RFP will be issued; contracts with currently contracted vendors will continue if vendor wishes to continue to provide services. • El Dorado Hills Vision Coalition (for up to three schools in the El Dorado Hills Area); • Black Oak Mine Unified School District (for up to four schools in the north County area, plus other children in the north County area if they meet eligibility criteria and can attend sessions at one of the four schools); and • Tahoe Youth and Family Services (for up to four schools in the South Lake Tahoe area).
Short-Term Goals	• Provide services in a school based setting to enhance access • Build protective factors by facilitating successful school adjustment • Target violence prevention as a function of skills training
Long-Term Goals	• To decrease school adjustment difficulties at an early age and build protective factors to foster youth resilience and mental health

[72] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: Primary Intervention Project 1d

Outcome Measures	Measurement 1: Administer Walker-McConnell Scale (WMS) assessment tool to students at the time student is selected to enter the program and again when the student exits the program (contracted vendor will be responsible for procuring use of the WMS tool). Measurement 2: Completion of service delivery report to the County on a monthly basis showing number of students served. Measurement 3: Completion of year-end progress report to the County showing annual number of students served and pre- and post- WMS scores, identifying program successes, challenges faced and post-PIP participation outcomes for the children.
Number of Services / Quantity of Service	Approximately 200 children annually, with an average cost per child of approximately $1,064.
Budget	Total annual funding is up to $212,700 for FY 2014-15 and FY 2015-16. Funding for FY 2016-17, if any, will be determined during the FY 2015-16 or FY 2016-17 community planning process. Up to $212,700 through December 31, 2014 (current contracts for calendar year 2014). Contracts will be amended to include the additional funding of: Up to $106,350 through June 30, 2015 on a reimbursement basis and up to $212,700 in FY 2015-16 on a reimbursement basis. The contracts for PIP services for the extended project period will be established to begin services at the end of the fall 2014 semester.

Project Name: SAMHSA Model Programs 1e

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☒ Incarcerations ☒ School Failure or Dropout ☐ Unemployment	☒ Prolonged Suffering ☐ Homelessness ☒ Removal of Children from Their Homes
Objective	Coordinate the implementation of the Substance Abuse and Mental Health Services Administration (SAMHSA) Model Programs at all schools within the County to address needs identified. The programs will focus on anti-bullying, reducing substance abuse, and developing positive behaviors in youth. The funds would be used to purchase program materials, staff training and implementation cost, and ongoing support.	
Target Population(s)	☐ 0-5 Years ☒ Elementary School ☒ Middle School ☒ High School	☐ Adults ☐ Older Adults ☐ All Ages
Service Location(s)	Countywide in schools	
Project Duration	Through FY 2015-16.	
Activities Performed	**Outreach:** Outreach will be to students, along with their parents. **Access and Linkage to Medically Necessary Care:** Students and parents will be provided with information about where and how to access mental health services. **Stigma and Discrimination Reduction:** The programs will focus on reducing stigma and discrimination as part of the curriculum. **Activities:** • Develop a menu of program choices for school districts from the SAMHSA National Registry of Evidence-Based Programs and Practices (www.nrepp.samhsa.gov). • Facilitate a needs assessment at each school site to guide the selection of the appropriate model program. • Develop implementation plans for each site. • Monitor and support implementation at each site.	

Project Name: SAMHSA Model Programs 1e

	• Evaluate effectiveness.
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Support[73] El Dorado County Office of Education, and its volunteers
Procurement Method	Sole source to EDCOE
Short-Term Goals	• Develop and implement programs • Identify activities to improve teens' relationships and increase their repertoire of safe, healthy activities
Long-Term Goals	• Increase mental wellness of youth • Improve family relationships • Reduce stigma and discrimination • Reduce bullying • Reduce substance abuse
Outcome Measures	Measurement 1: Increase youth engagement in school and community activities that are safe and healthy. Measurement 2: Students and school personnel are able to identify warning signs of vulnerable students at risk of suicide. Measurement 3: Satisfaction surveys completed by families and youth. Measurement 4: Program outcome measures for the individual SAMHSA Model Programs implemented.
Number of Services / Quantity of Service	Approximately 28,000-29,000 students throughout El Dorado County schools. 2011-12 enrollment was 28,965 students per the El Dorado County Office of Education, Public Education in El Dorado County Public School Facts 2012-13 (http://www.edcoe.org/documents/FingertipFactsEDCOE-Winter2013pub.pdf). The average cost per child in FY 2014-15 is approximately $10.

[73] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: SAMHSA Model Programs 1e

Budget	Up to $192,500 remaining from in FY 2013-14 on a reimbursement basis rolling into FY 2014-15. Up to $100,000 in FY 2014-15 and FY 2015-16 annually on a reimbursement basis, plus the rollover funds from FY 2013-14. EDCOE will commit ongoing in-kind contributions of administrative oversight, staff time, technology, and resources to support this PEI project.

Project Name: Prevention and Early Intervention for Youth in Schools If

New Project in FY 2014-15

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☒ Incarcerations ☒ School Failure or Dropout ☒ Unemployment	☒ Prolonged Suffering ☒ Homelessness ☒ Removal of Children from Their Homes
Objective	Professional and para-professional staff placed on school campuses to improve youth mental health and address social and familial variations and stressors. This is a pilot program through June 30, 2016. This program partners with the CSS Project 1b: Family Strengthening Academy and Project 3a: TAY Engagement, Wellness and Recovery and collaboratively with several other PEI projects.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☒ Middle School ☒ High School	☒ Adults (parents/guardians) ☒ Older Adults (parents/guardians) ☐ All Ages
	As a pilot project, only students attending one of the pilot schools will be eligible to participate in this project. The target age group are students at middle schools, high schools, alternative education school sites (grades 7 through 12) and K-8 schools for grades 6 through 8, and parents of those students.	
Service Location(s)	Schools, homes, libraries and other locations identified by the students or the family and approved by the service provider as a safe, private and appropriate place for the activities provided under this project.	
Project Duration	Ongoing	
Activities Performed	**Pilot Project** The provision of a school-based PEI project for middle and high school students incorporating activities such as outreach, referrals, groups, classes, individual and family therapeutic services and on-going case management is an ambitious one given the limited PEI funding, the issues that the project is designed to address, the number of schools in El Dorado County and the geographical distance between regions of the County. Therefore, this project will begin as a pilot in a limited number of schools to test the design of the project, develop the curriculum and services to be provided, and review the processes and project outcomes	

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	to determine project success. The pilot project will run through June 30, 2016. This project will receive ongoing evaluation and adjustments will be incorporated as needed. Substantial project changes will be made when there is an MHSA Plan Update. Minor modifications approved by the MHSA team not affecting the project intent may be made at any time during the pilot implementation as need to ensure the project is on target of reaching project goals. During the community planning process for FY 2016-17, this project will be evaluated for expansion to other middle and high schools. **Pilot School Selection Criteria**[74] Based on the results of the California Healthy Kids surveys for school year 2012-13 (or 2011-12 if more recent data was unavailable), the schools identified to participate in the pilot are: • El Dorado County Office of Education Non-Traditional Schools (Charter Community School and El Dorado Trade School) • Camerado Springs Middle School • Oak Ridge High School • Ponderosa High School These high schools were selected for this pilot based on the total percent of students identifying feelings of hopelessness ("During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more that you stopped doing some usual activities?") or thoughts of suicide ("During the past 12 months, did you ever seriously consider attempting suicide?"), along with the total number of students representative of the percentage (i.e., if 25% of the students identified they felt hopeless and there are 600 students, then approximately 150 students may have feelings of hopelessness). The data for individual middle schools was not available online, however composite data for the district was available. Camerado Springs Middle School was selected due to its district's overall response percentage and number of students, proximity to Ponderosa, total number of students, and the interest presented to the MHSA team for additional resources on its campus. Additionally, students from Camerado Springs Middle School generally advance to Ponderosa High School, so the continuity of services between middle and high school between those two schools will be available for evaluation during this pilot. Although Camerado Springs

[74] The schools identified to participate in this pilot program must be willing to have this project available on their campus. In the event a school is unable to host this pilot project, then an alternate school will be identified in its place.

Project Name: Prevention and Early Intervention for Youth in Schools If

	Middle School is a smaller school than other local middle schools, this pilot program has selected two large high schools in addition to the non-traditional schools and therefore a more modest middle school program will be started and evaluated for potential expansion. **Student Eligibility Criteria** 1. Students must attend one of the schools participating in the pilot of this project. 2. All students at participating schools are eligible to receive general outreach information or referrals to community resources. 3. Students participating in group and/or class activities must meet one of the following criteria. Students will be admitted to the groups and/or classes based on the order identified below, however once enrolled in a class a student will not be unenrolled for another student to enter. A waiting list may be established if necessary. a. Students referred to this project by school personnel due to mental health concerns. b. Students who self-refer, or through a referral from another source such as parents, friends, mentors, or others due to mental health concerns. c. Students not experiencing any mental illness symptoms who wish to effectuate a positive culture change at their schools and in their communities as it relates to mental health. d. Students who are interested in learning more about mental health. Students will complete an initial self-assessment form to identify their self-perceived needs and the referring individual will also complete an assessment form to identify their concerns that resulted in the referral. Project staff will review the assessments forms for each student to determine if this project is appropriate for the needs of each student. If enrollment in this project is not appropriate for a student, the student may still be provided with referrals to other community resources that may meet their needs. 4. Students eligible to participate in individualized services require more intensive therapeutic interventions to address their mental health needs, and be referred to this project by school personnel due to mental health concerns, self-referred by the student, or referred from another source such as parents, friends, mentors, or others due to mental health concerns. Students receiving individualized services will likely have a diagnosable mild to moderate mental illness or have significant risk factors that require individualized mental health services to prevent the elevated mental health needs from arising.

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	Project Design The purpose of this project is to develop a school-based system of support for the students that addresses prevention of or early intervention for mild to moderate mental illness that is complementary to other services students may be receiving. It is the intent of this project that participating students will gain increased knowledge about and skills to deal more effectively with depression, stress, teasing, bullying, relationships, anger, frustration, hopelessness, and other mental health issues. This program is not meant to provide all mental health services that a student may need, but it is designed to provide a long-term positive impact on the student's mental health. Through this project, students and parents will receive assistance in addressing risk factors for mental illness, and this project will also explore with students the underlying risk factors for mental illness and work to engage a change in culture surrounding the perception of mental illness. This project is not designed to supplant or bypass the schools' standard procedures for addressing a student's educational needs. Rather, this program is to provide additional support that may not otherwise be available. Students with an IEP who receive mental health services through that IEP would continue to do so. Students receiving mental health services through another source (e.g., insurance) would continue to receive those services. However, those students could participate in group activities or classes provided they meet the eligibility criteria. Those students would not, however, be eligible to receive additional individual counseling if they are receiving individual counseling elsewhere or are eligible for mental health services through the IEP program. MHSA funding cannot be utilized to supplant other State or federal funding or private insurance. **PEI Requirements:** Common to all schools will be the standard core elements of a PEI project: • **Outreach:** Provide outreach to students, parents and school personnel regarding services available through this project, other school-based and community services, and how to access services. Provide general education regarding the importance of mental wellness, signs and symptoms of mental illnesses, and information about more specific topics such as depression, suicide, and underlying causes and risk factors for mental illness. • **Access and Linkage to Medically Necessary Care:** Provide assistance in obtaining linkage to medically necessary care, including services provided through a private insurance network, private payor, and the County MHD. There will also be follow-up with students

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	and parents to confirm linkage with services and other referrals that may be needed. • **Stigma and Discrimination Reduction:** Key to the success of this project is working with students, parents and school personnel to reduce the stigma and discrimination that is frequently associated with mental health issues and mental illness. Positive messaging about mental illness will be provided, along with a focus on the importance of addressing mental health needs early and how to manage exterior impacts that may contribute positively or negatively to one's mental health. **Service Availability:** All services will be available at each participating school site, but not all students are eligible for all services (see eligibility criteria above). It is anticipated that the program at the high school level would look different than the program at the middle school level, and there may be other project differences between each school based on the services already offered at a school, the needs of the students and the method that proves to be most effective in reaching the students and providing services to meet their needs. It is anticipated that this project will require a ramp up period to establish school-site processes, forms and other procedures, and therefore not all activities may begin immediately. **Extended Service Delivery Hours:** During the community planning process, concern was expressed for the amount of time a student may need to miss classes to participate in mental health services. Therefore, services available through this project will focus on minimum interruption to a student's class time, and make services available not only during the school day, but also provide services during lunch, after school, in the evening and on weekends, based upon the requirements of the schools and the schedules of the students and their parents. **Service Delivery Locations:** Schools, homes, libraries and other locations identified by the students or the family and approved by the service provider as a safe, private and appropriate place for the activities provided under this project. **Groups / Classes:** Groups and classes offered will utilize effective methods likely to bring about intended outcomes and shall be based upon evidence-based practices (preferable), promising practices, or community/practice-based evidence standards. Groups and classes for students may be single gender or co-ed, providing psycho-educational opportunities, youth development and youth assets, and/or talking circles. Groups/classes will address issues such as, but not limited to, personal empowerment, self-esteem, peer or family pressures, family dynamics, bullying, sexual harassment, leadership development, peer

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	counseling, stress reduction, substance abuse, or how to talk about mental illness. Groups and classes for school personnel may also be made available, but it would be anticipated that this project will coordinate with the educational instruction that will be provided through WET Program 4: Early Indicators of Mental Health Issues and WET Program 5: Suicide Education and Training. **Individualized Services:** If it is determined that a student is in need of more intensive or individualized services, the project staff will coordinate those services with the appropriate school personnel (to determine if the youth has, or should have, an IEP that addresses the youth's mental health needs), parents (to the extent required by law) and the student. If the student is not receiving individualized services through another program, the student and his/her parents will receive case management and other services designed to meet the individual needs of the student. These services may include, but are not limited to, individual and family counseling and other services beyond traditional student-focused counseling. It would be anticipated that these students have a diagnosable mild to moderate mental illness and that the student would benefit from receiving mental health services. Key to the success of this level of the project is parental involvement and ongoing case management services, including periodic follow-ups with the student and family to determine if there are issues that continue to need to be addressed. This intent of this project is to engage the student and their parents in services to improve the mental health of the student, and to foster the long-term success of those services. Students receiving individualized services will also participate in the groups and classes for additional support and further development of treatment objectives. Key to this program design is the mental health professionals to provide school-based mental health interventions for those who meet the criteria. These individualized services may include, but are not limited to, individual and family counseling, crisis intervention, and conflict resolution, using recognized models and practices, such as but not limited to Cognitive Behavioral Therapy (CBT), Moral Reconation Therapy (MRT) or Dialectical Behavior Therapy (DBT). Case management services are a strong component of these individualized services. **Referrals for Specialty Mental Health Services:** Students in need of potentially in need of specialty mental health services will be referred to the County MHD for triage and assessment (or to the school if it has not already been determined whether the student is receiving mental health services through an IEP or other provider). If it is determined through

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	the triage process that the County Mental Health is the appropriate provider for the student, the County MHD will perform an assessment to determine the student's eligibility for specialty mental health services. Should a student be determined to meet the criteria for County-provided specialty mental health services, the student will return to the service provider of this project through CSS Project 1b: Family Strengthening Academy for specialty mental health services or transition to the County's MHD through CSS Project 3a: TAY Engagement, Wellness and Recovery Services. Students engaged in these two CSS services may continue to benefit from participation in the groups/classes offered on campus. **Parental Involvement:** Parent involvement plays is a key factor in a child's development and well-being, and this project seeks to create an alliance between parents and school personnel in working together to support the needs of the students. During the community planning process, the role of the parent in the educational performance of their child and risk factors for mental illness was identified. Parents range from very little involvement in their child's academics or life, to being overly involved or placing high expectations on their child to succeed. Either of these extremes can be detrimental to a child's mental health, with a wide range of variations in between. Therefore, a key component of this project is to engage parents. **Linkage with Other MHSA Projects** This project will coordinate with the providers of other PEI projects where the subject matter of the project is appropriate for the age group and service needs (e.g., SAMHSA Model Programs, Mental Health First Aid, PFLAG Community Education, Foster Care Continuum Training, Suicide Prevention and Stigma Reduction). This project will provide linkage to two CSS projects for those students who meet the criteria for specialty mental health services through the County MHD: • CSS Project 1b: Family Strengthening Academy: The provider of services under this PEI project will also be required to provide Medi-Cal specialty mental health services under Project 1b: Family Strengthening Academy to provide continuity of services and build upon already established relationships between the student, their parents and the therapists when the needs of the youth exceed the limitations of the PEI program. The services provided through the Family Strengthening Academy are expected to be provided at the same service locations identified above. The Family Strengthening Academy is designed to promote family unification (or reunification) through a range of promising, best, and

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	evidence-based treatment strategies for children who have been diagnosed with a serious emotional disturbance/serious mental illness and their families/guardians. Services include but are not limited to individual and family counseling sessions to strengthen the family unit, classes for the children, parents/guardians or family unit, and other practices based on evidence-based models. • CSS Project 3a: TAY Engagement, Wellness and Recovery Services: The TAY project provides services to meet the unique needs of transitional age youth and encourage continued participation in mental health services once they turn 18. These services are provided through the County MHD. Services through the CSS TAY project work on issues related to fostering emerging independence, supporting youth-developed goals, and helping the youth live up to their individual potential -- all supporting the goals of recovery and resiliency in the youth. Youth will be empowered to take responsibility for themselves and for their future, including continued participation in mental health services, but they will be supported in their development journey through this project. **Staffing Requirements** The mental health professionals will be responsible for establishing cohesion and collaboration between school personnel, parents, students, and community organizations in the provision of services under this project. This project will utilize Licensed Clinical Social Workers (LCSWs), Associate Social Workers under required supervision (ASWs) or credentialed School Counselors to provide outreach, referrals, therapeutic interventions and case management services. Licensed Marriage and Family Therapists (LMFTs) or Marriage and Family Therapists Interns under required supervision (MFTIs) may provide therapeutic interventions through this project, but the primary case manager shall be a LCSW, ASW or credentialed School Counselor. All therapeutic interventions must be performed by appropriately licensed or pre-licensed individuals. The California Board of Behavioral Sciences provides clarification as to the LCSW and LMFT services: What is a Licensed Marriage and Family Therapist (LMFT)? Section: 4980.02. PRACTICE OF MARRIAGE, FAMILY, AND CHILD COUNSELING; APPLICATION OF PRINCIPLES AND METHODS For the purposes of this chapter, the practice of marriage and family therapy shall mean that service performed with individuals, couples, or groups wherein interpersonal relationships are examined for the purpose of achieving

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	more adequate, satisfying, and productive marriage and family adjustments. This practice includes relationship and premarriage counseling. The application of marriage and family therapy principles and methods includes, but is not limited to, the use of applied psychotherapeutic techniques, to enable individuals to mature and grow within marriage and the family, the provision of explanations and interpretations of the psychosexual and psychosocial aspects of relationships, and the use, application, and integration of the coursework and training required by Sections 4980.37, 4980.40, and 4980.41. What is a Licensed Clinical Social Worker (LCSW)? Section: 4996.9. CLINICAL SOCIAL WORK AND PSYCHOTHERAPY DEFINED The practice of clinical social work is defined as a service in which a special knowledge of social resources, human capabilities, and the part that unconscious motivation plays in determining behavior, is directed at helping people to achieve more adequate, satisfying, and productive social adjustments. The application of social work principles and methods includes, but is not restricted to, counseling and using applied psychotherapy of a nonmedical nature with individuals, families, or groups; providing information and referral services; providing or arranging for the provision of social services; explaining or interpreting the psychosocial aspects in the situations of individuals, families, or groups; helping communities to organize, to provide, or to improve social or health services; or doing research related to social work. Psychotherapy, within the meaning of this chapter, is the use of psychosocial methods within a professional relationship, to assist the person or persons to achieve a better psychosocial adaptation, to acquire greater human realization of psychosocial potential and adaptation, to modify internal and external conditions which affect individuals, groups, or communities in respect to behavior,

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	emotions, and thinking, in respect to their intrapersonal and interpersonal processes.[75] Credentialed School Counselors are defined by the The specialization in School Counseling authorizes the holder to perform the following duties: • Develop, plan, implement, and evaluate a school counseling and guidance program that includes • academic, career, personal, and social development • Advocate for the high academic achievement and social development of all students • Provide schoolwide prevention and intervention strategies and counseling services • Provide consultation, training, and staff development to teachers and parents regarding students' needs • Supervise a district-approved advisory program as described in California Education Code, Section 49600[76] Para-professionals trained in the group/class models offered may also be utilized for delivery of those programs and for assistance with referrals, linkage to services, follow-up regarding linkage, and other supportive non-clinical services. Administrative staff may be utilized for basic coordination, rep reporting and invoicing. **Pilot Project Evaluation** Evaluation of this project will be performed by the County's MHSA team on a regular basis utilizing the criteria set forth below for Outcome Measures, and determining the progress towards reaching the Short-Term and Long-Term Goals identified below, and may involve the service provider, students, their parents, school personnel and other individuals or entities (e.g., the Mental Health Commission). Outcomes will also be reviewed as part of the annual community planning process. The contracted provider will be required to submit monthly demographic reports, quarterly services reports and annual project reports. **Project Differentiation** This PEI project is distinguished from the CSS projects (Project 1b:

[75] California Department of Consumer Affairs, Board of Behavioral Sciences, http://www.bbs.ca.gov/consumer/what_is.shtml.
[76] State Of California, Commission On Teacher Credentialing. *Pupil Personnel Services Credential For Individuals Prepared in California*. http://www.ctc.ca.gov/credentials/leaflets/cl606c.pdf.

Project Name: Prevention and Early Intervention for Youth in Schools If

	Family Strengthening Academy and Project 3a: TAY Engagement, Wellness and Recovery Services) in that this PEI project provides preventative and early intervention for students experiencing mild to moderate mental illness, or other students who may wish to be included in the groups or classes to effectuate a positive culture change at their schools and in their communities as it relates to mental health and, if capacity allows, those who are interested in learning how to address any future mental health needs they may experience may also participate.
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Support[77] One contracted vendor will be selected to implement this pilot project at all schools identified above. Contracted vendor must also meet the criteria for provision of Medi-Cal specialty mental health services required by CSS Project 1b: Family Strengthening Academy.
Procurement Method	Competitive procurement process
Short-Term Goals	• Identify campus needs, including the needs of the students, parents and school personnel. • Establish procedures, forms and other documentation to implement this project. • Perform outreach. • Identify students to engage in participation. • Increase school-based mental health services. • Increased knowledge of community resources. • Early identification of the signs and symptoms of mental illness.
Long-Term Goals	• Raise awareness about mental illness. • Reduce stigma and discrimination. • Improve student wellness and mental health. • Improve the family relationship. • Improve school culture as it relates to minimizing activities that may be risk factors for mental illness and encouraging positive mental health. • Reduce suicidal ideation, attempted suicides and completed suicides. • Increase academic success, which may not mean higher grade point averages, but could be other successes such as higher rate of

[77] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: Prevention and Early Intervention for Youth in Schools If

	completion of homework, increased academic confidence or increased willingness to reach out for academic assistance. • Increase school attendance rates for participants. • Decreased referrals for behavior problems or other disciplinary actions for participants. • Improved results from the California Healthy Kids survey, which would show a reduction in the number of students with feelings of hopelessness or suicidal thoughts. • Reduction in substance use and/or self-medicating. • Current substance abusers will decrease use of substances (alcohol, prescription drugs, marijuana, other illicit and life endangering drugs).
Outcome Measures	Measurement 1: Continued engagement of students and parents in this project, including rate of attendance/missed appointments. Measurement 2: Self-assessments measuring pre-, interim- and post-participation self-perceptions, and pre-, interim- and post-participation assessments completing by the referring party, as allowed by law, to measure the referring parties' perceptions of the students enrolled in this project. May also include parental assessments. Measurement 3: Truancy rates/absences of the students enrolled in this project. Measurement 4: The number of referrals for behavior problems or other disciplinary actions for the students enrolled in this project. Measurement 5: The number of school dropouts within the students enrolled in this project. Measurement 6: The number of incarcerations within the students enrolled in this project. Measurement 7: The number of attempted or completed suicides by students enrolled in this project. Measurement 8: School-wide surveys to determine the level of knowledge about mental illness, available resources and willingness to discuss mental health concerns. Measurement 9: The California Healthy Kids Surveys will measure the long-range outcomes at the schools where this project is implemented as it relates to feelings of hopelessness and suicidal thoughts. This outcomes of this measurement may not be available annually or during the pilot period of the project.

Project Name: Prevention and Early Intervention for Youth in Schools If

Number of Services / Quantity of Service	As a pilot project, it is difficult to ascertain the number of students and families who may benefit from this project. Outreach efforts could reach all students at the participating schools, which would be nearly 5,000 students. Groups and classes would be anticipated to reach approximately 400 students annually, while individual and family direct services, as a subset of those participating in the groups, would be anticipated to reach up to 200 students annually. It is likely that this project will not begin until at least the Fall of 2014 due to the time necessary for the development of the Request for Proposals and resulting contract. Therefore, the first year of this project would likely operate at approximately 60-75% of annual capacity (which also allows for start-up time). The average cost per student would be approximately $250, depending upon the level of participation. By the nature of this program, some students and their parents will receive a higher level of service. However, there will not be a minimum or maximum service value set for any student.
Budget	Up to $75,000 in FY 2014-15 on a reimbursement basis. As a new project in FY 2014-15, any unexpended funds from FY 2014-15 roll into FY 2015-16. Up to $100,000 in FY 2015-16 and FY 2016-17 on a reimbursement basis in addition to any rollover funds from FY 2014-15.

Project Name: Mental Health First Aid 2a

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☒ Incarcerations ☒ School Failure or Dropout ☒ Unemployment	☒ Prolonged Suffering ☒ Homelessness ☒ Removal of Children from Their Homes
Objective	This evidence-based project introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and provides an overview of common treatments, using the curriculum developed by Mental Health First Aid USA. There are two programs available: Mental Health First Aid, which focuses on risk-factors and mental illness in adults and Youth Mental Health First Aid, which focuses on risk-factors and mental illness in youth ages 12 to 25. There is also a military-focused module for the adult program which focuses on the needs of activity duty military personnel, veterans and their families.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☒ High School (16+)	☒ Adults ☒ Older Adults ☐ All Ages
	Adults. Youth aged 16 and 17 upon special request and approval of the MHSA Program Manager.	
Service Location(s)	Countywide. Instructors may provide training on a very limited basis in neighboring counties upon special request and approval of the MHSA Program Manager to support Statewide prevention and early intervention activities.	
Project Duration	Ongoing.	
Activities Performed	**Outreach:** Mental Health First Aid instructors reach out to organizations that may benefit from the training, including community-based organizations, service organizations, faith-based organizations, primary care professionals, employers and business leaders, school personnel and educators, law enforcement, nursing home staff, volunteers, young people, families and the general public. **Access and Linkage to Medically Necessary Care:** Attendees learn a five-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer,	

	social, and self-help care. **Stigma and Discrimination Reduction:** The class encourages open discussion regarding mental illness, resulting in attendees gaining a better perspective on what mental illness is, what the risk factors are for mental illness, and how to better communicate with those experiencing a mental health crisis. Through better understanding of mental illness, the stigma associated with mental illness is lessened and discrimination against those with mental illness is reduced. **Activities:** Mental Health First Aid brings together individuals who have a desire to better understand how to help friends, family members and community members address mental health and risk factors for mental illness, and to help identify available resources for seeking treatment. Having a better understanding of the importance of mental health fosters a healthier community. Instructors perform activities such as: outreach, ordering class supplies, scheduling and coordinating classes, providing training, coordinating post-training follow-up and evaluation, networking with other Mental Health First Aid providers, participating in continuing education, and monitoring certification status. A team of two of Mental Health First Aid instructors provide the 8-hour training session, which includes: • Identifying the potential risk factors and warning signs for a range of mental health problems, including depression, anxiety/trauma, psychosis, eating disorders, substance use disorders, and self-injury. • An understanding of the frequency of various mental health disorders in the U.S. and the need for reduced stigma/shame in their communities. • An action plan including the skills, resources and knowledge to evaluate the situation, select and implement appropriate interventions, and to help an individual in crisis connect with appropriate professional care. • Information on various resources available to help someone with a mental health problem. Upon completion of the training, attendees receive a Mental Health First Aid certification that is valid for three years. Preferred minimum class size is 12 attendees. Preferred maximum class size is 30 attendees.

Project Name: Mental Health First Aid 2a

Services Provided By	☒ Contracted Vendor[78] ☒ Volunteers ☒ County Staff Mental Health First Aid Certified Instructors, who are County employees or community volunteers. Currently, there are six County employees, one EDCOE staff and one community volunteer certified in Mental Health First Aid (Adult and/or Youth Mental Health First Aid). One of the six County employees is also certified in the military module for Mental Health First Aid. Contracted vendor staff may be utilized if they are certified Mental Health First Aid instructors.
Procurement Method	Services provided by HHSA staff. Should new certified instructor training opportunities arise, County staff would receive priority in attendance. In the event additional seats are available for training, applications from the community will be accepted. Applications reflecting a dedication to service in El Dorado County, experience in mental health, and the capacity to provide the required number of annual trainings to maintain certification will be ranked for attendance priority. For add-on modules, such as Youth or Rural Mental Health First Aid, currently certified instructors would receive priority in attendance. Sole source contracts may be executed with service providers who have certified Mental Health First Aid instructors on staff and will cover the cost of instructor time for preparing for, providing, and evaluating the Mental Health First Aid training, along with reimbursement for mileage to and from each training session.
Short-Term Goals	Raise personal awareness about mental health, including increasing personal recognition of mental illness risk-factors.
Long-Term Goals	Community members use the knowledge gained in the training to assist those who may be having a mental health crisis until appropriate professional assistance is available. Opens dialogue regarding mental health, mental illness risk factors, resource referrals, and suicide prevention. Work towards stigma and discrimination reduction in our communities and networks.

[78] These services will be provided by County Staff and Volunteers; potential use of Contracted Vendors at a future point in time.

Project Name: Mental Health First Aid 2a

Outcome Measures	Measurement 1: Class evaluation provided to attendees at the end of each session. Measurement 2: Evaluation survey provided to attendees six months after taking the class, including information regarding application of material learned. Measurement 3: Identify attendees who re-register for the class after three years in order to maintain their certification.
Number of Services / Quantity of Service	Estimated at twelve or more Mental Health First Aid courses annually based on community demand, each class providing training to 12 to 30 individuals, resulting in training for approximately 240 individuals, or more, per year. The average cost per attendee is estimated at $500.
Budget	Annual cost is estimated at potentially up to $120,000. MHSA funds would be utilized for the following types of expenses: staff time, books, mileage, supplies, refreshments, training, and equipment. Staff time to perform project-related activities, including but not limited to: outreach, order class supplies, schedule and coordinate classes, provide training, coordinate post-training follow-up and evaluation, networking with other Mental Health First Aid providers, continuing education, and monitor certification status. Books for each training participant cost approximately $20 per person and each participant must receive one book. Mileage and general supplies for activities associated with the Mental Health First Aid training, and refreshments to be served during training sessions. Refreshments may also be made available at follow-up events, which would be held to gather feedback from previous attendees regarding application of learned skills (e.g., at six months, one year, two years). Equipment necessary to provide the training, including a projector, a screen, laptop, speakers, and other peripheral equipment (including but not limited to power cords), or repairs to or replacement of equipment. Additionally, cost to certify additional Mental Health First Aid instructors, and/or recertifying or expanding the certification of current Mental Health First Aid instructors, including but not limited to registration fees, travel, accommodation, and staff time are included. Other costs not identified above may be necessary to effectively implement and monitor the project.

Project Name: National Alliance on Mental Illness Training 2b

Objective	The National Alliance on Mental Illness (NAMI) is a non-profit, charitable organization offering support, education, advocacy, and hope to families and individuals affected by mental illness. The objective is to provide awareness, education and support as a means to encourage hope, health and a positive change in the community's mental health system.
Discontinued Effective 7/1/14	NAMI has requested that this contract not be pursued, therefore this project is discontinued effective July 1, 2014. NAMI will continue to provide community training through alternate funding. The MHD would like to thank NAMI for providing continued educational opportunities in our County.

Project Name: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education — 2c

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☐ Incarcerations ☒ School Failure or Dropout ☐ Unemployment	☒ Prolonged Suffering ☒ Homelessness ☐ Removal of Children from Their Homes
Objective	Support differences, build understanding through community involvement, and provide education to reduce shame and support to end discrimination.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☒ Middle School ☒ High School	☒ Adults ☒ Older Adults ☐ All Ages
Service Location(s)	Countywide	
Project Duration	Ongoing	
Activities Performed	PFLAG provides outreach, education and training to mental health providers and interested community members/groups. PFLAG provides an opportunity for dialogue about sexual orientation and gender identity and acts to create a society that is healthy and respectful to human differences. PFLAG will broaden its target audience to network with various community-based service organizations and diversify its library of educational materials. **Outreach:** Informational packets and educational materials will be purchased and distributed throughout the community, including libraries and community mental health providers. Additionally, educational DVDs are available to community mental health providers and other organizations for improving their knowledge of the subject and to share with their clients. The MHD partners with PFLAG to provide outreach and education to mental health providers and interested community members. Outreach costs such as mileage reimbursement, postage, packet materials and other multimedia information, and food costs may be paid for as well. An outreach plan and year-end progress report will be submitted to the MHD by PFLAG. **Access and Linkage to Medically Necessary Care:** Attendees may self-refer to services.	

Project Name: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education 2c

	Stigma and Discrimination Reduction: Education, in the form of presentations/discussions, to the general public regarding sexual orientation. PFLAG raises awareness about mental wellness and stigma and discrimination reduction for the Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ) community through publications and presentations. PFLAG provides an opportunity for dialogue about sexual orientation and gender identity, and acts to create a society that is healthy and respectful of human diversity. This program will also be linked with other stigma and discrimination reduction activities.
Services Provided By	☐ Contracted Vendor ☒ Volunteers ☒ County Staff
Procurement Method	None. This program is provided by community volunteers (PFLAG members) and County staff.
Short-Term Goals	• Continue to reduce stigma and discrimination regarding those who are LGBTQ through community education and outreach.
Long-Term Goals	• Reduction of stigma and discrimination associated with being lesbian, gay, bisexual, transgender or questioning. • Education, in the form of presentations/discussions, to the general public regarding sexual orientation.
Outcome Measures	Measurement 1: Number of informing material distributed. Measurement 2: Number of people reached through presentations. It is difficult to measure the outcomes of general public outreach activities due to their non-specific target population and methodology.
Number of Services / Quantity of Service	Approximately 1,000 booklets, pamphlets, or other educational materials. Materials are distributed to community-based partners, including education, as requested, or are available for check-out for educational purposes. The actual number of individuals reached through this project could be 1,000 (one person for every pamphlet) and an additional 100 for presentations, or approximately $4.54 per person.
Budget	Up to $5,000 annually.

Project Name: Community Information Access 2d

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☐ Incarcerations ☐ School Failure or Dropout ☐ Unemployment	☒ Prolonged Suffering ☐ Homelessness ☐ Removal of Children from Their Homes
Objective	To provide a free, web-based community education and information resource center for consumers of mental health services, family members and community stakeholders.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☒ High School (16+)	☒ Adults ☒ Older Adults ☐ All Ages
Service Location(s)	Countywide from any high-speed internet connection	
Project Duration	Ongoing	
Activities Performed	**Outreach:** The County distributes bookmarks throughout the community, specifically to libraries and community partners, that promote the availability of the Community Access Site (CAS) site and there is a link to the CAS site from the County's MHD website. The CAS website is available at: http://cas.essentiallearning.com/edcmhCAS/. **Access and Linkage to Medically Necessary Care:** Users of the site gain increased awareness about the need for services and may refer friend/family or even themselves to services. **Stigma and Discrimination Reduction:** Education about mental illness will show how common it is in the general population. **Activities:** The CAS is a free, web-based community education and information resource center for consumers of mental health services, family members and community stakeholders. Included on this site is a comprehensive library of interactive online courses for use by mental health professionals and the public. Topics include: • Mental health • Addiction, treatment and recovery • Peer education • Workforce skills • Issues related to older adults	

Project Name: Community Information Access 2d

	• Needs of returning veterans In addition, the CAS allows user to build, edit and store a personal Wellness Recovery Action Plan, which is a self-designed plan for staying well. It was developed for people who have experienced mental health difficulties, but has been found to be a useful tool for people with other medical conditions, and as a guide to improve interpersonal relationships and achieve life goals.
Services Provided By	☒ Contracted Vendor ☐ Volunteers ☒ County Staff Support[79] Relias Learning
Procurement Method	This program is provided by the contracted vendor, Relias Learning, with support by County staff to update the information regarding local services and partners.
Short-Term Goals	• Continue to reduce stigma and discrimination through education.
Long-Term Goals	• Reduction of stigma and discrimination associated with mental illness. • Education, in the form of interactive online classes, to the general public regarding mental health and wellness, including behavioral health, addiction, developmental disabilities, trauma in veterans and issues specific to the mental health needs of older adults. • It is anticipated that the community will become better informed about mental illness, reduction of the stigma and discrimination association with mental illness, and overall improvement in the health of the community by being better educated about mental health in general.
Outcome Measures	Measurement 1: Number of people accessing web-based information. Measurement 2: Number of bookmarks distributed. It is difficult to measure the outcomes of general public outreach activities due to their non-specific target population and methodology.
Number of Services / Quantity of Service	It is anticipated that this service would be accessed by approximately 100 or more users annually. The MHD continues to work with the vendor on determining the actual number of users and site access frequency.

[79] County staff will be utilized to perform tasks such as: administrative activities (e.g., updating site information, marketing, contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: Community Information Access 2d

Budget	Approximately $12,000 for FY 2014-15. Approximately $14,000 for FY 2015-16. Approximately $16,000 for FY 2016-17. Cost increases reflect anticipated increases in contract amounts.

Project Name: Suicide Prevention and Stigma Reduction 2e

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☐ Incarcerations ☐ School Failure or Dropout ☐ Unemployment	☒ Prolonged Suffering ☐ Homelessness ☐ Removal of Children from Their Homes
Objective	Outreach to all ages Countywide to reduce suicide, increase awareness and access to services, identify how and when to access mental health services, and reduce stigma.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☐ Adults ☐ Older Adults ☒ All Ages
	Age appropriate prevention activities.	
Service Location(s)	Countywide via various media, public service announcements (PSAs), printed materials, speakers or other methods.	
Project Duration	Ongoing	
Activities Performed	**Outreach:** Information, awareness, and publicity for all ages and communities. This will inform all members of the community about the problems of depression, suicide, and other mental health issues, including underlying causes. This program will also integrate with the Statewide Suicide Prevention program and school-based suicide prevention activities, capitalizing on the Suicide Education and Training provided to school personnel under Workforce Education and Training (WET). **Access and Linkage to Medically Necessary Care:** The project will include information about where to seek assistance. **Stigma and Discrimination Reduction:** Through the media, PSAs, printed materials, speakers or other methods, individuals will gain a better understanding of mental illness, which will work towards the reduction of stigma and discrimination. This program will integrate with the statewide Stigma and Discrimination Reduction (SDR) program to integrate available materials into the local program. **Activities:** • This program links with the Suicide Education and Training program under the WET Component. • Identification and/or development of program content (e.g., PSAs, printed materials).	

Project Name: Suicide Prevention and Stigma Reduction 2e

	• Distribution and marketing of program content. • Pre- and post-surveys to determine effectiveness. • To the extent possible, work with students to develop locally produced media and PSAs. • Establish linkage with the Statewide Suicide Prevention and SDR programs to utilize existing resources; adapt as necessary for El Dorado County. • Outreach to transition age youth and adults whose lives have been impacted by suicide and/or stigma and provide training (if necessary) to those individuals to speak out regarding their experiences with suicide in the community.
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff & Support[80] In certain circumstances, such as, but not limited to, prior to the execution of an agreement for services, a lapse in services resulting from a vendor change, and/or for as-requested services, the El Dorado County HHSA, MHD, will utilize Mental Health staff to provide services under this project.
Procurement Method	Competitive procurement process
Short-Term Goals	• Increase awareness of mental illness, programs, resources, and strategies. • Increased referrals.
Long-Term Goals	• Reduce the number of suicides in El Dorado County. • Change negative attitudes and perceptions about seeking mental health services. • Eliminate barriers to achieving full inclusion in the community and increase access to mental health resources to support individuals and families. • Promote positive attitudes regarding living with mental illness. • Share messages of wellness, hope and recovery.

[80] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: Suicide Prevention and Stigma Reduction 2e

Outcome Measures	Measurement 1: Program quality will be measured by interviews and surveys about the program. Measurement 2: Long term success will be measured by the school-wide California Healthy Kids Survey, conducted every other year. Measurement 3: This project shall use a validated method to measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness that are applicable to the specific prevention program/approach implemented.
Number of Services / Quantity of Service	It is difficult to measure the outcomes of general public outreach activities due to their non-specific target population and methodology. A public outreach campaign such as this could reach 5,000 individuals or more, for an average cost per person of $6.00.
Budget	Up to $30,000 annually on a reimbursement basis.

Project Name: Foster Care Continuum Training 2f

Project Type:	☒ Prevention	☐ Early Intervention
Negative Outcome(s) Addressed:	☐ Suicide ☐ Incarcerations ☐ School Failure or Dropout ☐ Unemployment	☐ Prolonged Suffering ☐ Homelessness ☒ Removal of Children from Their Homes
Objective	Improve the ability of foster parents, parents/guardians, foster family agency staff and County staff to identify mental health risk factors and to address negative behaviors early to improve placement stability of foster children and youth.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☒ Adults ☒ Older Adults ☐ All Ages
	Foster parents, parents/guardians, support network members, foster family agency staff, and County staff	
Service Location(s)	In the community, County facilities and/or in homes.	
Project Duration	Ongoing	
Activities Performed	**Outreach:** Outreach will be directed to foster parents, families involved with Child Welfare Services, support networks, foster family agency staff and Child Welfare Services staff. **Access and Linkage to Medically Necessary Care:** Parents/guardians and foster parents, and their support networks, will be provided with information regarding how to obtain services for themselves and their children. **Stigma and Discrimination Reduction:** Conduct workshops on need of mentors for young children to help recognize signs, reduce stigma, and discrimination. This program will also be linked with other stigma and discrimination reduction activities. **Activities:** Training of foster parents, families involved with Child Welfare Services, support networks, foster family agency staff and Child Welfare Services staff to address behaviors linked to the core issues and functions driving child and adult behavior. Teach foster parents, parents/guardians, support networks and staff easy but useable behavioral tracking. Training to develop foster parents, parents/guardians and support networks to be	

Project Name: Foster Care Continuum Training 2f

	mentors.
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Support[81]
Procurement Method	Competitive procurement process
Short-Term Goals	• Improve accountability of behavior. • Improve foster parent, support networks, family, foster family agencies and County staff expertise.
Long-Term Goals	• Improve quality of care in the home. • Reduce seven-day notices for change of child placements. • Reduce the number of placements for children in out-of-home care. • Develop strong support networks for foster families (i.e., those who provide support to foster families, including but not limited to extended family members, friends, child care providers, respite care providers)
Outcome Measures	Measurement 1: A reduction in seven-day notices. Measurement 2: An improvement in foster care placement stability. Measurement 3: Behavior tracking shows a decrease in maladaptive behavior. Measurement 4: Behavior tracking shows increase in strengths. Measurement 5: Increase in discharges to permanency.
Number of Services / Quantity of Service	Approximately 300 foster youth and their families annually, for an average cost of $167 per person.
Budget	Up to $50,000 annually on a reimbursement basis.

[81] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: Community Outreach and Resources 2g

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☒ Incarcerations ☒ School Failure or Dropout ☒ Unemployment	☒ Prolonged Suffering ☒ Homelessness ☒ Removal of Children from Their Homes
Objective	During the community planning process, a concern was identified that many people do not know what services are available or where to obtain services. Provide printed information related to mental health, services available, support available, reference materials and resources.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☐ Adults ☐ Older Adults ☒ All Ages
Service Location(s)	Countywide	
Project Duration	Ongoing	
Activities Performed	**Outreach:** Outreach will be accomplished by increasing the awareness of mental health issues and service providers, including the services available in the community and how to obtain services. Outreach will also be accomplished through purchasing space at community health events and printing of resource-related materials. **Access and Linkage to Medically Necessary Care:** Individuals, service providers and other businesses will have more information available to them to provide linkage for their clients to medically necessary care. **Stigma and Discrimination Reduction:** Increasing the dialogue about mental health, or mental wellness, and openly discussing mental illness will raise awareness about the topic. Through the discussions and the reference materials, people will gain a better understanding of mental illness, which will work towards the reduction of stigma and discrimination. **Activities:** It is anticipated that the community will become better informed about mental illness, know where to go for help, reduce the stigma and discrimination association with mental illness, and overall improve the health of the community by being better informed and supported. Activities include, but are not limited to: • Staff engagement at health-related fairs and other community-based	

Project Name: Community Outreach and Resources 2g

	events (e.g., Kids Expo) and community-based outreach efforts, through local organizations and companies; • Purchase of incentives as handouts at events; • Printed materials, such as newspaper feature inserts; • Updates to the Mental Health resource documentation.
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff
Procurement Method	Initially, these services will be provided by County Staff and Volunteers. In the event this program is transitioned to a contracted vendor in whole or in part, the vendor(s) will be selected through a competitive procurement process and multiple vendors may be selected to provide these services.
Short-Term Goals	• Raise awareness about mental health issues and services available in our community.
Long-Term Goals	• Reduction of stigma and discrimination associated with mental illness.
Outcome Measures	Measurement 1: Number of people accessing web-based information. Measurement 2: Number of brochures and other reference materials distributed. Measurement 3: Number of individuals involved in future MHSA planning activities. It is difficult to measure the outcomes of general public outreach activities due to their non-specific target population and methodology.
Number of Services / Quantity of Service	Participate in at least two community events annually (e.g., Kid's Expo). Printing and distribution of reference materials and resource materials. It is difficult to measure the outcomes of public outreach activities due to their non-specific target population and methodology. A public outreach campaign such as this could reach 7,000 individuals or more (through newspaper inserts), for an average cost per person of $3.86 in FY 2014-15.
Budget	Approximately $20,000 in FY 2014-15. Approximately $10,000 in FY 2015-16 and FY 2016-17. Costs include staff, administration, overhead, printing materials, signage, distribution of materials, and purchase of incentives.

Project Name: Wennem Wadati: A Native Path to Healing 3a

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☒ Incarcerations ☒ School Failure or Dropout ☒ Unemployment	☒ Prolonged Suffering ☒ Homelessness ☒ Removal of Children from Their Homes
Objective	The County of El Dorado's Native American Resource Collaborative has designed a program called "Wennem Wadati: A Native Path to Healing," which applies a combination of mental health services and traditional cultural teachings unique to the local Native American community. The Program was designed to provide culturally specific Native American services through use of Cultural Specialists, who are Native American community members, working in a professional capacity that access unique cultural contexts and characteristics through the use of traditional Native American healing approaches. The Program will use various prevention and early intervention strategies to address all age groups in the target population with the intent to maintain mental health well-being, improve wellness, and decrease health disparities experienced by the Native American community.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School Native Americans	☐ Adults ☐ Older Adults ☒ All Ages
Service Location(s)	Foothill Indian Education Alliance in Placerville, schools and other community-based sites that are accessible to the Native American population.	
Project Duration	Ongoing.	
Activities Performed	**Outreach:** Outreach to Native American youth and families to encourage participation in the Wennem Wadati activities, promote mental health well-being, improve wellness, and decrease health disparities experienced by this population. **Access and Linkage to Medically Necessary Care:** A dedicated crisis line will be available from 8 a.m. to 8 p.m. Monday through Friday to provide students access to a Native American mental health Cultural Specialist who will be available via answering service to respond, by telephone or in person, to situations where Native American students are experiencing a mental health crisis.	

Project Name: Wennem Wadati: A Native Path to Healing 3a

	Stigma and Discrimination Reduction: Through raising awareness about mental illness, fear and misunderstanding will be reduced. It is frequently the fear and misunderstanding related to mental illness that leads to stigma and discrimination. By reducing the underlying concerns about mental illness and raising awareness about mental illness, the associated stigma and discrimination will be reduced. **Activities:** Talking Circles will be conducted at schools and other community-based sites that are accessible to Native American individuals, each facilitated by Cultural Specialists. Monthly traditional gatherings and cultural activities designed to spread cultural knowledge and support family preservation. Gatherings/activities will be held at the Foothill Indian Education Alliance in Placerville or at other community-based sites agreed upon by the group and accessible to the target population. Prevention and Youth Activities will be conducted at various community sites. Generally, these activities will be conducted by the Student Leadership/Prevention Activities Specialists. One multi-day field trip will be scheduled for the Student Leadership group annually.
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Support[82] Foothill Indian Education Alliance, which may utilize volunteers for some activities
Procurement Method	Services provided by Foothill Indian Education Alliance contracted Cultural Specialists, Student Leadership/Prevention Activities Specialists and volunteers.
Short-Term Goals	• Increased awareness in the Native American community about the crisis line and available services.
Long-Term Goals	• Improve the overall mental health care of Native American individuals, families and communities; • Reduce the prevalence of alcoholism and other drug dependencies; • Maximize positive behavioral health and resiliency in Native American individuals and families reducing suicide risk, prolonged suffering, and incarceration; • Reduce school drop-out rates; and • Support culturally relevant mental health providers and their prevention efforts.

[82] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: Wennem Wadati: A Native Path to Healing 3a

Outcome Measures	Measurement 1: Casey Life Skills Native American Assessment, to be given when an individual joins the Talking Circles and when they end their participation. Measurement 2: Quarterly client registration which includes client demographic data as well as specific client issues to be addressed. Measurement 3: Year-end annual report which will includes a summary analysis of the Casey Life Skills Assessment, program accomplishments, community collaboration activities, program activities offered, and program outcome measures.
Number of Services / Quantity of Service	Target population – All Native Americans living in the County of El Dorado. It is estimated that approximately 350 individuals or more will receive direct services through this project, for an average cost of $359 per person, with outreach activities providing an even wider reach.
Budget	Up to $125,725 annually on a reimbursement basis.

Project Name: Latino Outreach 3b

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☒ Incarcerations ☒ School Failure or Dropout ☒ Unemployment	☒ Prolonged Suffering ☒ Homelessness ☒ Removal of Children from Their Homes
Objective	This program addresses isolation in the Spanish-speaking or limited English-speaking Latino adult population and peer and family problems in the youth population as community issues resulting from unmet mental health needs by contributing to system of care designed to engage Latino families and provide greater access to culturally competent mental health services.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☐ Adults ☐ Older Adults ☒ All Ages
	Spanish-speaking or limited English-speaking Latino adults; Spanish-speaking or limited English-speaking Latino children, or children of Spanish-speaking or limited English-speaking Latino adults; and their family units.	
Service Location(s)	Community-based agencies on both the West Slope and Tahoe Basin using the Promotora model. In the Tahoe Basin, direct mental health services are also provided by the contracted vendor. Limited mental health services are provided on the West Slope.	
Project Duration	Ongoing	
Activities Performed	**Outreach:** The Latino Outreach program for the western slope of the County is a Promotora outreach and engagement program that utilizes a non-professional Latino peer to provide community-based outreach and engagement to the various geographically-spread communities in the western slope, in addition to community-based bilingual/bicultural licensed clinical mental health services for adults. The goal of the El Dorado County Latino Engagement Program is to collaborate with existing agencies in the areas of outreach, engagement and provision of support services while adding the availability of bilingual and bicultural mental health services for the Latino community. The South Lake Tahoe community primarily voiced a need for funding to pay for bilingual/bicultural mental health services. This community is	

	geographically concentrated and has an existing family resource center located in the heart of the Latino residential community with a strong Latino participant base. Therefore, although outreach is a component of the program in the Tahoe Basis, it is not the primary component of the program and additional funds for services are provided for the Tahoe Basin. **Access and Linkage to Medically Necessary Care:** The Latino population faces the potential of isolation and challenges to transportation due to the spread out geography of the County, along with potential language barriers, and thereby, greater challenges accessing mental health services. The Latino Outreach program is designed to improve access, improve accuracy of diagnosis, use of appropriate and individualized service planning and delivery, use of effective integration of client families into services, and use of community and natural resources. Through these services, the disparities in mental health service access, unmet needs, and the resulting community issues should decline. Further, an enriched system of care for Latino service engagement and significantly improved relations with the Latino community and their providers should be result, as well. In the Tahoe Basin, program funds are utilized also to provide services to the Latino community through the contracted vendor. **Stigma and Discrimination Reduction:** The MHSA vision for the Latino population in El Dorado County is one in which there is community awareness and understanding regarding mental illness and mental health thereby removing the stigma that creates barriers to service access. **Activities:** The Latino Outreach program requirements include: • a Promotora services model that provides bilingual/bicultural Spanish-speaking outreach, engagement, screening, administration of outcome and satisfaction survey measures, integrated service linkage, interpretation services and peer/family support for Latino individuals and families; • clients served must be of Latino descent; • clients served must be El Dorado County residents; • support in spirit and practice for the five essential elements of the MHSA; • services and activities that support the required PEI components of outreach, access/linkage and stigma reduction. • adherence to the El Dorado County MHSA policies regarding the MHSA principles and culturally competent practice expectations and requirements; • providing forms, program documentation, brochures, and other

	program documents in Spanish in a format approved by the County; • access to bilingual Spanish-speaking interpreters to provide Promotora services; • clinical services must be provided by a bilingual licensed mental health professional; • participation in performance indicator measures and community satisfaction surveys that reflect outcomes and responses to the integrated MHSA programs; • submittal of quarterly performance indicator reports and budget reports; • submittal of monthly invoices and service delivery reports; • participation in regularly scheduled meetings with HHSA to ensure coordination and ongoing planning; • capacity to transmit data electronically via high speed internet; • participation in quarterly cultural competency and annual MHSA compliance training; • development of provider-specific policies and procedures for the Latino Outreach program on the western slope; • program administrator and Latino Outreach team members must sign the El Dorado County Mental Health Confidentiality Statement and Code of Conduct agreements; and • adherence to all contract requirements. On the West Slope, the primary focus of the Latino Outreach program is outreach, engagement, screening, administration of outcome and satisfaction survey measures, integrated service linkage, interpretation services and peer/family support for Latino individuals and families. Limited mental health services may be available. Services in the Tahoe Basin also include, but are not limited to: • A Promotora services program that provides bilingual/bicultural Spanish-speaking outreach, engagement, screening, administration of outcome and satisfaction survey measures, integrated service linkage, interpretation services and peer/family support for Latino individuals and families. This strategy is intended to promote mental health and reduce the barriers to mental health services thereby decreasing the mental health/health disparities experienced by the Latino population. • A comprehensive community-based mental health services center providing culturally specific outreach, engagement, screening, service linkage, interpretation services, peer and family support, and youth, adult and family psycho-education, skill development, and counseling. To this end, a team of Contractor's staff shall work in concert with the Promotoras.

	• An early intervention counseling program that provides bilingual/bicultural Spanish-speaking counseling services for at-risk Latino individuals and their families, which may include but is not limited to peer counseling, one-on-one counseling of limited duration, group counseling, and/or support groups as part of the overall Latino Outreach MHSA program. Not all services provided by the Family Resource Center are funded through MHSA, however should funding for other programs decrease or be lost, MHSA funding may be utilized for the programs provided by the Family Resource Center, including but not limited to: • Brief Strategic Family Therapy program; • Families and Schools Together; • Parabajitos groups; • Parent and Child Together/Parent and Child Interactive Literacy Activities; • Los Años Increibles (Incredible Years) (ages 3-8); • Cafecitos; and • Kinship Care. In addition, the Latino Outreach service provider are to collaborate with community groups and medical providers, including but not limited to: • El Dorado County Community Health Center • Shingle Springs Tribal Health Program • Marshall Hospital • Barton Hospital • HHSA, including Mental Health, Public Health, and Women, Infants and Children program • Community-based providers of mental health services • Education • Health care providers • Lake Tahoe Collaborative • Community Strengthening Coalition The service delivery area for the Tahoe Basin includes all areas of the County to the east of the ridge line along the Sierra Nevada Mountain Range stemming from Echo Summit and north and south therefrom. The service delivery area for the West Slope includes all areas of the County to the west of the ridge line along the Sierra Nevada Mountain Range stemming from Echo Summit and north and south therefrom. Communities to be served include: • northern (e.g., Georgetown Divide, Cool, and surrounding areas); • southern (e.g., Grizzly Flats, Somerset, Fairplay, and surrounding

areas);
- western (e.g., El Dorado Hills, Cameron Park, Rescue, Shingle Springs, and surrounding areas);
- mid-County (e.g., Pollock Pines, Camino, and surrounding areas); and
- Placerville area (e.g., Placerville, Diamond Springs, and surrounding areas).

The community identified the need for an MHSA Latino Outreach program to:

1) Collaborate with existing outreach, engagement and community support activities.

2) Augment the service delivery system with bicultural/bilingual Spanish-speaking mental health clinicians.

3) Gather further information from the local Latino community regarding their unmet mental health needs by means of bicultural/bilingual familiar individuals (Promotora model).

4) Research evidence-based or best practice models of mental health service delivery to the Latino community.

5) Recognize that there is a continuum of engagement, that services for each point in this continuum are critical, and that the Western Slope region and the South Lake Tahoe region have different assets and needs vis-à-vis this continuum of service engagement.

Use of the Promotora model and bilingual/bicultural community-based mental health services are consistent with the MHSA goal of cultural competence and client and family-driven services. This initiative also furthers the goals of community collaboration and service integration by means of establishing these services through community service providers. Finally, the wellness focus will be promoted as peers role model strengths and focus on community empowerment as a means to increase service access.

The negative outcome of prolonged suffering resulting from issues of isolation and peer and family problems has been identified as the primary negative outcome resulting from unmet mental health needs that must be addressed within a wellness model. Additional negative outcomes that may be addressed through the Latino Outreach program include suicide, incarceration, school failure or dropout, unemployment, homelessness, and removal of children from their homes.

The ability to live and participate fully and in a meaningful fashion in the community will be addressed on a continuous basis by providing services

Project Name: Latino Outreach 3b

	designed to engage individuals, families and the Latino community. Community and home-based peer outreach and education, information and referral, and support groups are strategies all aimed at enhancing individual and community strengths. The ability to rebound from difficulties (resilience) is addressed through the building and enhancement of skills and the creation of supports and resources. Use of the Promotora model in providing outreach and support groups serves to offer hope, empowerment and mentoring within a culturally appropriate framework.
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff[83] Tahoe Basin: South Lake Tahoe Family Resource Center (previously awarded through a competitive procurement process) West Slope: New Morning Youth and Family Services
Procurement Method	New contracts to be awarded based on a competitive procurement process. In certain circumstances, such as a lapse in services resulting from a vendor change, the El Dorado County HHSA, MHD, will utilize bilingual Mental Health staff to assist Spanish-speaking members of our community under the funding of Prevention and Early Intervention (PEI). Once the contract with the new vendor is fully executed, the County will arrange for client transitions to the new vendor and then cease to allocate staff time for direct client services to the Latino Outreach project.
Short-Term Goals	• Increased mental health service utilization by the Latino community. • Decreased isolation that results from unmet mental health needs. • Decreased peer and family problems that result from unmet health needs.
Long-Term Goals	• Stigmas and discrimination lessen • Integration of prevention programs already offered in the community is achieved. • Reduction in suicide, incarcerations, and school failure or dropouts.

[83] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges). County staff will also be utilized for direct services in events such as a lapse in services resulting from a vendor change.

Project Name: Latino Outreach 3b

Outcome Measures	Measurement 1: Customer satisfaction surveys. Measurement 2: Client outcome improvement measurements. Measurement 3: Increased engagement in traditional mental health services. Quarterly reporting will also include, but is not limited to, client demographic data.
Number of Services / Quantity of Service	Approximately 500 individuals annually Countywide, for an average cost per person of $462 per person.
Budget	Up to $231,128 annually on a reimbursement basis, consisting of: • Tahoe Basin $135,128 • West Slope $96,000

Project Name: Wellness Outreach Ambassadors and Linkage to Wellness — 4a

Project Type:	☐ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☒ Incarcerations ☐ School Failure or Dropout ☒ Unemployment	☒ Prolonged Suffering ☒ Homelessness ☒ Removal of Children from Their Homes
Objective	The partnership with the Wellness Center enables individuals who would traditionally not be eligible for mental health services, to attend the Wellness Center, receive basic services and referrals. These individuals must meet the following criteria to be eligible for this program: 1) The individual is seeking mental health services. 2) The individual does not meet the criteria to enter the mental health system. 3) The individual would benefit from working with an early intervention mental health staff for connecting with appropriate community agencies. This program also allows family and friends who provide a support system to Wellness Center participants to attend activities at the Wellness Center to learn how to enhance their support roles. Without this PEI program, the Wellness Centers could only be available to MHD clients.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☒ Adults ☒ Older Adults ☐ All Ages
Service Location(s)	South Lake Tahoe and Diamond Springs	
Project Duration	Ongoing	
Activities Performed	**Outreach:** The PEI Wellness program allows program capacity to provide screening and service linkage to adults who may not meet eligibility for or require specialty mental health services but who are deemed "at-risk" of needing such services and who can potentially benefit from services offered in the Wellness Center. **Access and Linkage to Medically Necessary Care:** Wellness Outreach Ambassadors will serve as another layer of early intervention by applying use of outreach and early identification of vulnerable adults, screening and service linkage for mental health services, substance abuse screening,	

and primary healthcare services. Linkages to resources in support of sustaining healthy community-based living will be accessed. This may include linkage to supports for physical health, financial, transportation, and social and culturally-specific needs.

Stigma and Discrimination Reduction: The Wellness Center is designed to be a location where individuals with a mental illness diagnosis can learn important life skills. Individuals who participate in the Wellness Center activities, along with the family/friend support network participants, bring the messages about mental illness back into the community and help the community better understand what mental illness means. Community-based activities through the Wellness Center also increase the community's understanding of mental illness, which leads to a reduction in stigma and discrimination.

Activities:

Activities within the Wellness Center include individual discussions with participants regarding their mental health and support needs, referrals to appropriate community-based resources, independent living skill building, groups which focus on self-healing and improvement (including, but not limited to, improving communication skills, healthy cooking, gardening, hobby development, anger management, raising awareness about importance of physical health care, how to advocate for yourself with primary care physicians and mental health professionals, and Alcoholics Anonymous).

Surveys were made available to Wellness Center participants during the month of June 2013. Thirty-six surveys were completed (21 from Placerville, 14 from South Lake Tahoe and 1 did not identify the location). The survey asked respondents "In which of the following Wellness Center/Clubhouse activities (existing or new) would you participate?"

Activity	% of Respondents Who Would Participate
Field Trips	71%
Art	62%
Volunteering	56%
Educational Discussion on Mental Health Topics	53%
Games	53%
Relationship Skills	53%
Music	47%
One-on-One Discussions with Mental Health Staff	47%

Project Name: Wellness Outreach Ambassadors and Linkage to Wellness — 4a

	Computer Skill Building ..... 41% Crafts ..... 41% Gardening ..... 41% Cooking ..... 38% Independent Living Skills ..... 38% Leadership Class ..... 38% Peer Support Group ..... 38% Exercise ..... 35% Job Skill Building ..... 32% Photography ..... 29% Providing Community Education regarding Mental Health Topics ..... 29% Educational Discussions on Non-Mental Health Topics (such as travel, sports, etc.) ..... 26% Nutrition ..... 26% T-House Outreach / Community Building ..... 26% Skill Sharing ..... 24% Theatrical Performance ..... 21% Foreign Language Skills ..... 15% The Wellness Centers will focus on providing activities that meet participants' interests and provide a learning experience. Costs included under this project include but are not limited to the purchase of training materials, project evaluation, activity supplies, office and household supplies, cleaning supplies, equipment, and furniture, as well as staff time and overhead. Staff time includes activity preparation. Additionally, food items are purchased to provide Wellness Center participants with healthy food choices and education regarding food preparation. Other support may be provided to the participants in the form of, but not limited to, transportation or transportation costs (e.g., bus script/passes), toiletries, and laundry. Replacement and repair of Wellness Center items (e.g., equipment, furniture) are also included.
Services Provided By	☐ Contracted Vendor ☒ Volunteers ☒ County Staff
Procurement Method	None.

Project Name: Wellness Outreach Ambassadors and Linkage to Wellness — 4a

Short-Term Goals	• Participants gain greater independence through staff interaction, peer interaction and group educational opportunities. • Participants linked with community-resources.
Long-Term Goals	• Recovery and resiliency for participants. • Reduction of stigma and discrimination associated with mental illness.
Outcome Measures	Measurement 1: Number of participants and family/friends in their support network. Measurement 2: Linkage with medically necessary care. Measurement 3: Continued or increased attendance at the Wellness Center.
Number of Services / Quantity of Service	It is estimated that approximately 30 individuals who may not meet eligibility for or require specialty mental health services will participate in the Wellness Center activities annually, and approximately 50 family or friends who provide a support system to Wellness Center participants may participate in activities to enhance their supportive role. This is an average of approximately $625 per person.
Budget	Approximately $50,000 annually.

Project Name: Senior Peer Counseling 4b

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☐ Incarcerations ☐ School Failure or Dropout ☐ Unemployment	☒ Prolonged Suffering ☐ Homelessness ☐ Removal of Children from Their Homes
Objective	Senior Peer Counseling provides free confidential individual counseling to adults age 55 and older. Senior Peer Counseling volunteers evaluate the needs of potential clients, frequently referring them or assisting them in making contact with other community services, including Mental Health evaluation and treatment. Senior Peer Counseling also provides community education and collaboration with other older adult services and professionals. Volunteers make frequent informational presentations to interested service groups and agencies and attend numerous community forums. The approach of Senior Peer Counseling counseling is to meet the expressed needs of the individual and provide prevention and early intervention on mental health issues. Senior Peer Counseling focuses on wellbeing, empowering clients to find their own solutions, make independent decisions, and thereby become active participants in their own lives. Volunteer counselors assess lifestyle issues know to contribute to mental health and help clients select habits and activities that support emotional, cognitive, and physical wellbeing. The supervisory services of a licensed mental health clinician are essential to the operation of Senior Peer Counseling. The supervisor meets weekly for at least two hours with the volunteers, reviewing the progress of each client, which ensures that standards of practice are met protecting clients, counselors and the community.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☐ Adults ☒ Older Adults ☐ All Ages
	Older adults (age 55 and over)	
Service Location(s)	Senior Peer Counseling Office (Placerville), clients' homes and other community meeting places on the West Slope of the County. Future plans include exploring how services may be expanded to or developed for the Tahoe basin.	

Project Name: Senior Peer Counseling 4b

Project Duration	Ongoing
Activities Performed	**Outreach:** Use publicity (newspapers, senior center announcements, service organization presentations, etc.) to recruit new volunteers for training, including residents of outlying areas such as Pollock Pines, Somerset, and Georgetown. Publicity materials will be developed and distributed. Community informational presentations to agencies, service organizations, and resident groups will be made to inform older adults about Senior Peer Counseling services. **Access and Linkage to Medically Necessary Care:** Clients will be provided with information about other services that may be available. Mandated reporter requirements will be met. **Stigma and Discrimination Reduction:** Senior Peer Counselors will raise awareness about mental wellness through staff training and individual discussions with clients and presentations. This program will also be linked with other stigma and discrimination reduction activities. **Activities:** Approximately 30% of the population of El Dorado County is age 55 or older. Senior Peer Counseling counselors encourage their clients to focus on increasing the number of positive "Therapeutic Lifestyle Changes" in which they engage to develop client improvements in well-being. With assistance from their counselor, at the beginning of counseling, clients choose a presenting problem (emotional / cognitive / behavioral) which they wish to alleviate. Senior Peer Counseling counselors assist clients in regular self-assessment of their feelings of well-being using a standardized measurement tool. The program will also include updating the training curriculum, scheduling new volunteer training every 12-18 months (or more or less frequently based on demand), participating in community collaboration, and developing the outcome measures to record changes in positive lifestyle activities. Costs may also include mileage reimbursement for volunteers, office supplies and equipment, publicity, marketing materials, clinical supervision costs, facility costs for trainings, and part-time administrative support.
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Support[84] EDCA Lifeskills as the fiscal and administrative contractor on behalf of Senior Peer Counseling. The Senior Peer Counseling program utilizes volunteers as peer counselors.

[84] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: Senior Peer Counseling 4b

Procurement Method	Sole source to the Senior Peer Counseling Program
Short-Term Goals	Client Short-Term Goals 1) Clients demonstrate an increased number of "Therapeutic Lifestyle Changes" over the course of their counseling. 2) Clients identify the primary issue of focus (presenting problem) for counseling. 3) Clients achieve improvements in their feelings of well-being as shown on the Outcome Rating Scale (ORS) measurement tool. 4) Clients are informed about other relevant mental health and support services. Program Short-Term Goals 1) Contractual agreements with the licensed clinical supervisor are finalized. 2) New volunteers are obtained through the use of publicity, including volunteers from outlying areas, prior to the next training in 2014. 3) Agencies interested in collaborating to establish a Senior Peer Counseling program in the South Lake Tahoe area are identified and consulted. 4) Implement revised training in Spring 2014, and thereafter new volunteer trainings are presented every 12-18 months, or more or less frequently based upon demand. 5) Collaborative arrangements are established for new locations in which to counsel clients in outlying areas of the western slope. 6) A "Therapeutic Lifestyle Changes" (TLC) rating form is constructed and implemented. 7) The production of publicity materials is completed. Presentations to agencies, service organizations, and residents groups are ongoing.
Long-Term Goals	Client Long-Term Goals 1) Through the use of TLCs, clients improve their mental health and self-sufficiency. 2) Clients ameliorate their distress as described in their presenting problem. 3) Clients' mental health and satisfaction with life is increased as evidenced by scores on the ORS measurement tool. 4) Clients know of, and successfully access, other needed mental health services. Program Long-Term Goals 1) A job description is completed for a part-time program assistant to manage the program, keep records, and analyze data from the measurements made. Hire the assistant in the latter part of the

Project Name: Senior Peer Counseling 4b

	first year or in the second year. 2) Depending on the number of active volunteers, as additional licensed clinical supervisor is hired in the third year, and meets with a second supervision group weekly. 3) In collaboration with other human services agencies and interested older adult organizations, during the third year of this proposal a plan is written for expanding Senior Peer Counseling into the South Lake Tahoe area, if there is community interest for the program. 4) Procedures are developed to reimburse counselors' travel expenses for client visits, to increase services to outlying areas.
Outcome Measures	**Measurement 1:** Counselors will complete a pre- and post-rating form which measures TLCs, primarily pro-health and pro-mental health activities and habits which have been shown to lead to positive physical, emotional and cognitive improvements in people of all ages. The categories to be measured are: 1) Exercise 2) Nutrition / Diet 3) Nature 4) Relationships 5) Recreation / Enjoyable Activities 6) Relaxation / Stress Management 7) Religious / Spiritual Involvement 8) Contribution / Service **Measurement 2:** Volunteers will record the clients' self-reported improvement in the presenting problem as selected by the client at the start of counseling. **Measurement 3:** ORS which measures the following 4 psychological categories: 1) Individually (personal well-being) 2) Interpersonally (family, close relationships) 3) Socially (work, school, friendships) 4) Overall (general sense of well-being)
Number of Services / Quantity of Service	Senior Peer Counseling expects to serve approximately 40 new clients annually, in addition to maintaining current case loads. However, the number of clients will be increased based upon program capacity (the number of volunteer Senior Peer Counselors). Expansion of current capacity could be average $875 per person.

Project Name: Senior Peer Counseling 4b

Budget	FY 2014-15: Up to $35,000 on a reimbursement basis. FY 2015-16: Up to $45,000 on a reimbursement basis. FY 2016-17: Up to $55,000 on a reimbursement basis. Increase in annual costs reflects program expansion as new volunteers are trained.

Project Name: Older Adults Program 4c

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☒ Incarcerations ☐ School Failure or Dropout ☒ Unemployment	☒ Prolonged Suffering ☒ Homelessness ☐ Removal of Children from Their Homes
Objective	Focus on depression among older adults and the community issues of isolation and the inability to manage independence that result from unmet mental health needs. The goal is to reduce institutionalization or out of home placement. This program partners with the CSS Older Adults Program.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☐ Adults ☒ Older Adults ☐ All Ages
	Older adults (age 60+) who have unmet mental health needs, with an emphasis on the diagnostic category of depression. This population may include Medi-Cal, Medicare, and uninsured individuals under the Prevention and Early Intervention (PEI) program. The CSS Older Adults Program would treat individuals who are Medi-Cal or uninsured.	
Service Location(s)	Countywide, including services in local community centers and clients' homes.	
Project Duration	Ongoing	
Activities Performed	**Outreach:** Use publicity (newspapers, senior center announcements, service organization presentations, etc.) to distribute information about the program. Community informational presentations to agencies, service organizations, and other groups will be made to inform older adults and their families about available services. **Access and Linkage to Medically Necessary Care:** Clients will be provided with information about other services that may be available. Mandated reporter requirements will be met. **Stigma and Discrimination Reduction:** This program is intended to raise awareness about mental wellness through staff training and individual discussions with clients. This program will also be linked with other stigma and discrimination reduction activities. **Activities:** The Older Adult Program advances the goal of expanding mental health	

Project Name: Older Adults Program 4c

	services to older adults who may be under-served or un-served and who may be at risk of institutionalization or out-of-home placement. Services would be provided to the older adults in their homes if that is the preferred location of the individuals. The use of community-based services and a personal services plan ensure that services are client and family-centered. The interagency triage process would provide mobile outreach, assessment, referral, case management and brief treatment specifically targeting isolated and hard-to-reach older adults, many of whom may be suffering from depression. The program is wellness focused, aimed at supporting clients' resilience. Cultural competence relative to age, gender, ethnicity, and spiritual and social frameworks will be critical to remove barriers to service utilization. Strategies to educate and engage family and the extended natural support system and community will also be critical to effectively maintain older adults in the community. Transportation assistance, as available, may be provided. Costs for this program include, but are not limited to, staff time, mileage and other operating expenses (e.g., rent, overhead).
Services Provided By	☒ Contracted Vendor ☐ Volunteers ☒ County Staff Support[85]
Procurement Method	Competitive procurement process
Short-Term Goals	• Identify the primary issue(s) of focus for each client. • Clients achieve improvement to reduce out-of-home placements. • Clients are informed about other relevant mental health and support services.
Long-Term Goals	• Clients improve their mental health and self-sufficiency. • Clients' mental health and satisfaction with life is increased as evidenced by scores on the outcome measurement tool. • Clients know of, and successfully access, other needed services.
Outcome Measures	Measurement 1: Clients will complete a pre- and post-rating form. Measurement 2: Number of clients that are referred to out-of-home placement for care.

[85] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: Older Adults Program 4c

Number of Services / Quantity of Service	Per the 2010 census, there are 39,494 (22%) residents of El Dorado County age 60+, but it is difficult to determine how many individuals will be in need of services annually. If the program were to reach 100 older adults, the average cost per person would be $750 in FY 2014-15.
Budget	Up to $75,000 in FY 2014-15 on a reimbursement basis Up to $80,000 in FY 2015-16 on a reimbursement basis Up to $85,000 in FY 2016-17 on a reimbursement basis

Project Name: Community-Based Mental Health Services 5a

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☒ Incarcerations ☒ School Failure or Dropout ☒ Unemployment	☒ Prolonged Suffering ☒ Homelessness ☒ Removal of Children from Their Homes
Objective	Provide prevention and early intervention mental health services in local communities. This program partners with the CSS program of "Community-Based Mental Health Services". Clinical staff will visit local communities to provide mental health services to clients under CSS, and will provide information and preventative/early intervention services under Prevention and Early Intervention (PEI) funding when they are not seeing clients under CSS.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☐ Adults ☐ Older Adults ☒ All Ages
Service Location(s)	Countywide in local communities (e.g., El Dorado Hills, North County, South County, Pollock Pines, South Lake Tahoe, Placerville). Multi-disciplinary team meetings at various locations throughout the County.	
Project Duration	Ongoing	
Activities Performed	**Outreach:** Outreach will be accomplished through direct consumer contact, publications, flyers, web-based content and other media outlets. Outreach will increase the awareness of mental health issues and service providers, including the services available in the community and how to obtain services. County staff will also participate on multi-disciplinary teams utilized as a gateway to services (e.g., School Attendance Review Board (SARB), Child Parent Resource Team (CPRT)) and be a resource partner with education and community-based organizations. **Access and Linkage to Medically Necessary Care:** Staff will provide referrals/linkage to medically necessary care services. **Stigma and Discrimination Reduction:** Bringing mental health services to the local communities will increase the dialogue about mental health, or mental wellness, and will raise awareness about the topic. Through the discussions and reference materials available, people will gain a better understanding of mental illness, which will work towards the reduction of	

Project Name: Community-Based Mental Health Services 5a

	stigma and discrimination. **Activities:** Mental Health clinical staff will visit various locations in the County and participate in and coordinate with multi-disciplinary teams and community-based organizations to receive referrals. This program can include the services previously identified under the PEI program "Early Intervention Program for Youth", which was discontinued effective June 30, 2013.
Services Provided By	☒ Contracted Vendor[86] ☐ Volunteers ☒ County Staff
Procurement Method	Initially, these services will be provided by County Staff. In the event this program is transitioned to a contracted vendor in whole or in part, the vendor(s) will be selected through a competitive procurement process and multiple vendors may be selected to provide these services.
Short-Term Goals	Engage community members in their local environment to educate them about mental wellness and mental health services available; assess individuals in need of mental health services.
Long-Term Goals	Improve community health through local services.
Outcome Measures	Measurement 1: Number of individuals/families served, and outcomes for each. Measurement 2: Client satisfaction surveys.
Number of Services / Quantity of Service	It is difficult to measure the outcomes of general public outreach activities due to their non-specific target population and methodology. It is possible that an outreach program such as this may reach 150 individuals annually, for an average cost of $196 per person in FY 2014-15. These services will reach local communities in the County.
Budget	Approximately $29,338 in FY 2014-15 and $30,262 in FY 2015-16 and FY 2016-17 when funded in partnership with the CSS program of "Community-Based Mental Health Services".

[86] These services will be provided by County Staff; potential use of Contracted Vendors at a future point in time.

Project Name: Community Health Outreach Worker 5b

Project Type:	☒ Prevention	☒ Early Intervention
Negative Outcome(s) Addressed:	☒ Suicide ☒ Incarcerations ☒ School Failure or Dropout ☒ Unemployment	☒ Prolonged Suffering ☒ Homelessness ☒ Removal of Children from Their Homes
Objective	Provide a point of contact for general mental health information coordination and community resources.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☐ Adults ☐ Older Adults ☒ All Ages
Service Location(s)	Countywide	
Project Duration	Ongoing	
Activities Performed	**Outreach:** Outreach will be accomplished by increasing the awareness of mental health issues and service providers, including the services available in the community and how to obtain services. Resource materials will be developed and distributed throughout the community. Community informational presentations to agencies, service organizations, and resident groups will be made. **Access and Linkage to Medically Necessary Care:** The purpose of this program is to provide better linkage to needed services and medically necessary care as described below. **Stigma and Discrimination Reduction:** This program will raise awareness about mental illness as a medical disease and the need for and availability of treatment options in the community. As mental health services become more integrated with primary care medicine, mental illness is anticipated to be viewed more as a medical diagnosis, just as heart disease or diabetes is, and therefore a reduction in the stigma associated with the field of mental health that has existed would be anticipated to be reduced. Clients may be more likely to seek treatment through a medical facility rather than a mental health clinic. **Activities:** The Community Mental Health Coordinator would work closely with primary care providers, hospitals, Public Health Nurses, community-based organizations, caring friends and family, and individuals in need of services to determine the appropriate referrals for individuals and	

Project Name: Community Health Outreach Worker 5b

	families, and to work closely with those individuals and families in establishing services. Such resources would include identification of service providers and insurance accepted, support groups, transportation, housing options, online resources, etc., and development and maintenance of mental health resource materials, including but not limited to brochures, web-based materials, mobile phone application, speakers list, etc. Costs for this program include establishment of a dedicated phone number that would be identified as a non-crisis community information line, establishment of a resource tracking tool, staff time, mileage and other operating expenses (e.g., rent, overhead). This program is not meant to provide mental health crisis response nor replace other community response lines. Rather, this program will provide linkage to those services. However, to the extent that partnerships and consolidation of services are possible, this program would pursue those options to determine if such consolidation is viable. For example, this program could partner with general health information coordination and provide partial funding for a single point of contact for health and mental health community resources and referrals.
Services Provided By	☒ Contracted Vendor ☐ Volunteers ☒ County Staff Support[87]
Procurement Method	Competitive procurement process, with the potential for one or more organizations to receive all or a portion of the available funds.
Short-Term Goals	• Identify community mental health resources • Establish a mechanism for tracking resources • Establish a dedicated phone line for general community mental health information
Long-Term Goals	• Improved health and wellness of the community. • Reduction in calls to 911 for non-emergency information. • Reduction in emergency room visits for non-emergency issues.

[87] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Project Name: Community Health Outreach Worker 5b

Outcome Measures	Measurement 1: Number of service providers contributing information to the resource tool. Measurement 2: Number of calls annually. Measurement 3: Number of calls to 911 for non-emergency information. Measurement 4: Number of emergency room visits for non-emergency issues.
Number of Services / Quantity of Service	Per the 2010 census, there are 181,058 residents of El Dorado County, but it is difficult to determine how many individuals would be in need of services annually. If the program were to reach 200 individuals annually, the average cost per person would be $175.
Budget	Up to $35,000 annually on a reimbursement basis.

Discontinued PEI Programs/Projects

The following PEI projects are discontinued as of the date identified in the project description:

- National Alliance on Mental Illness (NAMI)

Realigned PEI Programs/Projects (to another MHSA Component)

- None

Sub-Component: Prevention and Early Intervention-Training, Technical Assistance and Capacity Building (PEI-TTACB)

Sub-Component Definition

PEI Training, Technical Assistance and Capacity Building funds are primarily intended to be used to improve the capacity of local partners as well as County staff and individuals who participate or are involved with the development, implementation and evaluation of prevention and early intervention work plans, programs and activities.

Discontinued PEI-TTACB Program

All TTACB projects have been discontinued due to the end of the funding and the maintenance of the resource documentation will be funded through Project 2g: Community Outreach and Resources.

FY 2014-15 Budget

MHSA no longer provides funding for PEI-TTACB activities. All funds have either been utilized or are subject to reversion.

For additional information regarding MHSA allocations and expenditures, please see Attachment E.

PEI-TTACB Program

Throughout the community planning process, it was reiterated by participants that the community is not aware of mental health services and/or programs offered through the MHD and community organizations, and that the community does not know where to go to find the information. Larger community-based service providers indicated, for the most part, that they have a mental health resource (and other resources) specialist on staff, but smaller organizations and non-mental health providers do not have a person serving in that capacity. Additionally, several organizations within the County distribute resource lists, but this list will focus on the needs of individuals seeking mental health services and services that an individual with a mental illness may need to access.

Therefore, the remaining PEI-TTACB funds were utilized to develop a resource guide, and the information will be posted on a resource page accessed through the County's MHSA web page (www.edcgov.us/mentalhealth/mhsa.aspx). There were inadequate resources to develop a mobile phone application. The web-based resources will be posted online in 2014.

This project increased capacity not only for El Dorado County, but for neighboring counties who may rely upon services in El Dorado County, by families who may have a family member living in El Dorado County, and by consumers who are in need of services. Through the PEI Project 2g: Community Outreach and Resources, this list will continue to be updated starting in FY 2014-15.

Sub-Component: Prevention and Early Intervention-Statewide Projects

Sub-Component Definition

In 2007, the MHSOAC approved various Statewide Prevention and Early Intervention (PEI) Projects and corresponding funding amounts. In May 2008, the MHSOAC determined that the following three Statewide PEI Projects would be most effectively implemented through a single administrative entity:

1. Suicide Prevention

2. Student Mental Health Initiative

3. Stigma and Discrimination Reduction (SDR)

A number of California counties, including El Dorado County, joined CalMHSA, an Independent Administrative and Fiscal Governments Agency focused on the delivery of the Statewide PEI Projects. As a CalMHSA member, El Dorado County's Statewide PEI Program Component Allocation is assigned directly to CalMHSA to implement these three projects.

Through CalMHSA, resources can be maximized for the most efficient purchasing of products, such as materials translated into threshold languages for target populations, or services, such as technical assistance, and completion of administration requirements, such as reporting. CalMHSA provides a mechanism at the Statewide level for counties to collectively represent their best interests and will act as a planning body representing counties for Statewide projects.

FY 2014-15 Budget

MHSA funding for the Statewide PEI Projects ends June 30, 2014. CalMHSA is requesting that each county contribute a share of its local PEI funding to CalMHSA so that the Statewide PEI projects can continue. The recommended level of funding is between 4% and 7%, with the minimum contribution at 1% to continue participation with CalMHSA.

El Dorado County is not contributing to the Statewide programs in FY 2014-15 because sufficient information was not available to discuss this issue during the community planning process. This issue will be revisited in the FY 2015-16 MHSA Community Planning Process to determine what level of participation El Dorado County will contribute.

If the decision is made to contribute funds to the Statewide PEI projects, it will result in additional expenditures totaling up to $66,291 (7% contribution), and require a reduction in other services.

Community Services and Supports (CSS)

Component Definition

"Community Services and Supports" refers to service delivery systems for mental health services and supports for children and youth, transition age youth, adults, and older adults.[88] There are four service categories under CSS: (1) Full Service Partnership (FSP); (2) General System Development; (3) Outreach and Engagement; and (4) Mental Health Services Act Housing Program.[89] These programs provide direct services to adults who have a severe mental illness or children who have a serious emotional disturbance.

CSS projects provide direct services to adults and children who meet the criteria set forth in MHSA. Individuals must meet the criteria for receiving specialty mental health services to be eligible for MHSA programs. These criteria are set forth in WIC §5600.3 as follows:

"(a)(1) Seriously emotionally disturbed children or adolescents.

(2) For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:

(A) As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:

(i) The child is at risk of removal from home or has already been removed from the home.

(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

(B) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.

(C) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

(b)(1) Adults and older adults who have a serious mental disorder.

[88] CCR, Title 9, Division 1, Chapter 14, Section 3200.080, Community Services and Supports.
[89] CCR, Title 9, Division 1, Chapter 14, Section 3615, Community Services and Supports Service Categories.

(2) For the purposes of this part, "serious mental disorder" means a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

(3) Members of this target population shall meet all of the following criteria:

(A) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance use disorder or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).

(B) (i) As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.

(ii) For the purposes of this part, "functional impairment" means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills, or physical condition.

(C) As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.

(4) For the purpose of organizing outreach and treatment options, to the extent resources are available, this target population includes, but is not limited to, persons who are any of the following:

(A) Homeless persons who are mentally ill.

(B) Persons evaluated by appropriately licensed persons as requiring care in acute treatment facilities including state hospitals, acute inpatient facilities, institutes for mental disease, and crisis residential programs.

(C) Persons arrested or convicted of crimes.

(D) Persons who require acute treatment as a result of a first episode of mental illness with psychotic features.

(5) California veterans in need of mental health services and who meet the existing eligibility requirements of this section, shall be provided services to the extent services are available to other adults pursuant to this section. Veterans who may be eligible for mental health services through the United States Department of Veterans Affairs should be advised of these services by the county and assisted in linking to those services.

(A) No eligible veteran shall be denied county mental health services based solely on his or her status as a veteran.

(B) Counties shall refer a veteran to the county veterans service officer, if any, to determine the veteran's eligibility for, and the availability of, mental health services provided by the United States Department of Veterans Affairs or other federal health care provider.

(C) Counties should consider contracting with community-based veterans' services agencies, where possible, to provide high-quality, veteran specific mental health services.

(c) Adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence."

Some MHSA programs may be more restrictive in terms of target service populations given the nature of the program. For example, programs falling under the "Full Service Partnership" category are designed for those clients who have a higher level of acuity and therefore need more intensive services.

Services provided under CSS fall into at least one of the following three categories:

- **Full Service Partnership (FSP)** – funds to provide "whatever it takes" for initial populations

  With the initial implementation and funding of the MHSA, the State will take the first step in funding counties to develop full service partnerships with identified initial populations. These partnerships shall be culturally competent and shall include individualized client/family-driven mental health services and supports plans which emphasize recovery and resilience, and which offer integrated service experiences for clients and families. In selecting initial populations, specific attention should be paid to populations and individuals that are currently unserved, and to reducing racial/ethnic disparities. The goal will be to eventually provide all needed cost-efficient and effective services and supports for all those in need of mental health services and their families, consistent with the individualized plans.

  Funding for the services and supports for Full Service Partnerships may include flexible funding to meet the goals of the individual services and supports plans. Access to generic community services should be obtained whenever feasible and appropriate. Mental Health Services Act funds are for community services and

supports when access to these services cannot be obtained from other sources and such expenditures are consistent with other MHSA requirements.

- **General System Development (GSD)** – funds to improve programs, services and supports for the identified initial full service populations and for other clients

  General system development funds are needed to help counties improve programs, services and supports for all clients and families (including initial Full Service Partnership populations and others) to change their service delivery systems and build transformational programs and services. Strategies for reducing ethnic disparities should be considered. Examples for this kind of funding are client and family services such as peer support, education and advocacy services, mobile crisis teams, funds to promote interagency and community collaboration and services, and funds to develop the capacity to provide values-driven, evidence-based and promising clinical practices. This funding may only be used for mental health services and supports to address the mental illness or emotional disturbance. (Mental health services and supports include mental health treatment, rehabilitation services including supportive housing and supportive employment, and personal service coordination/case management. In collaborative programs, the cost of the mental health component only is allowable for positions with blended functions, only the proportion of costs associated with the mental health activities are allowable. Costs for community supports such as rental subsidies, other treatment such as health care or substance abuse treatment, and respite care are not allowable under General System Development. These examples are allowable under Full Service Partnerships.)

- **Outreach and Engagement (OE)** – funds for outreach and engagement of those populations that are currently receiving little or no service

  This funding is established in recognition of the special activities needed to reach unserved populations. Outreach and engagement can be one component of an overall approach to reducing ethnic disparities. Examples of this type of funding would be funding for racial ethnic community-based organizations, mental health and primary care partnerships, faith-based agencies, tribal organizations and health clinics; organizations that help individuals who are homeless or incarcerated, and that link potential clients to services; funds for clients and families to reach out to those that may be reluctant to enter the system; funds for screening of children and youth; and school and primary care-based outreach to children and youth who may have serious emotional disorders. This funding may only be used for those activities to reach unserved populations. Some individuals may have had extremely brief and/or only crisis oriented contact with

and/or service from the mental health system and should be considered as unserved.[90]

CSS Budget

Of the total MHSA funding received by the County, a net 76% must be allocated to CSS per the MHSA. CSS funds must be expended within three years or the funds are subject to reversion to the State. There is no risk of reversion of CSS funds in FY 2014-15.

Total anticipated FY 2014-15 revenues for CSS are:

MHSA	$5,006,756
Public Safety Realignment 2011 (AB 109)	$110,000
Private Payor/Other Insurance	$8,400
Total	$5,125,156

Total anticipated offsetting expenditures for CSS are:

Medi-Cal, Insurance, Private Payor	$1,529,396

The future level of MHSA funding is unknown, therefore this Plan will anticipate the same level of funding as was received in FY 2012-13 for FY 2015-16 and FY 2016-17, and will adjust revenues in future Plan Updates as needed.

As of the beginning of FY 2014-15, the remaining CSS fund balance from previous fiscal years is anticipated to be $5,509,074. This is an increase of the fund balance that existed at the start of FY 2013-14. The fund balance will be utilized to cover amounts in excess of the CSS revenues, reallocation to WET and in the future reallocation to CFTN. However, based on current projections the CSS fund balance will be nearly depleted at the end of Fiscal Year 2015/16. No public comments were received regarding this fiscal concern, however the Mental Health Commission identified their priorities and submitted a proposed CSS budget. This topic was discussed at the public meeting on July 16, 2014. Based on the input received from the Mental Health Commission, the CSS budget has been revised to allow a full range of CSS services to continue in FY 2014-15, during which time more intensive discussions can occur regarding future CSS expenditures. The Mental Health Division will continue to discuss this topic with the public and the Mental Health Division, and will continue to monitor project progress.

Full Service Partnership Funding

MHSA requires counties to direct the majority of the CSS funds to the FSP service category (excluding CSS-Housing funds).[91] Planned FSP expenditures (not including FSP services within

[90] California Department of Mental Health, Information Notice 05-05, Enclosure 1, *Mental Health Services Act, Community Services and Supports*, August 1, 2005, Three-Year Program and Expenditure Plan Requirements, pages 7-8.

[91] CCR, Title 9, Division 1, Chapter 14, Section 3620, Full Service Partnership Service Category, subsection (c)

the TAY Engagement, Wellness and Recovery Services program or the future project of Assisted Outpatient Treatment) are:

Fiscal Year	FSP Projects as Percent of Total Budget
FY 2014-15	55%
FY 2015-16	52%
FY 2016-17	51%

Total FSP expenditures (as opposed to GSD or OE expenditures) in the TAY Engagement, Wellness and Recovery Services program will be determined based upon client need. However, it is estimated that approximately 40% of the expenditures in the TAY Engagement, Wellness and Recovery Services program may be FSP expenditures, but FSP expenditures within the TAY Engagement, Wellness and Recovery Services program will not be limited to only 40%.

For additional information regarding MHSA allocations and expenditures, please see Attachment E.

Funding by Age

Of the total CSS funding for projects (excluding administrative costs and reallocation to WET), approximately:

- 15% is allocated to projects addressing the needs of children (from birth through age 18) or children and their families:
  - Project 1a: Youth and Family Full Service Partnership
  - Project 1b: Family Strengthening Academy
  - Project 1c: Foster Care Enhanced Services
- 4% is allocated to projects addressing the needs of transitional age youth (ages 16 through 24):
  - Project 3a: TAY Engagement, Wellness and Recovery Services
- 70% is allocated to projects specifically designed to address the needs of adults (age 18+, and includes TAY and older adults):
  - Project 2a: Wellness Centers
  - Project 2b: Adult Full Service Partnership
  - Project 2c: Older Adults Program (Partner program to PEI Older Adults Program)
  - Project 3a: TAY Engagement, Wellness and Recovery Services
  - Future Potential Project 2d: Assisted Outpatient Treatment
- 1% is allocated to projects specifically designed to address the needs of older adults (age 60+):
  - Project 2c: Older Adults Program
- 15% is allocated to projects designed for outreach and engagement and general system improvement:
  - Project 4a: Outreach and Engagement Services
  - Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)

- Project 4c: Resource Management Services

Funding by Geographic Location

Of the total CSS funding for projects (excluding administrative costs), approximately:

- 61% is allocated to projects that are performed in various locations throughout the County based on client preference and/or location:
  - Project 1a: Youth and Family Full Service Partnership
  - Project 1c: Foster Care Enhanced Services
  - Project 2b: Adult Full Service Partnership
  - Project 2c: Older Adults Program (Partner program to PEI Older Adults Program)
  - Project 3a: TAY Engagement, Wellness and Recovery Services
  - Future Potential Project 2d: Assisted Outpatient Treatment
- 24% is allocated to projects that serve eligible populations in the County, but the services must be provided at a specific location due to necessary facilities/equipment:
  - Project 1b: Family Strengthening Academy
  - Project 2a: Wellness Centers
- 2% is allocated to projects offered in locations in the community:
  - Project 4b: Community-Based Mental Health Services
- 13% is allocated to outreach and engagement and resource management, which may be performed through the outpatient clinics or in various locations in the community:
  - Project 4a: Outreach and Engagement Services
  - Project 4c: Resource Management Services

All CSS programs are offered on both the West Slope and in the Tahoe Basin.

CSS Programs

Program/Project	FSP	GSD	OE	FY 14-15	FY 15-16	FY 16-17	FY 14-15 % of Expenditures (includes future potential project)
Revenues:							
Fund Balance				$5,509,074	$2,695,818	$198,259	
Revenues (MHSA)				$5,006,756	$4,913,550	$4,913,550	
Other Revenues (e.g., AB 109, interest, Medi-Cal Admin)				$118,400	$118,400	$118,400	
Offsetting Expenditures (e.g., Medi-Cal reimbursement)				$1,529,396	$1,529,396	$1,529,396	
Available Revenues				**$12,163,626**	$9,257,164	$6,759,605	
Expenditures:							
Program 1: Youth and Family Strengthening Program							
Project 1a: Youth and Family Full Service Partnership	✓			$425,000	$430,000	$430,000	4%
Project 1b: Family Strengthening Academy		✓		$100,000	$52,000	$52,000	1%
Project 1c: Foster Care Enhanced Services	✓			$825,766	$827,969	$827,969	9%
Program 2: Wellness and Recovery Services							
Project 2a: Wellness Centers		✓	✓	$2,120,769	$2,205,000	$2,205,000	22%
Project 2b: Adult Full Service Partnership	✓			$3,846,189	$3,202,500	$3,202,500	41%
Project 2c: Older Adults Program (Partner program to PEI Older Adults Program)		✓	✓	$50,500	$50,500	$50,500	1%
Program 3: Transitional Age Youth (TAY) Services							
Project 3a: TAY Engagement, Wellness and Recovery Services	✓	✓	✓	$342,387	$367,500	$367,500	4%
Program 4: Community System of Care							
Project 4a: Outreach and Engagement Services			✓	$1,055,798	$840,000	$840,000	11%

Program/Project	FSP	GSD	OE	FY 14-15	FY 15-16	FY 16-17	FY 14-15 % of Expenditures (includes future potential project)
Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)		✓	✓	$157,613	$157,500	$157,500	2%
Project 4c: Resource Management Services		✓	✓	$175,000	$183,750	$183,750	2%
Administrative Costs							
Per Department of Mental Health Information Notice 10-01[92]			✓	$208,425	$215,010	$215,010	2%
Total CSS Program Expenditures				$9,307,447	$8,531,729	$8,531,729	
Reallocation to WET				$35,361	$166,000	$156,000	<1%
Reallocation to CFTN				$0	$136,176	$232,473	0%
Contribution to the Prudent Reserve				$0	$0	$0	0%
Total Reallocation of CSS				$35,361	$302,176	$388,473	

Total CSS Expenditures				$9,342,808	$8,833,905	$8,920,202	

Anticipated Year-End Fund Balance (prior to implementation of the Future Potential Project)				$2,820,818	$423,259	($2,160,597)	

Future Potential Project:

NEW Project 2d: Assisted Outpatient Treatment	✓			$125,000	$225,000	$175,000	1%

[92] California Department of Mental Health, Information Notice 10-01, *Proposed Guidelines for the Mental Health Services Act (MHSA) Fiscal Year 2010/11 Annual Update to the Three-Year Program and Expenditure Plan*, January 19, 2010. http://www.dhcs.ca.gov/formsandpubs/Pages/MIH-InfoNotices-Archive2010.aspx.

Total Future Potential CSS Expenditures				$125,000	$225,000	$175,000

Anticipated Year-End Fund Balance If Future Potential Project /Projects are Funded				$2,695,818	$198,259	($2,335,597)

Local Prudent Reserve

Anticipated Prudent Reserve in FY 2014-15	$1,898,284

Community Services and Supports (CSS)

Project Name: **Youth and Family Full Service Partnership (formerly Youth and Family Wraparound)** **Project 1a**

Project Type:	☒ Full Service Partnerships ☐ General System Development ☐ Outreach/Engagement
Name Change:	The term "Wraparound" brought challenges in identifying the funding, method and/or purpose of this project. The distinction between applying wraparound principles and services (as defined in WIC §18251(d)), utilizing a specific wraparound model, or services provided under the former Senate Bill (SB) 163 Wraparound program was not always clear. Therefore, the County is recommending a name change for this project from "Youth and Family Wraparound" to "Youth and Family Full Service Partnership" to more closely align with the terminology utilized under the Mental Health Services Act (MHSA). The intent of the project remains the same.
Objective:	Services are aimed at helping El Dorado County youth avoid more restrictive and expensive placements, including group home placement, hospitalization and incarceration. A FSP project provides an individualized approach to meeting needs for mental health and support services to children/youth, and their families, who are at risk of foster care placement, or who are already in foster care to prevent placement in a higher level of care facility. The intent of this project is to support children/youth, their caretakers, and the community by keeping children/youth healthy and safe at home, in school and out of trouble.
Target Population(s):	Children/youth identified as seriously emotionally disturbed (SED) are eligible for FSPs if they meet the criteria set forth in WIC §5600.3, subdivision (a). These criteria are as follows: SED children/youth who fall into at least ONE of the following groups: Group 1: 1. As a result of the mental disorder, the child/youth has substantial impairment in at least two of these areas: a. Self–care. b. School functioning. c. Family relationships. d. Ability to function in the community. and 2. Either of the following occur:

	a. The child/youth is at risk of or has already been removed from the home. b. The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment. Group 2 – The child/youth displays at least ONE of the following features: 1. Psychotic features. 2. Risk of suicide. 3. Risk of violence due to a mental disorder. Group 3 – The child/youth meets special education eligibility requirements under Chapter 26.5 of the Government Code. SED Transition-Age Youth (youth 16 years to 25 years old) who meet ALL of the following: 1. They fall into at least one of the groups in (A) above. 2. They are unserved or underserved. and 3. They are in one of the following situations: a. Homeless or at risk of being homeless. b. Aging out of the child and youth mental health system c. Aging out of the child welfare systems d. Aging out of the juvenile justice system e. Involved in the criminal just system f. At risk of involuntary hospitalization or institutionalization, or g. Have experienced a first episode of serious mental illness Non-minor dependents (NMD) (individuals who remain in foster care under AB12, Extended Foster Care) who are receiving services under this project as of their 18th birthday are eligible to continue services under this project while they continue to be NMDs. The NMD must continue to meet the eligibility requirements for the Extended Foster Care (EFC) project. Participation in the Youth and Family FSP is completely voluntary for NMDs, and they may be terminated at any time. As used in this description, the terms "child", "children" and "youth" also

	include NMDs. This project will serve children who are on Medi-Cal, who are not yet enrolled in Medi-Cal but are eligible for Medi-Cal and seeking to obtain coverage, or who do not have any health insurance. Children may have an active Child Welfare Services case, but involvement with Child Welfare Services is not a requirement for project eligibility. This project will serve only children who reside in the County. Children placed in group homes are not eligible for Youth and Family FSP services. A juvenile who is incarcerated due to criminal activity is not eligible for Youth and Family FSP services.
Service Location(s):	Countywide.
Project Description:	According to the CCR, Title 9, Section 3200.130, a FSP is "the collaborative relationship between the County and the client, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals" For children, the County has identified wraparound principles and services as the FSP project. Wraparound principles include family voice and voice, team-based decision making, use of natural supports, collaboration, community-based service, cultural competence, individualized plans, strength-based interventions, persistence and outcome-based strategies. Per WIC §18251(d): "Wraparound services" means community-based intervention services that emphasize the strengths of the child and family and includes the delivery of coordinated, highly individualized unconditional services to address needs and achieve positive outcomes in their lives. Wraparound services are a collaborative, team-based, family-driven service delivery model that includes clinical case management, an individualized treatment plan, and flexible supports and services. Case management and service delivery are implemented in a convenient and comfortable location for the family who also directs the use of family, community and system supports. Individualized plans are client and family-driven and strengths-based. Use of the wraparound team model supports community collaboration and integrated service delivery. Cultural competence is also a critical goal addressed individually with each family to ensure respectful, ethnic-specific, and age/gender-

	appropriate services. Wellness concepts for family and children/youth are embedded in the Youth and Family FSP project. Client and family strengths are defined from the initial conversation with the family and drive the determination of intervention strategies. Adults are encouraged to establish goals consistent with ensuring meaningful roles for themselves in addition to their role as parent. With the FSP team, children/youth and families are continuously encouraged to identify, reflect on and acknowledge each step of growth, effective coping strategies, and success which demonstrates child/youth resiliency. The family is also encouraged to draw on natural supports and community supports in their individual plan which serves as a treatment plan for the family unit. **Project Eligibility** Prior to referral, children are assessed by County Mental Health clinicians and together with parents or guardians, specific services are determined. A qualifying Child/Adolescent Levels of Care Utilization System (CALOCUS) score for this project would likely be 4 or 5, however lower CALOCUS score could be acceptable based upon a totality of the circumstances surrounding the child's and family's risk factors and mental health needs as determined by the clinician. The County's current Placement Committee will serve as an authorizing body for the Youth and Family FSP enrollments. South Lake Tahoe will create an Access Team to serve a similar function. Eligibility for the project would be recommended based on the child's specific needs and eligibility criteria as identified above, and would include consideration of the following: • Parents/guardians are willing to be active, or are active, in their child's treatment. • Participation is anticipated to lead toward the child's recovery and resiliency. • Participation is anticipated to help with avoiding more restrictive and expensive placements for the child. • Families/guardians may be working with Child Welfare Services, but involvement with Child Welfare Services is not a requirement for project eligibility. When a child/youth is enrolled in the Youth and Family FSP project, all mental health-related services and supports provided to the child/youth and the child/youth's family are billed to the Youth and Family FSP project, including counseling and medication management, which should

	be provided in coordination with the FSP services. When a child/youth receiving FSP services is a runaway, the Mental Health Clinician will make a determination to continue benefits when the child/youth is absent for 3 consecutive days or more during a calendar month. If the child/youth does not return within 30 days, FSP services must be terminated. Eligible children/youth can terminate and re-enter the Youth and Family FSP project. **FSP Services** Many, but not all, services are provided under contract with a specialty mental health service provider. Services are to be relevant, appealing to the strengths and desires of the child, contribute to their well-being, and help them meet the goals identified in their individualized treatment plan. Services provided will recognize and strengthen characteristics of resiliency in children/youth: • Well-regulated temperament (e.g. easygoing disposition, not easily upset); • Problem-solving skills; • Positive ethnic and cultural identity; • Abstract thinking, reflectivity, flexibility, and the ability to try alternatives; • Social competence; • Emotional responsiveness, flexibility, empathy and caring, communication skills, a sense of humor, and ability to get along with others; • Positive relationships with cultural mentors; • Autonomy; • Self-awareness, sense of identity, ability to act independently, ability to exert control over the external environment, self-efficacy, and an internal locus of control; • Concept of purpose and future orientation; • Healthy expectations, goal-directedness, future orientation, goal-attaining skills; • Optimism – hopeful outlook, active problem-focused coping strategies; • Academic and social successes; • Protective factors; • Decreased risk of behavioral disorders, possessing of talents that are valued by self and society; and • Ability to build upon and support unique cultural strengths that

	contribute to resiliency, such as a strong sense of family support and an extended family network, an emphasis on interconnectedness (collectivism), connections to spiritual and cultural heritage, participation in cultural activities, and connections to faith-based support organizations. Services and supports to be provided may include, but not be limited to, the following: • Child/youth involvement in planning and service development (individualized treatment plan); • Services and supports provided at school, in the community, and in the home; • Use of evidence-based practices, which support child/youth/family selected goals, including but not limited to, Incredible Years, Aggression Replacement Therapy (ART), Functional Family Therapy, Parent-Child Interactive Therapy (PCIT) and DBT; • Family preservation and education services (parenting classes, problem solving, and daily living skills); • Crisis response 24/7; • Education for children/youth/families regarding mental illness and medications; • Values-driven, evidence-based practices, which support child/youth/family selected goals, integrated with overall service planning; • Childcare; • Transportation; • Flexible hours; • Community-based services; • Socialization experiences and recreational activities to develop peer relationships and psychosocial skills; • Build skills in budgeting, cleaning, basic home repair, and other functions essential to maintaining a fiscally responsible household; • Supportive services; and • The Parent Partner will serve as support and advocate for each FSP family and is arranged through the contracted service provider. Family members will not run the service but as part of the service team, their role will be to: • Participate on all family treatment teams; • Provide mentoring/support for parents and consumer; • Assist facilitator in finding appropriate community resources; • Plan celebrations;

	• Advocate for family by teaching parents how to navigate the various systems; • Orient parent to Wraparound model; • Co-facilitate Incredible Years model parenting class; and • Increase families' knowledge re: services and supports available. Once a child/youth is assigned to the Youth and Family FSP project, an individualized treatment plan is developed that details the provisions of the services. The child/youth remains eligible for the Youth and Family FSP project for the time period specified in the individualized treatment plan. At the end of the time period specified in the individualized treatment plan, the child's participation in the Youth and Family FSP project is re-evaluated to determine if continued participation is necessary and if so, re-authorized by the Placement/Access Team. **FSP Team** The child/youth and family are the center of the FSP team. Each child's FSP team will be staffed by a Facilitator (introduces the family to the model, sets up, coordinates, and facilitates meetings), Parent Partner (advocates, educates, and develops community resources), and Family Coordinator or wraparound worker (therapeutic behavioral aide providing family support activities, mentoring and coaching, and assisting with community resource access), in addition to the family and other members selected by the family. Family orientation is provided to each family on an individual basis upon beginning the project. Each family will be assisted in identifying their measurable treatment goals. Referrals to and coordination with appropriate agencies will be made for families in need of additional resources (e.g., food, housing, clothing, employment). The child, family and FSP team will be mindful of the need to continually move families forward, offering opportunities for increased reliance on their natural and community resources. Training contract provider staff on the model, principles, phases of service, and roles and responsibilities under the wraparound model will be the responsibility of the contracted provider. **Collaboration** The Youth and Family FSP project collaborates with other agencies and community-based organizations, and these partners will be used to refer families for Youth and Family FSP services, to participate on individualized teams, and to provide a range of services and supports as directed by the individualized family plans. Collaborative outreach with the MHSA Latino Outreach project and the Wennem Wadati project will be used to

ensure access for the Latino and Native American populations. All of these partnerships serve to ensure strengths-based, client-centered practice, cultural competence, service access, and integrated service delivery all of which improve the service delivery system and client outcomes.

Cultural Competency

Cultural competence is a critical goal addressed individually with each family to ensure respectful, ethnic-specific, and age/gender-appropriate services. This comprehensive FSP model is designed to improve access to mental health services, improve accuracy of diagnosis, improve use of appropriate and individualized service planning and delivery, use of effective integration of client families into services, and use of community and external resources -- all goals of culturally competent service delivery.

The FSP project will provide culturally competent services tailored to family culture, values, norms, strengths, and preferences. The FSP team will consist of the appropriate membership per the request of the family. Families will be encouraged to communicate and share their cultural perspective and needs. During each of the phases, the role of culture and belief systems will be raised for family input. The team will also seek to find ways to celebrate successes within the cultural framework of the family. An assessment of cultural issues and language needs will be included in the individual planning process. Data regarding client culture and language will be collected and evaluated. Interpretation services will be available and all project literature will be available in both English and Spanish. Forms and brochures will be available in English and Spanish.

Risk factors reported among LGBTQ children/youth and the stigma barrier will be addressed as part of the anti-stigma campaign to improve community education, service access, and timely identification of children/youth in need. Sexual orientation, gender and the different psychologies of men, women, boys and girls. Training regarding service delivery that is sensitive to issues surrounding sexual orientation, gender differences, and the varying psychologies based on gender, developmental stages, and generational issues will be provided for all team members. The assessment and treatment phases of the project will explore issues of sexuality and gender-related issues. Ensuring an awareness of the mental health stressors associated with sexual orientation issues, the increased barriers associated with gender differences, and the varying manifestations of issues of gender and sexuality at different developmental stages are critical to the delivery of culturally competent and client centered service delivery that celebrates individual strengths and diversity. The complexity of these issues increases when dealing with

	the family unit -- family members themselves will have varying perspectives and different issues along the lines of sexuality and gender, including generational differences. **Supportive "Flex Funds" (Flexible Supports and Services)** MHSA funds will be used to access non-mental health resources identified within the treatment plan that are needed by the child/family to successfully fulfill their individualized treatment plan. Supports such as child/youth activities, food, and transportation, as well as other approved activities, can be funded by MHSA for stabilization purposes. MHSA funds will also be utilized for resources needed to keep the family intact. In case of family emergencies, MHSA funds may be used to provide temporary housing stability or temporary support to a family in crisis. Youth and Family FSP payments are not for the child's basic placement needs, but for the services and additional supportive services provided. Examples of uses for flex funds include, but is not limited to: • Moving expenses specific to providing safe, affordable, and adequate living arrangements for the child/youth and family; • Transportation to and from services and/or community support opportunities; • Child-care costs as necessary to promote participation in treatment; • Home improvement projects that promote and/or enhance the safety and adequacy of the living environment of the child/youth and family; • Community services expenses that allow the child/youth and family to participate in meaningful community services; • Skill-building lessons that enhance the independent living skills of the child/youth and family; • Educational expenses that promote the child/youth's success in school; • Medications necessary to assist the child/youth and family in achieving and maintaining mental and physical well-being; • Emergency food, shelter, or clothing for children/youth and families experiencing unexpected immediate hardship; • Emergency household item purchases for children/youth and families in immediate need; • Other expenses that the FSP team considers appropriate and are previously approved in the individualized treatment plan; and • Objects, fees and services utilized to accomplish the above needs (e.g., bus passes, car repair costs that will result in a safer means of transportation, work gloves for participating in community

	services, supplies needed for skill building lessons).
Services Provided By:	☒ Contracted Vendor ☐ Volunteers ☒ County Staff Current Vendors: Sierra Child and Family Services, West Slope and South Lake Tahoe Summitview Child and Family Services, West Slope Additional contracted vendors may be added through the procurement method identified below.
Procurement Method:	The current contract with Sierra Child and Family Services will continue, and an open procurement and/or competitive procurement process will be utilized for new contacts. Interested vendors will provide HHSA with a description of their agency, the wraparound service model utilized, their staff qualifications, service locations and rates. The County will review the information and, if approved, enter into an agreement for services with the vendor, however there is no guarantee that the County will refer clients for services. El Dorado County HHSA, MHD, will provide programmatic coordination, clinical oversight, and evaluation support.
Project Goals:	• Reduce out-of-home placement for children • Safe and stable living environment • Strengthen family unification or reunification • Improve coping skills • Reduce at-risk behaviors • Reduce behaviors that interfere with quality of life
Outcome Measures:	Measurement 1: Days of psychiatric hospitalization Measurement 2: Days in shelters Measurement 3: Days of arrests Measurement 4: Type of school placement Measurement 5: School attendance Measurement 6: Academic performance Measurement 7: Days in out of home placement Measurement 8: Child care stability

Community Services and Supports (CSS)

Project Name: Youth and Family Full Service Partnership (formerly Youth and Family Wraparound) **Project 1a**

Number Served / Quantity of Service:	There is an estimated 400 children/youth at risk of out-of-home placement in El Dorado County each year. The actual number of children served through the Youth and Family FSP project will be based on client need. It would be anticipated that the average number of children enrolled in this project would be 27 annually and that the average cost per child would be $15,740 in FY 2014-15. However, some children may have a higher level of need, and the actual cost per child will not be limited to $15,740.
Budget:	Up to $425,000 in FY 2014-15 and $430,000 in FY 2015-16 and FY 2016-17. Contracted services are on a reimbursement basis. Insurance (e.g., Medi-Cal) reimbursement and client share-of-cost (as determined by the Uniform Method of Determining Ability to Pay (UMDAP)) will be accessed to leverage the investment of MHSA funds.

Community Services and Supports (CSS)

Project Name: Family Strengthening Academy **Project 1b**

Project Type:	☐ Full Service Partnerships ☒ General System Development ☐ Outreach/Engagement
Objective:	This project is designed to promote family unification or reunification through a range of promising, best, and evidence-based treatment strategies for children who have been diagnosed with a serious emotional disturbance/serious mental illness and their families/guardians. This program partners in part with the Prevention and Early Intervention (PEI) Project 1f: Prevention and Early Intervention for Youth in Schools.
Target Population(s):	Children (under age 18) who are MHD clients and their families/ guardians, meeting the following criteria: • Parents/guardians are willing to be active, or are active, in their child's treatment. • Parents/guardians/family participation is anticipated to lead toward the family's recovery and resiliency. • Parents/guardians/family participation is anticipated to help with family unification or reunification.
Service Location(s):	Diamond Springs and South Lake Tahoe Mental Health Clinics. Schools, homes or other locations for those youth enrolled in this project through the PEI Project 1f: Prevention and Early Intervention for Youth in Schools. Other locations as may be determined.
Project Description:	In addition to addressing other mental health issues, activities include but are not limited to individual and family counseling sessions to strengthen the family unit, classes for the children, parents/guardians or family unit, and other practices based on evidence-based models. The Treatment Plan must indicate the expectations for the children and parents as it relates to the Family Strengthening Academy (e.g., classes to be attended, activities to be performed). Classes, groups and practices will be implemented to address and improve personal and family risk factors, such as: • Personal and family stress; • Communication; • Healthy relationships; • Family unification; • Social skill improvement; • Mindfulness – development of cognitive recognition skills so the participants can gain insight into difficulties and emotions they are experiencing • Distress tolerance – learning to recognize negative situations and their impact and appropriately address situations;

	• Emotional regulation – participants become aware of how their emotions are affecting their self, their family and others; and • Interpersonal effectiveness – learning skills to help participants balance priorities. Children and families will be referred for participation in classes, groups and practices to address the risk factors and may include, but are not limited to, Incredible Years, Parent Project, Anger Management, Teaching Pro-Social Skills, ART, Trauma-Focused CBT, DBT and Difficult Beginnings. A qualifying CALOCUS score for this project would likely be 2 or 3, however higher or lower CALOCUS scores would be acceptable based upon a totality of the circumstances surrounding the child's and family's risk factors and mental health needs as determined by the clinician. Participation in the Family Strengthening Academy would be evaluated quarterly at the same time the CALOCUS is revisited. Children participating exclusively in traditional assessment, medication management or individual child therapy would not be eligible for this project. Families/guardians may be working with Child Welfare Services, but involvement with Child Welfare Services is not a requirement for project eligibility. Families with a prior history of participation in MHSA Wraparound or Family Strengthening Academy where there has been little or no progress toward recovery and resiliency would not be eligible for this project, except by approval of a Mental Health Program Coordinator. Such decisions would be based upon a change in family circumstances and consideration of the totality of the circumstances surrounding the child's and family's risk factors and mental health needs For the Family Strengthening Academy activities, MHSA CSS funds would be utilized to purchase supplies (including but not limited to books, handouts, client activities, incentives), prepared food and household items, including but not limited to disposable plates, napkins, cups, and eating and serving utensils. The type and quantity of supplies, prepared foods and household items to be purchased depends upon the number of attendees, activities planned, and the time of day the classes are offered. Where there is a cost for an outside activity directly related to a group or class provided through the Family Strengthening Academy, MHSA funds would be utilized to pay for activity fees (including but not limited to entrance fees, admission ticket fees, rental fees). Childcare and transportation to and from groups and classes may also be provided on a case-by-case basis, addressing some barriers faced by families in receiving mental health services. The child's clinician would

	assess the family needs. Childcare and transportation services and costs would be approved by the Program Manager. **Project Differentiation** This project differs from the MHSA Youth and Family Full Service Partnership project in that the level of intensity of services is considerably higher in the Youth and Family Full Service Partnership project. Additionally, the flexible supports, resources and services that may be available to a child or family through the MHSA Youth and Family Full Service Partnership project are not available through the Family Strengthening Academy, other than those identified supports related to attendance at groups and classes. This project differs from traditional children's services in that the child and family is not limited to counseling only. Family members will be participating in a variety of other classes and groups to help strengthen the family dynamics, reduce family stress and improve family unification, while addressing the child's mental health issues.
Services Provided By:	☒ Contracted Vendor ☐ Volunteers ☒ County Staff
Procurement Method:	Initially, as well as during times when there is no contract in place with a vendor for Family Strengthening Academy overall project services, these services will be provided by County Staff. County staff may refer clients to vendors under contract with HHSA for specific activities (e.g., groups or classes). Vendor(s) that will be providing Family Strengthening Academy overall project services (e.g., case management, interventions, groups) will be selected through an open procurement and/or competitive procurement process. Interested vendors will provide HHSA with a description of their agency, the wraparound service model utilized, their staff qualifications, service locations and rates. The County will review the information and, if approved, enter into an agreement for services with the vendor, however there is no guarantee that the County will refer clients for services. When services are provided by the County, the County will access services through vendors under contract or if new vendors are needed, services will be procured through an open procurement and/or competitive procurement process wherein interested vendors will provide HHSA with a description of their agency, the group/class to be provided, their staff qualifications, service locations, and rates. The County will review the information and, if approved, enter into an agreement for services with the vendor, however there is no guarantee that the County will refer clients for services. This mechanism provides additional opportunities to address any needs of the families that may

	arise. This project includes a contracted vendor which will also be providing services through the new PEI Project 1f: Prevention and Early Intervention for Youth in Schools in an amount not to exceed $50,000 annually.
Project Goals:	• Reduce out-of-home placement for children. • Strengthen family unification or reunification. • Improve coping skills • Reduce at-risk behaviors • Reduce behaviors that interfere with quality of life
Outcome Measures:	Measurement 1: Service engagement. Measurement 2: School engagement. Measurement 3: Suicide attempts. Measurement 4: Number of hospitalizations. Measurement 5: Out-of-home placements or change of placements.
Number Served / Quantity of Service:	It is anticipated that approximately 25 children and their families could be enrolled in the Family Strengthening Academy in FY 2014-15. This project has been underutilized and is shifting focus as it progresses into the FY 2015-16. At that time, it is estimated that only 10 children and/or families will access the project in FY 2015-16 and FY 2016-17. It would be anticipated that the average number of children and their families enrolled in this project would be 25 in FY 2014-15 and that the average cost per child would be $4,080. However, some children may have a higher level of need, and the actual cost per child will not be limited to $4,080.
Budget:	Approximately $100,000 in FY 2014-15 and $52,000 in FY 2015-16 and FY 2016-17. Contracted services are on a reimbursement basis. Insurance (e.g., Medi-Cal) reimbursement and client share-of-cost (as determined by the UMDAP) will be accessed to leverage the investment of MHSA funds.

Community Services and Supports (CSS)

Project Name: Foster Care Enhanced Services **Project 1c**

Project Type:	☒ Full Service Partnerships ☐ General System Development ☐ Outreach Engagement
Objective:	Provide assessment and Intensive Care Coordination (ICC) and Intensive Home-Based Services (IHBS) for qualifying members of the target population through the development of a treatment plan that provides for the full spectrum of community services that may be needed so that the client can achieve the identified goals. This program is designed to provide mandated mental health and supportive services resulting from the *Katie A. vs. Bonta* class action settlement agreement.[93]
Target Population(s):	Children/youth are considered to be a member of the target population if they meet the following criteria: 1. Under the age of 21; 2. Are full-scope Medi-Cal (Title XIX) eligible; 3. Have an open child welfare services case; 4. Meet the medical necessity criteria for Specialty Mental Health Services as set forth in CCR, Title 9, Section 1830.205 or Section 1830.210; and 5. Meet either "a." or "b." below: a. Is currently in, or being considered for: i. Wraparound services; ii. Therapeutic Foster Care (TFC); iii. Therapeutic Behavioral Services (TBS); iv. Crisis Stabilization; v. Crisis Intervention or other equally intensive services; or vi. Has been assigned a specialized care rate due to behavioral health needs. or b. Is currently in, or being considered for: i. A foster care group home (Rate Classification Level [RCL] 10 or above); ii. A psychiatric hospital (e.g., psychiatric inpatient hospital,

[93] For more information about *Katie A. v. Bonta*, please visit http://www.dhcs.ca.gov/Pages/KatieAImplementation.aspx.

	community residential treatment facility); iii. 24-hour mental health treatment facility; or iv. Has experienced three or more placements within 24 months due to behavioral health needs. An "open child welfare services case" means the child is in foster care or the child has a voluntary family maintenance case (pre or post, returning home, in foster or relative placement), including both court ordered and by voluntary agreement. It does not include cases in which only emergency response referrals are made.
Service Location(s):	Countywide and in out-of-County (but in the State) locations where qualifying children/youth are located.
Activities Performed:	Activities performed under this project are designed to comply with requirements for implementation of the *Katie A. v. Bonta* State Settlement and associated State regulations and requirements. Child Welfare Services will provide Mental Health with requests for assessment for the children/youth potentially eligible for these services. Mental Health staff will perform the assessments based upon the results on the initial screening (i.e., children/youth determined through the screening to likely be in need of mental health services). In the event an assessment reveals the need for higher intensity mental health services as identified under this project, Mental Health staff, Contracted Vendors and Child Welfare Services will coordinate service provision. The services and supports required under this program may involve family members and other support systems (e.g., care providers, extended family members) to provide not only the child with the tools for recovery and resiliency, but also assist those around the child with tools for a healthy support system. The services to be provided are to be designed to meet the mental health needs of the child/youth as developed in coordination with the child/youth and family. Services will not necessarily be provided in a clinical or office setting. **ICC and IHBS**[94] ICC services utilize a team approach to develop and guide development of the treatment plan and service delivery. Activities performed under ICC are for the purpose of coordinating the child/youth's services, including ongoing determination of needs, service planning and implementation (plan development), and monitoring, adapting and transitioning the treatment plan as may be needed.

[94] County of Los Angeles, Department of Mental Health, June 26, 2013, No. 13-04 Quality Assurance Bulletin.

	Services may include but are not limited to: • Assessing the child/youth and family's needs and strengths; • In coordination with the child/youth, family, Child Welfare Services and other appropriate collateral contacts (e.g., schools, caregivers), developing a treatment plan to address the child/youth and family's assessed needs; • Evaluating effectiveness of previous treatment plan and services; and • Modifying treatment plan as needed based on evaluation of effectiveness. Children/youth are also eligible for IHBS services under this project when in need of the service, but IHBS is not a required activity if it is not an identified need in the treatment plan. IHBS are provided in the child/youth's home. **Services**[95, 96] Services include intensive, individualized and strength-based interventions to assist the child/youth and his/her significant support persons to develop skills to achieve the goals and objectives of the child/youth's treatment plan. Services may be provided in the home or other location, and may include but are not limited to: • Development of functional skills to improve self-care, self-regulation or other functional impairments by decreasing or replacing non-functional behavior; • Implementation of a positive behavioral plan and/or modeling interventions for the child/youth's significant support persons and assisting them to implement strategies; • Improvement of self-management of symptoms; • Education of the child/youth and/or the child/youth's significant support persons on how to manage the child/youth's mental health disorder; • Teaching skills or replacement behaviors that allow the child/youth to fully participate in the CFT and other community activities; • Individual, family or group counseling. A child/youth may receive the following services but not during the same hours of the day that the child/youth is receiving IHBS services:

[95] *Ibid.*
[96] State of California, Department of Health Care Services, Information Notice 13-11, May 3, 2013.

	1. Day Treatment Rehabilitative; 2. Day Treatment Intensive; 3. Group Therapy; 4. Therapeutic Behavioral Services (TBS). The following services are not reimbursable during the provision of IHBS services: 1. Psychiatric Inpatient Hospital (except on date of admission or discharge); 2. Psychiatric Inpatient Hospital Administrative Days; 3. Psychiatric Health Facilities (except on date of admission or discharge); and/or 4. Adult Crisis Residential (except on date of admission or discharge). Multiple services provided on the same day are Medicaid reimbursable. Specialty Mental Health Services, including ICC and IHBS, are not Medicaid reimbursable if: 1. Provided at a non-hospital facility where the beneficiary is: i) an inmate serving time for a criminal offense; or ii) confined involuntarily in a State or federal prison, jail, detention facility, or other penal facility (i.e., the beneficiary is an inmate of a public institution, as defined in Section 1905(a)(A) of the Social Security Act and Title 42, Code of Federal Regulations [CFR] Section 435.1009) 2. The beneficiary is a child/youth who is residing out-of-state at the time of service. Counties cannot claim ICC for children/youth in a hospital, psychiatric health facility, group home or psychiatric nursing facility, except when used solely for the purpose of coordinating placement of the child/youth for discharge. Under this condition, a child/youth may receive ICC during the 30 calendar days immediately prior to the day of discharge, for a maximum of three nonconsecutive periods of 30 calendar days or less per admission to the facility as part of discharge planning. Counties cannot claim IHBS as services provided for children/youth in group homes. However, counties may claim reimbursement for IHBS for children/youth that are transitioning to a permanent home environment when it is to facilitate the transition during single day and multiple day visits outside the group home setting.

Supportive "Flex Funds" (Flexible Supports and Services)

MHSA funds will be used to access specific non-mental health resources identified within the treatment plan that are needed by the child/family to successfully fulfill the individualized treatment plan. In case of family emergencies, MHSA funds may be used to temporarily provide housing stability or support to a family in crisis.

Supportive "Flex Funds" are not for the child's basic placement needs, but for the services and additional supportive services provided.

Examples of uses for flex funds include, but is not limited to:

- Transportation to and from services and/or community support opportunities;
- Child-care costs as necessary to promote participation in treatment;
- Skill-building lessons that enhance the independent living skills of the child/youth and family;
- Educational expenses that promote the child/youth's success in school;
- Medications necessary to assist the child/youth and family in achieving and maintaining mental and physical well-being;
- Emergency food, shelter, or clothing for children/youth and families experiencing unexpected immediate hardship;
- Emergency household item purchases for children/youth and families in immediate need;
- Other expenses that the ICC team considers appropriate and are previously approved in the individualized treatment plan; and
- Objects, fees and services utilized to accomplish the above needs (e.g., bus passes, car repair costs that will result in a safer means of transportation, supplies needed for skill building lessons).

Project Differentiation

This project differs from the MHSA Youth and Family Full Service Partnership project in that children/youth enrolled in this project may not require the highest intensity services, but do require services that are higher in intensity than traditional services, child/youth focused, and individualized for each child/youth. Additionally, the flexible supports, resources and services available through the Foster Care Enhanced Services project are more limited in scope than those available through the MHSA Youth and Family Full Service Partnership project. Additionally, services provided through the Youth and Family Full Service Partnership project may continue beyond a child/youth's involvement with Child Welfare Services, whereas the Foster Care Enhanced Services are strictly limited to children/youth with an open Child Welfare Case.

	This project differs from Family Strengthening Academy in that the Family Strengthening Academy is not a Full Service Partnership program and the type and level of services provided are lower intensity, focusing on strengthening the family dynamics, reducing family stress and improving family unification, while addressing the child's mental health issues. The Foster Care Enhanced Services are more child focused, of a higher intensity level, and may be provided in non-clinical/office settings. **Additional Activities Authorized through this Project** Funding in the amount of $20,000 is for CASA as a sole source contract to help ensure that all children receiving services through this project have an assigned CASA, providing the provision of such funding is not determined in conflict with the roles of an agency providing the children with services and CASA.
Services Provided By:	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Current Vendors: Sierra Child and Family Services, West Slope and South Lake Tahoe Summitview Child and Family Services, West Slope Additional contracted vendors may be added through the procurement method identified below.
Procurement Method:	These services will be provided by County Staff and Contracted Vendors. Contracted Vendors will be selected through an open procurement and/or competitive procurement process. Interested vendors will provide HHSA with a description of their agency, the ICC and IHBS service model to be utilized, their staff qualifications, service locations and rates. The County will review the information and, if approved, enter into an agreement for services with the vendor, however there is no guarantee that the County will refer clients for services. Volunteers may have a role in this program (e.g., transportation, family support), however mental health services will be provided by County Staff and Contracted Vendors.
Project Goals:	• Reduce out-of-home placement for children/youth • Safe and stable living environment • Strengthen family unification or reunification • Improve coping skills • Reduce at-risk behaviors • Reduce behaviors that interfere with quality of life
Outcome Measures:	Measurement 1: Days of psychiatric hospitalization Measurement 2: Days in shelters Measurement 3: Days of arrests

	Measurement 4: Type of school placement Measurement 5: School attendance Measurement 6: Academic performance Measurement 7: Days in out of home placement Measurement 8: Child care stability
Number Served / Quantity of Service:	There is an estimated 200 children/youth detained by Child Welfare Services annually, and approximately 400 open cases, which would be eligible to receive assessments. The actual number of children/youth served through this project will be based on client need as identified through an initial screening process, and for those meeting the specific target population, a mental health assessment. The full impacts to caseloads from the implementation of this mandated program are not yet know. It is anticipated that participation could increase by approximately 11 children per month for the remainder of FY 2013-14 and FY 2014-15 for a total of approximately 176 children enrolled in this project by June 2015. It is anticipated that the average cost per child would be approximately $11,000 annually. However, some children may have a higher level of need, and the actual cost per child will not be limited to $11,000.
Budget:	Approximately $825,766 in FY 2014-15. Future costs continue to be evaluated as the number of eligible children are identified through FY 2014-15. It would be anticipated that the actual cost of the program would be similar in FY 2015-16 and FY 2016-17, however other funding opportunities for implementation of the Katie A. settlement agreement will be pursued. Contracted vendors will compensated on a reimbursement basis. Insurance (e.g., Medi-Cal) reimbursement and client share-of-cost (as determined by the UMDAP) will be accessed to leverage the investment of MHSA funds.

Community Services and Supports (CSS)

Project Name: Wellness Centers **Project 2a**

Project Type:	☐ Full Service Partnerships ☒ General System Development ☒ Outreach/Engagement
Objective:	Provide a welcoming location for individuals with severe mental illness to receive mental health services, gain life skills for independence, and minimize negative effects of isolation frequently associated with mental illness.
Target Population(s):	Adult (age 18+) clients of Mental Health.
Service Location(s):	South Lake Tahoe and Diamond Springs
Project Description:	The Wellness Centers provide a welcoming setting, away from the stigma and discrimination so often associated with mental illness, where participants can receive mental health services, life skills training, community integration experience, support groups, health care information, and social interaction and relationship building frequently missing from the lives of those who have been diagnosed with a serious mental illness. The Wellness Centers strive to provide both inside and outside spaces for clients that are healthy, engaging and tranquil. These services are provided for mental health clients under the Wellness Centers CSS project, and others (such as family members of those with severe mental illness, or those who have not yet sought diagnosis or treatment for a mental illness) through the Prevention and Early Intervention (PEI) Wellness Outreach Ambassadors and Linkage to Wellness project. As identified in the State-approved FY 2008-09 CSS Plan, the Wellness Centers provide the setting from which to build local capacity to meet the diverse needs of the seriously mentally ill and their families. Collaboration with other disciplines, community-based organizations, Public Health, NAMI, consumers, and volunteers allows enhanced services to be provided to participants, including their family members and peer support. In combination with the PEI program, the Wellness Centers have been utilized as sites to engage vulnerable adults, and at-risk individuals who might not otherwise seek mental health services. Individuals experiencing mental distress can be assessed and supported with interventions and/or appropriate referrals to community resources. Once assessed, individuals can begin receiving mental health services through this project. Activities within the Wellness Centers include individual meetings between Mental Health staff and participants regarding the participant's mental health and support needs, referrals to community-based

resources, independent living skill building, groups/classes that focus on self-healing, resiliency and recovery (including, but not limited to, communication skills, healthy living, healthy cooking, hobby development, anger management, physical health care, advocating for yourself with primary care physicians and mental health professionals, and Alcoholics Anonymous). The Wellness Centers take an overall approach to mental health and wellness, focusing on many aspects of the participants' lives that impact their mental health.

In addition, the Wellness Centers offer adult mental health clients a place to meet, socialize, and participate in client-centered and client-directed activities that otherwise may not be available to individuals diagnosed with a serious mental illness. Isolation is a key concern for individuals with mental illness. Stigma and discrimination associated with mental illness frequently lead individuals to live an isolated life, and isolation can increase the severity of a mental illness and lead to other health-related issues.[97]

These activities form an invaluable foundation for client recovery, resiliency and wellness by providing them with independent living skills and recovery-oriented interventions and groups, and then providing clients with supervised opportunities for applying the skills in the community.

Key to the success of continued engagement with Mental Health and in the Wellness Centers is the availability of activities that are of interest to the participants, while providing an educational opportunity. Surveys were made available to Wellness Center participants during the month of June 2013. Thirty-six surveys were completed (21 from Placerville, 14 from South Lake Tahoe and one did not identify the location). The survey asked respondents "In which of the following Wellness Center/Clubhouse activities (existing or new) would you participate?"

Activity	% of Respondents Who Would Participate
Field Trips	71%
Art	62%
Volunteering	56%
Educational Discussion on Mental Health Topics	53%
Games	53%
Relationship Skills	53%
Music	47%

[97] Marano, H. E., July 1, 2003. Retrieved from http://www.psychologytoday.com/articles/200308/the-dangers-loneliness, August 22, 2013.

	One-on-One Discussions with Mental Health Staff ..... 47% Computer Skill Building ..... 41% Crafts ..... 41% Gardening ..... 41% Cooking ..... 38% Independent Living Skills ..... 38% Leadership Class ..... 38% Peer Support Group ..... 38% Exercise ..... 35% Job Skill Building ..... 32% Photography ..... 29% Providing Community Education regarding Mental Health Topics ..... 29% Educational Discussions on Non-Mental Health Topics (such as travel, sports, etc.) ..... 26% Nutrition ..... 26% T-House Outreach / Community Building ..... 26% Skill Sharing ..... 24% Theatrical Performance ..... 21% Foreign Language Skills ..... 15% The Wellness Centers will focus on providing activities that provide a learning experience to build the foundation from which life skills can be developed, while meeting participants' interests to encourage continued engagement, including providing staff to deliver curriculum for and support clients enrolled in the WET Project 6: Consumer Leadership Academy. Costs included under this project include but are not limited to the purchase of training materials, books, project evaluation, activity supplies, field trip costs (e.g., entrance fees, admission ticket fees, rental fees, food, beverages, transportation), office and household supplies, cleaning supplies, computers and peripheral equipment and supplies, equipment, and furniture, as well as staff time and overhead. Staff time includes activity preparation. Additionally, food items are purchased to provide Wellness Center participants with healthy food choices and education regarding food preparation. Other support may be provided to the participants in the form of, but not limited to, transportation or transportation costs (e.g., bus script/passes), toiletries, and laundry. Replacement and repair of Wellness Center items (e.g., equipment, furniture) are also included.

	With the South Lake Tahoe Wellness Center move that will occur in FY 2014-15, these MHSA funds will be utilized to facilitate a smooth transition from the Wellness Center's current locations to its new location to minimize negative impacts to participants. Costs may include, but are not limited to, moving expenses, construction costs and acquisition of items needed to make the Wellness Centers be usable and healthy spaces for the clients, necessary equipment for the new spaces to continue implementation of the Wellness Center, and storage. To the extent possible, items from the current Wellness Center will be utilized in the new Wellness Center.
Services Provided By:	☐ Contracted Vendor ☒ Volunteers ☒ County Staff
Procurement Method:	None.
Project Goals:	• Recovery and resiliency for participants. • Participants gain greater independence through staff interaction, peer interaction and educational opportunities. • Participants linked with community-resources. • Increased engagement in mental health services.
Outcome Measures:	Measurement 1: Number of participants and frequency of attendance. Measurement 2: Continued engagement in mental health services. Measurement 3: Attainment of individualized goals.
Number Served / Quantity of Service:	It is projected that the monthly participation rate will average approximately 750 visits. This represents total visits to the Wellness Centers, not the total number of unique individuals attending the Wellness Center. It is estimated that the monthly participation rate (unique individuals attending) will be approximately 100 individuals. However, recent trends have indicated that attendance is increasing at the Wellness Centers. At 9,000 client visits annually (750 clients per month x 12 months), the average cost per visit would be $236. The visits may include sessions with clinicians, psychiatrists, or other Mental Health staff.
Budget:	Approximately $2,120,769 in FY 2014-15. Approximately $2,205,000 in FY 2015-16 and FY 2016-17. Due to the timing of the South Lake Tahoe Wellness Center move, some of the expenses related to the move may rollover into Year 2. Insurance (e.g., Medi-Cal) reimbursement and client share-of-cost (as determined by the UMDAP) will be accessed to leverage the investment of MHSA funds.

Community Services and Supports (CSS)

Project Name: Adult Full Service Partnerships **Project 2b**

Project Type:	☒ Full Service Partnerships ☐ General System Development ☐ Outreach Engagement
Objective:	The FSP project assists clients in becoming more engaged in their recovery through intensive client-centered mental health and non-mental health services and supports focusing on recovery, wellness and resilience.
Target Population(s):[98]	(a) Individuals selected for participation in the Full Service Partnership Service Category must meet the eligibility criteria in WIC §5600.3(a) for children and youth, WIC §5600.3(b) for adults and older adults or WIC §5600.3(c) for adults and older adults at risk. (b) Transition age youth, in addition to (a) above, must meet the criteria below. (1) They are unserved or underserved and one of the following: (A) Homeless or at risk of being homeless. (B) Aging out of the child and youth mental health system. (C) Aging out of the child welfare systems (D) Aging out of the juvenile justice system. (E) Involved in the criminal justice system. (F) At risk of involuntary hospitalization or institutionalization. (G) Have experienced a first episode of serious mental illness. (c) Adults, in addition to (a) above, must meet the criteria in either (1) or (2) below. (1) They are unserved and one of the following: (A) Homeless or at risk of becoming homeless. (B) Involved in the criminal justice system. (C) Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment. (2) They are underserved and at risk of one of the following: (A) Homelessness. (B) Involvement in the criminal justice system. (C) Institutionalization. (d) Older adults, in addition to (a) above, must meet the criteria in either (1) or (2) below: (1) They are unserved and one of the following: (A) Experiencing a reduction in personal and/or community

[98] CCR, Title 9, Division 1, Chapter 14, Section 3620.05, Criteria for Full Service Partnerships Service Category.

	functioning. (B) Homeless. (C) At risk of becoming homeless. (D) At risk of becoming institutionalized. (E) At risk of out-of-home care. (F) At risk of becoming frequent users of hospital and/or emergency room services as the primary resource for mental health treatment. (2) They are underserved and at risk of one of the following: (A) Homelessness. (B) Institutionalization. (C) Nursing home or out-of-home care. (D) Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment. (E) Involvement in the criminal justice system. Priority shall be given to populations that are unserved. "'Unserved' means those individuals who may have serious mental illness and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved."[99]
Service Location(s):	Countywide.
Project Description:	A FSP is defined as "the collaborative relationship between the County and the client, and when appropriate the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals."[100] FSPs emphasize services that are client and family-driven, accessible, individualized, tailored to a client's "readiness for change", delivered in a culturally competent manner, and have a focus for wellness, outcomes and accountability."[101] FSPs require a "whatever it takes" approach to provision of services. "Whatever it takes means finding the methods and means to engage a client, determine his or her needs for recovery, and create collaborative services and support to meet those needs. This concept may include innovative approaches to "no-fail" services in which service provision and continuation are not dependent upon amount or

[99] CCR, Title 9, Division 1, Chapter 14, Section 3200.310, Unserved.
[100] CCR, Title 9, Division 1, Chapter 14, Section 3200.130, Full Service Partnership.
[101] California Department of Mental Health, Prepared by the California Institute for Mental Health. *Full Service Partnership Tool Kit, Adult.* 2011, page 11.

	timeliness of progress, or on the client's compliance with treatment expectations, but rather on individual needs and individual progress and/or pace on their path to recovery. Clients are not withdrawn from services based on pre-determined expectations of response."[102] FSP teams may utilize non-traditional interventions, treatments and supportive services tailored to each client's specific needs and strengths to aid in their recovery. It is important to note that within the context of the MHSA, "recovery" does not mean an individual will be "cured" of their mental illness. Rather, recovery means working towards specific goals identified for each client, with the focus on the key concepts of hope, personal empowerment, respect, social connections, self-responsibility, self-management and self-determination through fully serving each client and ensuring an integrated service experience. Being fully served means that "clients, and their family members who obtain mental health services, receive the full spectrum of community services and supports needed to advance the client's recovery, wellness and resilience."[103] **Full Spectrum of Community Services** The full spectrum of community services is "the mental health and non-mental health services and supports necessary to address the needs of the client, and when appropriate the client's family, in order to advance the client's goals and achieve outcomes that support the client's recovery, wellness and resilience."[104] "The services to be provided may also include services the County, in collaboration with the client, and when appropriate the client's family, believe are necessary to address unforeseen circumstances in the client's life that could be, but have not yet been included in the ISSP [Individual Services and Supports Plan]."[105] FSP services and supports are available to clients living in MHSA-eligible permanent supportive housing. CCR Section 3620, subsection (b) specifically states: "The County may pay for the full spectrum of community services when it is cost effective and consistent with the ISSP."[106] **Mental Health Services and Supports** The full spectrum of community services includes, but is not limited to, the following:

[102] *Ibid.*, page 12.
[103] CCR, Title 9, Division 1, Chapter 14, Section 3200.160, Fully Served.
[104] CCR, Title 9, Division 1, Chapter 14, Section 3200.150, Full Spectrum of Community Services.
[105] CCR, Title 9, Division 1, Chapter 14, Section 3620. Full Service Partnership Service Category, subsection (a).
[106] CCR, Title 9, Division 1, Chapter 14, Section 3620, Full Service Partnership Service Category, subsection (b).

	"(A) Mental health services and supports including, but not limited to: (i) Mental health treatment, including alternative and culturally specific treatments. (ii) Peer support. (iii) Supportive services to assist the client, and when appropriate the client's family, in obtaining and maintaining employment, housing, and/or education. (iv) Wellness centers. (v) Alternative treatment and culturally specific treatment approaches. (vi) Personal service coordination/case management to assist the client, and when appropriate the client's family, to access needed medical, educational, social, vocational rehabilitative and/or other community services. (vii) Needs assessment. (viii) ISSP[107] development. (ix) Crisis intervention/stabilization services. (x) Family education services."[108] Mental health treatments may include, but are not limited to, medication and psychotherapy interventions. Treatments are designed to reduce the symptoms associated with a client's mental illness and improve a client's "quality of life by helping a client gain insight into behaviors and symptoms and adopting behaviors that contribute to recovery goals. While the goals of both cognitive behaviorally based psychotherapies and the administration of psychiatric medication are not always explicitly grounded in the language of recovery, both are elemental in the recovery process."[109] **Non-Mental Health Services and Supports** The full spectrum of community services also includes, but is not limited to, non-mental health services and supports such as:

[107]Individual Services and Supports Plan (ISSP).
[108]CCR, Title 9, Division 1, Chapter 14, Section 3620. Full Service Partnership Service Category, subsection (a).
[109]California Department of Mental Health, Prepared by the California Institute for Mental Health. *Full Service Partnership Tool Kit, Adult.* 2011, page 60.

	"(B) Non-mental health services and supports including, but not limited to: (i) Food. (ii) Clothing. (iii) Housing, including, but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing. (iv) Cost of health care treatment. (v) Cost of treatment of co-occurring conditions, such as substance abuse. (vi) Respite care."[110] The County may also provide items necessary for daily living; travel, transportation and transportation-related expenses; medication; furniture; household products; appliances; community activities; school and/or vocational supplies and support; personal care; respite services for caretakers; goods necessary for caretaking; medical and dental expenses, provided such needs are identified on the ISSP.[111] Housing supports include, but are not limited to, housing subsidies, master leases, motel and other housing vouchers, rental security deposits, first and last month's rental deposits, eviction prevention, utilities, and purchase of household goods.[112] Other non-Medi-Cal client support expenditures including, but not limited to, staff delivering curriculum for and supporting clients enrolled in the WET Project 6: Consumer Leadership Academy, and "costs of salaries and benefits for employment specialists, housing specialists or peer support staff who do not bill for their services."[113] Peer support may be integrated into the FSP model. Peer support comes from individuals with lived mental health service experience who are either staff or volunteers in the role of a peer advocate or other appropriate role. **Intensive Case Management (ICM)** In El Dorado County, adults who are enrolled in the FSP program are

[110]CCR, Title 9, Division 1, Chapter 14, Section 3620. Full Service Partnership Service Category, subsection (a).
[111]California Department of Mental Health, Prepared by the California Institute for Mental Health. *Full Service Partnership Tool Kit, Adult.* 2011, page 108.
[112]*Ibid.*, pages 103 and 108.
[113]*Ibid.*, page 108.

	provided with a highly individualized and community-based level of intensive case management utilizing the ICM team approach. An ICM teams consist of staff with specialties in areas such as psychiatry, psychology, nursing, social work, substance abuse treatment, crisis response, community resourcing, housing, and vocational rehabilitation. Each FSP client has a single primary point of responsibility, also known as a Personal Service Coordinator (PSC). Caseloads are generally kept low, approximately 10 clients for each PSC. The services provided are centered around and planned in coordination with the client, and if appropriate his/her family, taking into consideration the needs, interests, and strengths of each client. This client-centered approach is key to the success of an FSP between the client and Mental Health. In developing this strength-based approach, the Mental Health staff and the client will develop an assessment, treatment plan (ISSP), and service delivery strategy focusing on client-self-management through a collaborative approach capitalizing on the client's strengths, and taking a holistic view of the client and focusing on achievable recovery. "Client self-management is the process by which clients increase their involvement in decisions about their care and recovery."[114] By providing client-centered and culturally competent services, the relationship with the client may include the client's extended family, traditional or spiritual healers, and other community members important to the client.[115] Crisis intervention services (psychiatric emergency services) are a key component of an ICM team. The ICM crisis staff provide crisis intervention services 24 hours per day, 7 days per week, to respond to crisis needs if and when they arise. Crisis staff may take a team approach in responding, which may include, but is not limited to, crisis clinician, nurse, law enforcement representative and resource specialist. This crisis team may respond directly to the individual's location if deemed safe to do so. **FSP Strategies** As identified above, the FSP model embraces the "whatever it takes" approach, and strategies supporting this approach include, but are not limited to, the following: • Linking clients with a "medical home" for primary care and assisting with coordination of health and dental care.[116] • Increasing clients' social networks and increasing opportunities to meet new people through social, nonprofessionally oriented

[114] *Ibid.*, page 52.
[115] *Ibid.*, page 50.
[116] *Ibid.*, page 76.

	interactions with other individuals who may act as community supports for the clients.[117] • Establishing safe, affordable, and permanent housing for each client, and identifying emergency housing as may be needed.[118] • Identifying clients who are living in board and care facilities but, with appropriate FSP supports, could make the transition to independent living.[119] • Seeking education, employment and volunteering opportunities that are meaningful to clients, contribute to their personal self-sufficiency and well-being, give back to the community, and help them transcend beyond their role as a client within the mental health system.[120] • Minimizing the role that mental health providers play in transporting clients by helping client learn to take public transportation and exploring group transportation options, which in turn fosters greater independence.[121] • Reducing client involvement in the criminal justice system and supporting a more proactive relationship with law enforcement. Engaging in proactive, advocacy-related work to the extent possible in the events clients become involved in the criminal justice system.[122] • Identifying financial goals and resolving insufficiencies.[123] • In the event a FSP client is hospitalized, assisting with the coordination of inpatient services and managing the transition to outpatient care once the client is discharged.[124] • Addressing a client's drug or alcohol use or other behaviors based on the client's level of readiness for change[125] and integrating services by "providing both substance use and mental health interventions concurrently and in relation to each other, as part of one treatment plan provided by one team or within a network of services with shared goals."[126] • Understanding a client's culture, the manner in which he or she makes decisions and the level of family and/or community involvement in the client's recovery. Developing goals for

[117] *Ibid.*, page 65.
[118] *Ibid.*, page 102.
[119] *Ibid.*, page 103.
[120] *Ibid.*, page 67.
[121] *Ibid.*, page 39.
[122] *Ibid.*, page 75.
[123] *Ibid.*, page 69.
[124] *Ibid.*, page 81.
[125] *Ibid.*, page 81.
[126] *Ibid.*, page 57.

	recovery, wellness and resiliency within the appropriate cultural context. • Assisting clients in becoming good tenants, neighbors, and community members by building the skills and supports necessary for living in the community.[127]
Services Provided By:	☒ Contracted Vendor[128] ☒ Volunteers ☒ County Staff Pending Vendor: Summitview Child and Family Services (for operation of an ARF and provision of FSP services to clients residing in the ARF).
Procurement Method:	These services will be provided by County Staff and volunteers. County staff may refer clients to contracted vendors already under contract with HHSA for specific activities (e.g., groups or classes). In the event operations of this project are transitioned to a contracted vendor in whole or in part, the vendor(s) will be selected through an open procurement and/or competitive procurement process and multiple vendors may be selected to provide these services. Interested vendors will provide HHSA with a description of their agency, the Full Service Partnership service model utilized, their staff qualifications, service locations and rates. The County will review the information and, if approved, enter into an agreement for services with the vendor, however there is no guarantee that the County will refer clients for services. Contracts for specific activities, groups or classes will be done through an open procurement and/or competitive process wherein interested vendors will provide HHSA with a description of their agency, the group/class to be provided, their staff qualifications, service locations, and rates. The County will review the information and, if approved, enter into an agreement for services with the vendor, however there is no guarantee that the County will refer clients for services. This mechanism provides additional opportunities to address any needs of the families that may arise.
Project Goals:	• Reduction in institutionalization • People are maintained in the community • Services are individualized • Work with clients in their homes, neighborhoods and other places where their problems and stresses arise and where they need support and skills

[127] *Ibid.*, page 105.
[128] These services will be provided by County Staff and volunteers; potential use of Contracted Vendors at a future point in time.

	• Team approach to treatment
Outcome Measures:	Measurement 1: Key Event Tracking (KET) - As changes occur in a client's status related to housing, employment, education, entry or exit from a psychiatric hospital, emergency department or jail. Measurement 2: Achieving goals identified on the ISSP. Measurement 3: Continued engagement in services.
Number Served / Quantity of Service:	It would be anticipated that the average number of adults enrolled in this project would be 150 annually and that the average cost per adult would be $25,641. However, some adults may have a higher level of need, and the actual cost per adult will not be limited to $25,641.
Budget:	$3,846,189 in FY 2014-15, and $3,202,500 in FY 2015-16 and FY 2016-17, for mental health and non-mental health services and supports, overhead, administrative support, quality assurance review, vehicle purchases (including 4WD to access remote areas of County and drive in winter weather conditions), and other costs attributed to this program. Insurance (e.g., Medi-Cal) reimbursement and client share-of-cost (as determined by the UMDAP) will be accessed to leverage the investment of MHSA funds.

Community Services and Supports (CSS)

Project Name: Older Adults Program **Project 2c**

Project Type:	☐ Full Service Partnerships ☒ General System Development ☒ Outreach Engagement
Objective:	Provide mental health services to older adults with a serious mental illness in client-preferred locations (e.g., home, community centers). Individuals must meet the criteria for receiving services through the MHD.
Target Population(s):	Individuals age 60 and above
Service Location(s):	Countywide
Project Description:	Older adults were cited by the community as under-served. A mental illness may be complicated by issues such as isolation, multiple losses, complex family dynamics and physical health concerns. Factors such as the stigma associated with mental illness, not wanting to bother others with their concerns, transportation barriers, cost, and/or misdiagnosis, older adults may not receive necessary mental health services. It is estimated that there is a large number of un-served or under-served individuals in the target population. Older adults (age 60+) represent 22% of the population in El Dorado County, and the older adult population is one of the fastest growing age groups within our County.[129] In the 2000 census, older adults (age 60+) represented 17% of the population.[130] The Older Adults project will provide a mobile mental health team approach. The goal is to provide holistic mental health services to frail and isolated older adults in order to repair, enhance, and redefine their safety net thereby maintaining them in their homes and avoiding institutionalization. This program partners with the Prevention and Early Intervention (PEI) Older Adults project to provide a continuum of services to older adults in our communities who may need brief prevention services to those who may need clinical mental health services. Older Adults in need of high intensity mental health services who qualify for Full Service Partnership services would be provided with those services under the MHSA Adult Full Service Partnership program. Referrals for services would be welcomed from all community members, including neighbors, family members, faith-based organizations, community-based organizations and governmental agencies. Older adults

[129] Retrieved from the 2010 census (http://quickfacts.census.gov/qfd/states/06000.html), March 7 and May 7, 2013.
[130] Retrieved from American Fact Finder, 2000 Census. http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=DEC_00_SF1_DP1&prodType=table, August 23, 2013.

would also be able to self-refer. It is anticipated that initial referrals for mental health services under CSS would be processed through the PEI Older Adults project.

Through the PEI Older Adults project, MHSA funds will be used initially to promote program development in the area of outreach, engagement and systems development in support of a mobile outreach, case management and brief treatment model program. In the outreach and engagement services for this hard-to-reach population, non-traditional referral sources (community members who, through their regular personal or business activities, come into contact with seniors) may receive information as to identifying and referring at-risk individuals to the senior services system. This community organization approach serves to empower and engage the broader community in assisting the older adult population. In the event an older adult is in need of specialty mental health services, those services would be provided through this CSS program. MHD staff may also deliver curriculum for and support clients enrolled in the WET Project 6: Consumer Leadership Academy through this project.

Older Adult Preferences for Services

The Older Adults Survey distributed during the community planning process identified that a majority of the respondents would prefer to receive mental health services in their home (71%) or in a doctor's office (68%). Only 11% of the respondents indicated they would prefer to receive mental health services at a County building. Further, 80% indicated they would prefer to receive individual services as opposed to group counseling (19%). Although the survey sample size was small, it does provide a general indicator of how seniors, both homebound and those who go to the West Slope Senior Centers, would like to receive mental health services.

The survey respondents also identified barriers to seeking and receiving mental health services:

Summary Category	**% of Responses**
Transportation	73%
Impact to Others	66%
Cost	64%
Lack of Information	48%
Stigma	44%
Physical Health Limitation	44%
Provider Issue	26%
Cultural/Language Differences	4%

	This program is designed to address a majority of those barriers. The program is wellness focused, aimed at supporting clients' resilience. Cultural competence relative to age, gender, ethnicity, and spiritual and social frameworks will be critical to remove barriers to service utilization. Strategies to educate and engage family and the extended natural support system and community will also be critical to effectively maintain older adults in the community. Transportation assistance, as available, may be provided. Costs for this program include, but are not limited to, staff time, mileage and other operating expenses (e.g., rent, overhead).
Services Provided By:	☒ Contracted Vendor ☒ Volunteers ☒ County Staff
Procurement Method:	These services will be provided by County Staff and volunteers. County staff may refer clients to contracted vendors already under contract with HHSA for specific activities (e.g., groups or classes). In the event operations of this project are transitioned to a contracted vendor in whole or in part, the vendor(s) will be selected through an open procurement and/or competitive procurement process. One or more vendors may be selected to provide these services. Contracts for specific activities, groups or classes will be done through an open and/or competitive procurement process wherein interested vendors will provide HHSA with a description of their agency, the group/class to be provided, their staff qualifications, service locations, and rates. The County will review the information and, if approved, enter into an agreement for services with the vendor, however there is no guarantee that the County will refer clients for services. This mechanism provides additional opportunities to address any needs of the families that may arise.
Project Goals:	Increased access to mental health services Decrease in institutional care placements for older adults
Outcome Measures:	Measurement 1: Initial engagement in mental health services Measurement 2: Continued engagement in mental health services Measurement 3: Days of institutional care placements Measurement 4: Pre- and post-survey measuring connectivity (opposite of isolation/loneliness)

Project Name: Older Adults Program **Project 2c**

Number Served / Quantity of Service:	Per the 2010 census, there are 39,494 (22%) residents of El Dorado County age 60+, but it is difficult to determine how many individuals would be in need of services annually. It is estimated that 50 older adults may be assessed for specialty mental health services on an annual basis. The majority of older adults will receive brief duration prevention and early intervention services under the PEI Older Adults project. It would be anticipated that the average number of older adults enrolled in this project would be 10 annually and that the average cost per adult would be $5,050. However, some adults may have a higher level of need, and the actual cost per adult will not be limited to $5,050.
Budget:	Approximately $50,500 annually. Contracted services are on a reimbursement basis. Insurance (e.g., Medi-Cal) reimbursement and client share-of-cost (as determined by the UMDAP) will be accessed to leverage the investment of MHSA funds.

Community Services and Supports (CSS)

Project Name: **FUTURE POTENTIAL PROJECT** **Project 2d**
Assisted Outpatient Treatment

Project Type:	☒ Full Service Partnerships ☐ General System Development ☐ Outreach Engagement
Objective:	The Mental Health Commission and HHSA are exploring implementation of an Assisted Outpatient Treatment (AOT) project. In California, the law allowing for such a project can be found in the WIC.[131] AOT requires close collaboration between the MHD, Law Enforcement and the Justice System for full implementation. These agencies will be invited to join the Mental Health Commission and HHSA in developing the foundation of this project, such as basic structure of the project and anticipated budgets. This project will then be brought into the MHSA community planning process for input.
History:	AOT provides for limited term, court-ordered outpatient mental health treatment for those individuals meeting the criteria set forth by the law. There has been concern in the past whether MHSA funding can be utilized to fund AOT. On September 9, 2013, Governor Brown signed SB 585, which explicitly allows MHSA funds to be utilized for implementation of AOT.[132]
Budget:	The final budget will be developed with the full project description and may vary from this initial estimate. Year 1: Estimated at $125,000 (approximately 6 months of implementation) Year 2: Estimated at $225,000 Year 3: Estimated at $175,000 Should it be determined that this project will not proceed or that less funding is necessary, the remaining funds will be reassigned to other CSS projects. Contracted services are on a reimbursement basis. It is estimated that on an annual basis, approximately 12 individuals Countywide would met AOT criteria, with an average per person cost of $20,833 in Year 1 and $18,750 in Year 2. The higher costs in Year 1 are due to project start-up costs.

[131] WIC §§5345-5349.5. http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=05001-06000&file=5345-5349.5.
[132] SB 585. http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201320140SB585.

Community Services and Supports (CSS)

Project Name: Transitional Age Youth Engagement, Wellness and Recovery Services **Project 3a**

Project Type:	☒ Full Service Partnerships ☒ General System Development ☒ Outreach Engagement
Objective:	Provide services to meet the unique needs of transitional age youth and encourage continued participation in mental health services. This program partners in part with the Prevention and Early Intervention (PEI) Project 1f: Prevention and Early Intervention for Youth in Schools.
Target Population(s):	Transitional age youth (ages 16 through 24). May include youth ages 13 through 15 based upon the needs of the youth as recommended by the clinician and approved by the Supervisor and Program Manager. Youth in foster care, youth who aged out of foster care, or youth who aged out of the juvenile justice system are eligible, but it is not required that the youth be in foster care, be emancipated from foster care or aging out of the juvenile justice system to participate in this project. Youth must meet the eligibility requirements for their age group to receive specialty mental health services. This project will serve only clients who reside in the County. Youth may leave this project and return to this project at a later date. If it is determined through collaboration with the youth that the youth qualifies for and services would better be provided through a different age-appropriate Mental Health project (e.g., Family Strengthening Academy, Youth and Family Full Service Partnership, Adult Full Service Partnership), the youth may be enrolled in another project instead of the Transitional Age Youth Engagement, Wellness and Recovery Services project. Youth would only be eligible to enroll in one of the projects at a time.
Service Location(s):	Countywide
Project Description:	Community input identified a growing need for services for transitional age youth. Concern was specifically expressed for the TAY population aging out of the child welfare or juvenile justice programs, followed closely by concern for those who are homeless or at risk of homelessness. Young people transitioning out of the foster care system are significantly affected by the instability that accompanies long periods of out-of-home placement during childhood and adolescence. The experiences of these youth place them at a higher risk for unemployment, poor educational outcomes, health issues, early parenthood, long-term dependency on public assistance, increased rates

	of incarceration and homelessness. There is no comprehensive MHSA mental health services project designed to meet the full range of services required by this population, including but not limited to, supports such as education/employment, housing, transportation and financial assistance. Child Welfare Services is developing a strong TAY program for youth involved in child welfare services, and this project will coordinate with Child Welfare Services when there are clients in common. When developing and implementing programs for the TAY population, it is important to consider the requirements for participation in mental health services and the rights between youth who are: • under the age of 18; • over the age of 18 and subject to court or probation involvement; and • over the age of 18 without court or probation involvement. It is also important to identify age-appropriate groups, classes and activities for the youth, considering such factors as time of day (for those who may be in school or work) and family involvement in services. Additionally, beyond focusing on the mental health needs of the youth, it is important to recognize the interdependence between all aspects of a youth's life on their mental wellness. Youth who were in the child welfare or juvenile justice systems may be unprepared or underprepared for adult life, which may be further complicated by their mental health issues. For example, youth may have: • inadequate housing; • lack of financial resources; • changes in home and school that leave youth unprepared; and • lack of adult role models or permanent connection. All of these items can negatively impact a youth's mental health. Therefore, clinicians working with the youth will work on issues related to fostering emerging independence, supporting youth-developed goals, and helping the youth live up to their individual potential -- all supporting the goals of recovery and resiliency in the youth. Youth will be empowered to take responsibility for themselves and for their future, including continued participation in mental health services, but they will be supported in their development journey through this project. This program is designed to improve access to mental health services, improve accuracy of diagnosis, and to provide for use of appropriate and individualized service planning and delivery, use of effective integration of client families into services, and use of community and external resources

	-- all goals of culturally competent service delivery. Costs for this program include, but are not limited to, staff time, mileage and other operating expenses (e.g., rent, overhead), as well as supportive "flex funds" discussed below. Costs associated with project development and specialized TAY training are also included. **Outreach and Engagement** The community planning process identified a need to ensure the linkage between mental health, child welfare services, justice system, probation, and substance abuse treatment programs to improve the timely access of services for youth through improved screening and coordinated case management. To help reduce recidivism in the justice system, this project will seek to engage eligible at-risk youth and transition age youth and their families in mental health, addiction treatment, and other specialized services upon the youth's release from juvenile hall through discharge planning and family-reunification services prior to and following release from the juvenile hall. This strategy is designed to engage youth and transition age youth and their families in mental health, addiction and other specialized treatment services in order to reduce recidivism and out-of-home placements. This project will also work with eligible youth emancipating from Child Welfare Services to accomplish the same goals. Except under specific circumstances, youth are not required to continue to participate in mental health services upon reaching the age of 18, and youth frequently make the decision to discontinue mental health services upon turning 18. Therefore, a key goal of this program is to encourage continued engagement in mental health services upon reaching the age of 18. To accomplish this, services provided to the youth will include non-traditional mental health services (not just counseling and medication management) and provision of services in non-traditional locations. For example, mental health services may be provided one-on-one or in small groups with the youth while participating in independent living skill activities (e.g., grocery shopping, doing laundry, driving to/from appointments). Such activities will be utilized as engagement tools. Through the engagement process, this project will seek to establish relationships with the youth, assess their needs and identify appropriate services. **Wellness and Recovery** The role of the youth (and their family for youth under the age of 18) in developing their treatment plan and goals will be key. Additionally, this program will collaborate with other agencies that may be involved with

	the youth, such as Child Welfare Services or Probation, to develop an appropriate treatment plan for the youth. MHSA goals will be advanced as the "Wellness Program" emphasizes principles of recovery, client-centered planning, and the use of community collaboration to ensure an integrated and comprehensive service delivery system. At the heart of quality service delivery will be the use of culturally competent and evidence-based practices, as well. Strategies for service provision include, but are not limited to: • Case management • Peer support • Integrated substance abuse and psychiatric treatment • Cross-agency and cross-discipline collaboration • Integrated service teams • Supportive housing • Self-directed self-sufficiency plan • Life skills classes • Crisis response services • Education for clients, and family if appropriate, regarding medications • Transportation assistance • Recreation and social activities • Collaboration with community-based and faith-based providers • Linkage to vocational services This age group also needs assistance with develop independent living skills, which also help to stabilize their mental health needs, including but not limited to: • Financial literacy • Nutrition and healthy food choices, grocery shopping, meal prep • Identification of suitable home and home maintenance • Child care and children needs • Automotive maintenance • Educational and career development • Obtaining medical, dental, vision and mental health care • Access to community resources • Strengthening ties to community • Developing and researching goals • Self-care • Home care (e.g., laundry, cleaning) • Drug and alcohol abuse awareness and prevention • Safe sex and reproductive health information This project will also seek to develop a support network for youth

	involved in the project. Adult youths will also be eligible to participate in the Consumer Leadership Academy through the MHSA Workforce Education and Training (WET) program to gain valuable skills to help with in pursuing volunteer positions or employment in the public mental health system. Recovery and Resilience as ongoing treatment goals will be included in the client plan. On an individualized basis, the personal services coordinator will work with the client to determine how they define meaningful participation in their community and how to gradually and successful pursue those roles. Further, as part of the strengths-based assessment (both of the individual and their community and resources) qualities and assets that will assist the client in rebounding from their difficulties will be identified. The client will be responsible for the treatment plan but will have support from the case manager and natural supports in the client's world. The treatment plan will include strategies for daily maintenance, identification of triggers, early warning signs, and crisis planning. The assessment and treatment phases of the project will explore issues of sexuality and gender-related issues. Ensuring an awareness of the mental health stressors associated with sexual orientation issues, the increased barriers associated with gender differences, and the varying manifestations of issues of gender and sexuality at different developmental stages are critical to the delivery of culturally competent and client-centered service delivery that celebrates individual strengths and diversity. Education and awareness will occur hand-in-hand with ongoing collaboration, outreach and networking with a diverse group of community-based or specialized agencies working with individuals who may be faced with the barriers of stigma and discrimination related to sexual orientation or gender-bias. **Collaboration** For those youth who may be involved with Child Welfare Services or the juvenile justice system, this project will collaborate with the these programs for each youth to the extent allowed by law or as authorized by the youth, or for youth under age 18, the youth's family. Consideration will be given as to the youth's age-appropriate preferences in terms of a collaborative team approach. **Supportive "Flex Funds" (Flexible Supports and Services)** MHSA funds will be used to access non-mental health resources identified within the treatment plan that are needed by the youth to successfully fulfill their individualized treatment plan. Supports such as groups, food (prepared and non-prepared), and transportation, as well as

	other approved activities, can be funded by MHSA for stabilization purposes. MHD staff may also deliver curriculum for and support clients enrolled in the WET Project 6: Consumer Leadership Academy through this project. In case of emergencies, MHSA funds may be used to temporarily provide housing stability or support to a youth in crisis. Examples of uses for flex funds include, but is not limited to: • Moving expenses, including housing deposits, specific to providing safe, affordable, and adequate living arrangements for the youth; • Transportation to and from services and/or community support opportunities; • Child-care costs as necessary to promote participation in treatment for parenting youths; • Home improvement projects that promote and/or enhance the safety and adequacy of the living environment of the youth; • Community services expenses that allow the youth and family to participate in meaningful community services; • Skill-building lessons that enhance the independent living skills of the youth; • Educational expenses that promote the youth's success in school; • Medications necessary to assist the youth and family in achieving and maintaining mental and physical well-being; • Emergency food, shelter, or clothing for youth experiencing unexpected immediate hardship; • Emergency household item purchases for youth in immediate need; • Other expenses that the youth's case manager considers appropriate and are previously approved in the individualized treatment plan; and • Objects, fees and services utilized to accomplish the above needs (e.g., bus passes, car repair costs that will result in a safer means of transportation, work gloves for participating in community services, supplies needed for skill building lessons). **Full Service Partnership** Individuals participating in this project who are eligible for TAY Full Service Partnership services would be eligible for the type and extent of activities and supportive services identified in the Children and Youth Full Service Partnership project or the Adult Full Service Partnership project, dependent upon the individual's age. Therefore, the mental health and non-mental health services and project costs identified in Children and Youth Full Service Partnership project and the Adult Full Service Partnership project are incorporated within this project description for

	the TAY population. **Avoiding Duplication of Services** To the extent that services and supportive flex funds are available to a youth through a non-MHSA program (e.g., education assistance), the other funds will be accessed first. MHSA funds cannot be utilized to supplant other funding options.
Services Provided By:	☒ Contracted Vendor[133] ☒ Volunteers ☒ County Staff
Procurement Method:	These services will be provided by County Staff and contracted vendors, through a collaborative approach. An open procurement and/or competitive procurement process will be utilized for new contacts. Interested vendors will provide HHSA with a description of their agency, the service to be provided to Transitional Age Youth, staff qualifications, service locations and rates. The County will review the information and, if approved, enter into an agreement for services with the vendor, however there is no guarantee that the County will refer clients for services.
Project Goals:	• Decreased days of homelessness, institutionalization, hospitalization, and incarceration • Safe and adequate housing • Increased access to and engagement with mental health services • Increased use of peer support resources • Increased connection to their community • Increased independent living skills
Outcome Measures:	Measurement 1: Number of days of institutional care placements Measurement 2: Number of days of homelessness / housing stability Measurement 3: Education attendance and performance Measurement 4: Employment status Measurement 5: Continued engagement in mental health services Measurement 6: Linkage with primary health care

[133]These services will be provided by County Staff and volunteers; potential use of Contracted Vendors at a future point in time.

Community Services and Supports (CSS)

Project Name: Transitional Age Youth Engagement, Wellness and Recovery Services **Project 3a**

Number Served / Quantity of Service:	It is estimated that 50 to 120 youth would qualify for this project per year. The number of youth participating in this project is anticipated to be small, perhaps 50 to 70 per year due to staffing and funding limitations. The remaining TAY would be funded through other appropriate projects (e.g., traditional services, CSS Project 1a: Youth and Family Full Service Partnership, CSS Project 2a: Wellness Centers or CSS Project 2b: Adult Full Service Partnership). It would be anticipated that the average number of youth enrolled in this project would be limited to 70 annually (although more youth will be served if staffing and funding allows) and that the average cost per youth would be $4,891. However, some youth may have a higher level of need, such as those in need of FSP services, and the actual cost per youth will not be limited to $4,891.
Budget:	Approximately $342,387 in FY 2014-15 and $367,500 in FY 2015-16 and FY 2016-17. Insurance (e.g., Medi-Cal) reimbursement and client share-of-cost (as determined by the UMDAP) will be accessed to leverage the investment of MHSA funds.

Community Services and Supports (CSS)

Project Name: Outreach and Engagement Services **Project 4a**

Project Type:	☐ Full Service Partnerships ☐ General System Development ☒ Outreach/Engagement
Objective:	To engage individuals with a serious mental illness in mental health services and to continue to keep clients engaged in services by addressing barriers to service.
Target Population(s):	Individuals with serious mental illness, or who initially identify themselves as having a serious mental illness.
Service Location(s):	Countywide.
Project Description:	Mental health professionals, in concert with peer counselors when possible, will provide outreach and engagement services for individuals with serious mental illness who are homeless, in the jails, receiving primary care services, and who require outreach to their homes in order to reach the at-risk population. Outreach and engagement efforts may also be performed in partnership with law enforcement and Crisis Intervention Teams. Outreach and engagement services, in coordination with the El Dorado County Veterans Affairs Office, will also be provided to veterans to assist them in receiving mental health services provided by the Veterans Administration in surrounding counties (e.g., Placer, Sacramento and Washoe County in Nevada). Outreach and engagement services for current Mental Health clients will also be included to help them continue engagement in services, including addressing barriers that may arise due to relocation of the MHD clinics and Wellness Centers. Additionally, through a family liaison staff member, family members may seek information about the processes involved with mental health services (in-patient and out-patient as appropriate), HIPAA requirements, and client-specific information to extent allowed by law. Individuals who contact Mental Health for services may not meet the criteria for "specialty mental health services". However, that assessment cannot be made until a clinician has interviewed the individual. Therefore, when an individual contacts the HHSA for mental health services, they are initially presumed to have a severe mental illness, and as such, triage calls may be funded under this project. Graduates of the Consumer Leadership Academy (previously a PEI project, now a WET project) may also have a role in outreach and engagement. For example, graduates may provide peer engagement support and act as transportation ambassadors. Staff costs for outreach and engagement activities under this project will be funded by MHSA, along with associated costs (e.g., vehicle cost, overhead cost). These funds may also be utilized for the costs of developing and printing materials utilized for outreach and engagement,

	to include publication via local media. HHSA is seeking federal Projects for Assistance in Transition from Homelessness (PATH) program funds in an amount of $34,834 in FY 2014-15 (plus a mandatory match of $1.00 for each $3.00 of PATH funding) to further assist in outreach and engagement activities. No more than 20% of the PATH funds may be used for housing assistance and no more than 10% of the PATH funds may be used for administrative costs. The PATH program will be subcontracted to a community-based organization, for outreach, case management, benefit applications, training (including SSI/SSDI Outreach, Access, and Recovery Technical Assistance (SOAR) training), linkage to services and housing assistance. The MHD may retain a portion of the PATH funds to assist with administrative costs and will contribute towards a portion of the required match. These funds are designed to help individuals/families who are homeless or soon to be homeless and who have a mental health issue (or a mental health issue and a substance abuse issue) receive necessary services, apply for public assistance/benefits (including SSI/SSDI), and assistance in obtaining housing or remaining in housing. An RFP will be issued to identify a provider of these PATH services Countywide. **Transportation Barriers** Transportation was identified as a key barrier to services in El Dorado County and a key barrier to service for veterans given the Veterans Administration services are provided primarily in surrounding counties. Location of services, the rural nature of our County and seasonal snow and ice conditions can make it difficult for clients to obtain services. Therefore, transportation assistance may be provided to individuals and families under this project. As identified in the FY 2012-13 MHSA Plan Update, the Outreach and Engagement project includes assisting the public with getting to the locations of the clinics and Wellness Centers. A Transportation Committee has been established to identify key transportation barriers to service and potential strategies to address those barriers. Staff developing the Transportation Plan may charge their time to this project. Costs associated with implementing the Transportation Plan may be charged to this project (e.g., direct costs, staff time). Strategies to address transportation barriers may include, but are not limited to: • Transportation assistance through Medi-Cal providers; • Provision of services in local communities; • Modification of appointment and class/group start times to better align with the bus schedule;

	• Provision of bus script and/or passes to clients; • Provision of gas cards to clients if they have their own vehicle or support person with a vehicle; • Purchase of and staffing to operate a van to assist clients with access to services at the clinic and Wellness Center locations within El Dorado County and to veterans to access services at the Veterans Administration facilities in surrounding counties; • Development and printing of informational materials necessary to provide clients and potential clients with information about how to get to the clinic and Wellness Center locations; • Working with transportation providers to expand/extend current schedules; and • Contracting with transportation carries, e.g., El Dorado Transit, to enhance current service or provide unique routes. Strategies that involve issuance of instruments with a cash value (e.g., bus script/passes, gas cards) will be done in compliance with County and HHSA policies and procedures. Collaboration with local transportation providers and other County departments will be utilized to maximize efficiencies with transportation barriers and needs, such as collaboration with El Dorado Transit to identify service needs (e.g., times, routes). **Other Barriers to Service Engagement** Other barriers to obtaining services were identified during the community planning process. For example, appointments between 8:00 a.m. and 5:00 p.m. Monday through Friday may be difficult to keep for clients and parents of clients who are working full time. Strategies to address this issue will be researched. Service locations were another barrier identified. The Outreach and Engagement project will not fund provision of services in rural areas, but rather will coordinate with other MHSA projects to help them identify where services could be provided that will better assist clients in engagement. Veterans may receive assistance for food and lodging in addition to transportation assistance when they need to attend multiple day mental health related events at Veterans Administration facilities (such as the "Stand-Down Event"). **Project Differentiation** This project differs from the CSS Community-Based Mental Health Services project in that this project is seeking to engage those who are already diagnosed with a severe mental illness, or who initially identify themselves as having a serious mental illness, in services rather than providing clinical services. The CSS Community-Based Mental Health Services project provides clinical services for MHD clients in the

	community setting, including rural areas of the County. This project differs from the Community-Based Mental Health Services (PEI) project in that this project is seeking to engage those who have a severe mental illness, or who initially identify themselves as having a severe mental illness, and to continue client engagement in services. The Community-Based Mental Health Services (PEI) project provides outreach, engagement and referrals for prevention and early intervention purposes for those who may be at risk for mental illness or who have not yet been diagnosed with a serious mental illness. This project differs from the Older Adult Project (both PEI and CSS) in that the Older Adult Project requires more specialty services to address the needs of older adults, and as such, those services will be contracted to a community provider. The Older Adults Projects will also receive referrals from friends, family or community members who are concerned for older adults in need of mental health services. The Outreach and Engagement project is directed more towards individuals seeking services, but may also field referrals as a secondary activity.
Services Provided By:	☒ Contracted Vendor[134] ☐ Volunteers ☒ County Staff
Procurement Method:	None required. PATH services will be procured through a competitive procurement process and a single vendor will be identified for services Countywide. In the event that additional assistance is required through a contracted vendor (e.g., transportation services), the services would be identified through a competitive procurement process or a sole source contract, depending upon the services to be procured and the number of potential service providers.
Project Goals:	• To engage individuals with a serious mental illness in mental health services. • Continue to engage clients in services by addressing barriers to service.
Outcome Measures:	Measurement 1: Service engagement. Measurement 2: Wellness Center attendance.

[134] These services will be provided by County Staff and Volunteers; potential use of Contracted Vendors at a future point in time.

Community Services and Supports (CSS)

Project Name: Outreach and Engagement Services **Project 4a**

Number Served/ Quantity of Service:	This component anticipates serving 200 unique clients per year in initial outreach and engagement activities and potentially all clients of Mental Health in continued engagement in services. Potential reach of this project could exceed 1,000 individuals annually and that the average cost per youth would be $1,055.
Budget:	Approximately $1,055,798 in FY 2014-15 and dropping to $840,000 pending funding availability thereafter.

Community Services and Supports (CSS)

Project Name: Community-Based Mental Health Services Project 4b

Project Type:	☐ Full Service Partnerships ☒ General System Development ☒ Outreach Engagement
Objective:	Provide assessments and specialty mental health services in local communities. This program partners with the Prevention and Early Intervention (PEI) program of "Community-Based Mental Health Services". Clinical staff will visit local communities to provide mental health services to clients under CSS, and will provide information and preventative/early intervention services under Prevention and Early Intervention (PEI) funding when they are not seeing clients under CSS.
Target Population(s):	Individuals eligible for specialty mental health services.
Service Location(s):	Countywide.
Project Description:	Staff will provide assessments and, for individuals meeting the criteria for specialty mental health services, deliver mental health services in local communities throughout El Dorado County. Clients who are not enrolled in one of the Full Service Partnership projects will no longer be required to solely receive services at the South Lake Tahoe or West Slope clinics, but may be provided with services in their local community, if appropriate space is available. HHSA will enter into agreements for space to provide mental health services (e.g., local medical clinics or office space) when necessary to facilitate the provision of services locally. Services may also be provided in other locations as agreed to by the clinician and the client (e.g., homes, parks, faith-based facilities). The location of service provision must be deemed a safe location as determined by the Mental Health staff and provide adequate privacy to allow the staff and client to speak in confidence. Implementation of this project is dependent upon identification of appropriate space in local communities for service provision. Groups/classes may also be provided in local communities provided there is adequate demand for the minimum number of attendees (each type of group/class has specific minimum attendees), and residents of the County may attend classes in any area of the County that is convenient for them. Costs for this program include, but are not limited to, staff time, mileage and other operating expenses (e.g., rent, overhead, group/class

	materials).
Services Provided By:	☒ Contracted Vendor[135] ☐ Volunteers ☒ County Staff
Procurement Method:	Initially, these services will be provided by County Staff. In the event this program is transitioned to a contracted vendor in whole or in part, the vendor(s) will be selected through a competitive procurement process and multiple vendors may be selected to provide these services.
Project Goals:	• Improve community health through local services • Increased access to and engagement with mental health services • Decreased days of homelessness, institutionalization, hospitalization, and incarceration • Increased connection to their community • Increased independent living skills
Outcome Measures:	Measurement 1: Continued engagement in mental health services Measurement 2: Days of homelessness, institutionalization, hospitalization, and incarceration Measurement 3: Linkage with primary health care Measurement 4: Levels of Care Utilization System (LOCUS)/CALOCUS Measurement 5: Outcome measurement tools (e.g., CANS)
Number Served / Quantity of Service:	All clients eligible for specialty mental health services would be eligible to receive services at designated local community centers, both children and adults. It would be anticipated that the average number of client enrolled in this project would be 30 annually and that the average cost per individual would be $5,241. However, some individuals may have a higher level of need, and the actual cost per individual will not be limited to $5,241.
Budget:	Approximately $157,613 in FY 2014-15 and $157,500 in FY 2015-16 and FY 2016-17. These funds will be leveraged with AB 109 (Public Safety Realignment of 2011) funds when services for CSS-eligible individuals are provided through the Community Corrections Center. Insurance (e.g., Medi-Cal) reimbursement and client share-of-cost (as determined by the UMDAP) will be accessed to leverage the investment of MHSA funds.

[135] These services will be provided by County Staff; potential use of Contracted Vendors at a future point in time.

Community Services and Supports (CSS)

Project Name: Resource Management Services **Project 4c**

Project Type:	☐ Full Service Partnerships ☒ General System Development ☐ Outreach Engagement
Objective:	Develop key community relationships, provide program evaluation and quality improvement oversight for the MHSA programs, and improve access and service delivery.
Target Population(s):	All
Service Location(s):	Countywide
Project Description:	This project is designed to develop key relationships and thereby build access to resources for the consumers and families served (health care, housing, vocational, educational, benefits, and substance abuse treatment), while also providing program evaluation and quality improvement oversight for the MHSA services program. As identified in the approved MHSA FY 2007-08 Expansion Proposal, we will also utilize MHSA-funds to engage in general systems development planning to improve access and service delivery. Developing key relationships and building access to resources includes identifying resources for clients and their families, including but not limited to health care, housing, vocational, educational, benefits, and substance abuse treatment; dissemination of the information; and ongoing resource coordination and management. Program evaluation and quality improvement oversight includes researching, developing, administering, scoring, analyzing and reporting activities related to program evaluation, utilization, outcome measures, quality improvement, and data management. Staff may receive necessary resource management training, as needed. Improving access and service delivery includes evaluating and designing services to be effective within our community and the MHD Wellness and Recovery Programs. With preparations for and the arrival of the Affordable Care Act, these services will also include close coordination between MHD staff and primary care physicians, including consultations between MHD psychiatrists and providers of primary health care services. This will also include coordination with ACCEL members, continued participation in the ACCEL collaborative, and financial support of ACCEL to continue to promote effective coordination between Mental Health and primary care providers. MHSA-funded psychiatry time to serve un-insured MHSA clients is included as well. Project funds will be utilized for staff time, overhead, supplies, equipment, training and travel needed to carry out this project. To encourage volunteers' attendance at quality review and improvement meetings,

	prepared food and beverage items, along with disposable plates, napkins, cups, and eating and serving utensils, may be purchased.
Services Provided By:	☐ Contracted Vendor ☒ Volunteers ☒ County Staff
Procurement Method:	None.
Project Goals:	• Improve the number and quality of resources available to clients and their families. • Improve access and service delivery. • Improve program evaluation process. • Improve client transitions between primary care providers and Mental Health.
Outcome Measures:	Measurement 1: Update and expansion of resource list; dissemination of information to clients. Measurement 2: Client wait times. Measurement 3: Client satisfaction surveys. Measurement 4: Establishment of standard evaluation process for MHSA programs and dissemination of information. Measurement 5: Results of EQRO annual audit. Measurement 6: Results of Program Improvement Plan for Primary Care Providers. Measurement 7: Primary care provider satisfaction surveys.
Number Served / Quantity of Service:	As a general system development program, there is not a specific number of clients that will be served. Rather, this program is designed to improve services to clients and other community providers, and to evaluate MHSA programs.
Budget:	Approximately $175,000 in FY 2014-15 and $183,750 in FY 2015-16 and FY 2016-17.

Community Services and Supports (CSS)

Project Name: Reallocation to Workforce Education and Training

Objective:	To provide ongoing workforce education and training to build and maintain a strong public mental health system workforce in El Dorado County.
Outcome Measures:	Please see the WET component project descriptions for the anticipated project outcomes.
Budget:	FY 2014-15: $35,361 FY 2015-16: $166,000 FY 2016-17: $156,000

Project Name: Reallocation to Capital Facilities and Technology (CFTN)

Objective:	To provide funding for ongoing CFTN projects.
Outcome Measures:	Please see the CFTN component project descriptions for the anticipated project outcomes.
Budget:	FY 2014-15: $0 FY 2015-16: $136,176 FY 2016-17: $232,473

Project Name: Contribution to the Prudent Reserve

Objective:	To maintain adequate funding to continue implementation of MHSA programs during years when revenues drop
Outcome Measures:	Please see the discussion about the Prudent Reserve for more information.
Budget:	FY 2014-15: $0 FY 2015-16: $0 FY 2016-17: $0

Discontinued CSS Programs/Projects

There are no CSS programs/projects to be discontinued under the FY 2014-15 MHSA Plan.

Sub-Component: Community Services and Supports-Housing (CSS-Housing)

Sub-Component Definition

Housing is a sub-component of the Community Services and Supports component, the funds for which are administered through the California Housing Finance Agency, and are used to acquire, rehabilitate or construct permanent supportive housing for clients with serious mental illness and provide operating subsidies.[136]

Consumers, family members and service providers in El Dorado County have consistently identified housing needs of the seriously mentally ill as a priority. The MHSA Housing Program provides funding for the development, acquisition, construction and/or rehabilitation of permanent supportive housing for persons with serious mental illness and their families who are homeless or at risk of homelessness. The housing program offers consumers housing and supportive services that will enable them to live more independently in our communities.

It is the primary objective of the supportive services plan to support the individual in maintaining tenancy. The overarching principles of the MHSA housing service plan are client/tenant choice and voluntary services for clients.

Application for an MHSA apartment is a two-part process. First, individuals interested in the housing must be determined to be MHSA-Housing Eligible. The eligibility criteria for each development is described below. Once an individual is determined to be eligible for MHSA housing, their application packet is forwarded to the apartment property manager for a determination of eligibility for the development. The property manager will review the client's completed application, credit report, and criminal history report, including reviewing the documents for discrepancies between the three documents. The property manager will determine eligibility for the specific property based upon the development's resident selection criteria.

CSS-Housing Budget

Funding for the two developments continues to be from the original $2,276,500 in CSS-Housing funds allocated to the County in FY 2007-08 and assigned to CalHFA in June 2010. No additional funding for CSS-Housing has been received by the County.

Program 1: West Slope – Trailside Terrace (formerly Sunset Lane Apartments), Shingle Springs

MHSA housing funds were approved for use in the development of Trailside Terrace, a 40-unit affordable housing (apartment) community, in 2010. Five units will be dedicated to the El

[136] CCR, Title 9, Division 1, Chapter 14, Section 3200.225, Mental Health Services Act Housing Program Service Category.

Dorado County MHSA housing program and will target households that are eligible for services under the MHSA Adult Full Service Partnership project.

Located on Sunset Lane near Mother Lode Drive and Highway 50 in the unincorporated community of Shingle Springs, this is the first permanent supportive housing program in El Dorado County. The MHSA Housing Program represents a partnership between Mercy Housing California 55, serving as the housing developer, Mercy Services Corporation serving as the property manager and the HHSA MHD to provide a supportive services program to the tenants of the MHSA units.

The estimated total development budget of the project is approximately $13,434,602. The project will be financed using a combination of State and federal funding, including Home Investment Partnership Program (HOME), Community Development Block Grant (CDBG), Low Income Housing Tax Credits, MHSA funding, and conventional financing. The request for MHSA funding for this program is $1,080,800, for capital outlay for development ($540,000) and operating subsidies and administrative fees ($540,000).

MHSA eligible applicants will be adults, aged 18 and over and be eligible for specialty mental health services, who are homeless or are soon-to-be homeless. Supportive services for MHSA-eligible residents will be provided through the Adult Full Service Partnership program (see the "Adult Full Service Partnership" project for more information about FSP services) and designed to promote housing stability and support the residents' recovery.

Status of Housing Completion: Mercy Housing California 55 began construction in March of 2012, and Trailside Terrace received its Certificate of Occupancy on August 2, 2013. Tenants began moving in mid-September. All MHSA units are occupied and the MHD maintains a waiting list of eligible individuals/families.

Program 2: East Slope – The Aspens at South Lake, South Lake Tahoe

In January 2013, MHSA housing funds were approved by the Board of Supervisors for use in the development of The Aspens at South Lake, a 48-unit affordable housing community. Of the 48 units, one two-bedroom unit is reserved for the resident manager, and 47 units target low-income households earning 50% and below of the El Dorado County area median income. Six units are dedicated to the El Dorado County MHSA housing program and target households that are eligible for services under the MHSA FSP program. MHSA programs support The Aspens at South Lake to meet anticipated outcomes by supporting MHSA participants to achieve wellness, allow for re-integration into the community, reduce hospitalizations and incarcerations, and increase employment.

Initial applications to The Aspens at South Lake were processed by lottery when completion of construction approached. After initial rent-up, applications will be processed in the order in which they are received. If no units are available, eligible applicants will be placed on a waiting list.

The property is located at 3521 and 3541 Pioneer Trail, near the intersection of Ski Run Boulevard, in the City of South Lake Tahoe. This development represents a partnership between Pacific West Communities, Inc. serving as the housing developer, Cambridge Real Estate Services serving as property manager, SLT Pacific Associates, a CA LP as the property

owner, and the HHSA MHD to provide a supportive services program to the tenants of the MHSA units.

The estimated total construction cost of the project is approximately $16 million. The project will be financed using a combination of State and federal funding, including State HOME, Low Income Housing Tax Credits, MHSA funding, and conventional financing. The request for MHSA funding for this program is $1,279,970, for capital outlay for development ($948,770) and operating subsidies and administrative fees ($331,200).

Individuals eligible for the MHSA Housing Program units will be individuals with serious mental illness who have complex and long-term social and medical issues. Consideration will be given to adult individuals diagnosed with a serious mental illness who have minor children, and all MHSA tenants will have experienced homelessness or will be at risk of homelessness. It is anticipated that all of the tenants for the MHSA-designated units in the housing project will be HHSA MHD clients who are assessed as eligible for MHSA FSP outpatient services.

The services and goals for The Aspens at South Lake will be developed in partnership with the tenants and will be individualized and client-directed, utilizing a strengths-based approach. Services will include a FSP approach designed to promote housing stability and support consumers' recovery. These services will include, but not be limited to: outreach and engagement services, peer and family support services, crisis intervention, mental health assessment and evaluation, individual services planning, care coordination, independent living skills training, budget planning, consumer leadership development, and mobility training. Tenant services will also promote linkage to existing supportive systems, such as primary healthcare, employment services, educational services, assistance with food and clothing, mainstream benefits, addiction treatment services, and community building resources. Services will occur onsite, and in community and clinic-based settings with a frequency that is individually determined.

Status of Housing Completion: Construction began mid-2013 and was completed ahead of schedule. Tenants began moving into The Aspens at South Lake in January 2014. All six MHSA units are currently leased.

Workforce Education and Training (WET)

Component Definition

"Workforce Education and Training" includes education and training programs and activities for prospective and current public mental health system employees, contractors and volunteers.[137] "Public mental health system" means publicly-funded mental health programs/services and entities that are administered, in whole or in part, by the State or County. It does not include programs and/or services administered in or by correctional facilities.[138] WET provides funding to remedy the shortage of staff available to address mental illness, improve the competency of staff, and to promote the employability of consumers.

WET funds may be utilized for programs within the following categories:

- **Training and Technical Assistance:** Programs and/or activities that (1) increase the ability of the Public Mental Health System workforce to promote and support the MHSA General Standards; (2) support the participation of clients and family members of clients in the public mental health system; (3) increase collaboration and partnerships among public mental health system staff and individuals and/or entities that participate in and support the provision of services in the public mental health system; and (4) promote cultural and linguistic competence.[139]

- **Mental Health Career Pathway Programs:** These programs may fund, but are not limited to, the following: (1) programs to prepare clients and/or family members of clients for employment and/or volunteer work in the public mental health system; (2) programs and coursework in high schools, adult education, regional occupational programs, colleges and universities that introduce individuals to and prepare them for employment in the Public Mental Health System; (3) career counseling, training and/or placement programs designed to increase access to employment in the public mental health system to groups such as immigrant communities, Native Americans and racial/ethnic, cultural and linguistic groups that are underrepresented in the public mental health system; (4) focused outreach and engagement in order to provide equal opportunities for employment to individuals who share the racial/ethnic, cultural and linguistic characteristics of the clients served; and (5) supervision of employees in public mental health system occupations that are in a mental health career pathway program.[140]

- **Residency and Internship Programs:** These programs may fund, but are not limited to, the following: (1) time required of staff, including university faculty, to supervise psychiatric residents training to work in the public mental health system; (2) time required of staff, including university faculty, to supervise post-graduate interns training to work as psychiatric nurse practitioners, masters of social work, marriage and family

[137] CCR, Title 9, Division 1, Chapter 14, Section 3200.320, Workforce Education and Training.
[138] CCR, Title 9, Division 1, Chapter 14, Section 3200.253, Public Mental Health System.
[139] CCR, Title 9, Division 1, Chapter 14, Section 3841, Training and Technical Assistance Funding Category.
[140] CCR, Title 9, Division 1, Chapter 14, Section 3842, Mental Health Career Pathway Programs Funding Category.

therapists, or clinical psychologists in the public mental health system; (3) time required of staff, including university faculty, to train psychiatric technicians to work in the public mental health system; (4) time required of staff, including university faculty, to train physician assistants to work in the public mental health system and to prescribe psychotropic medications under the supervision of a physician; and (5) addition of a mental health specialty to a physician assistant program.[141]

- **Financial Incentive Programs:** These programs may fund financial assistance programs that address one or more of the occupational shortages identified in the County's Workforce Needs Assessment, such as scholarships, stipends and loan assumption programs.[142]

- **Workforce Staffing Support:** These programs may fund, but are not limited to, the following: (1) public mental health system staff to plan, recruit, coordinate, administer, support and/or evaluate WET programs and activities; (2) staff to support Regional Partnerships when performing activities that address shortages within the workforce or shortages of workforce skills identified as critical by the Regional Partnership, deficits in cultural and/or linguistic competence, or promotion of employment and career opportunities in the public mental health system for clients and family members of clients; (3) staff to provide ongoing employment and educational counseling and support to clients entering or currently employed in the public mental health system workforce, family members of clients who are entering or currently employed in the public mental health system workforce or family members who are entering or currently employed in the public mental health system workforce; (4) staff to provide education and support to employers and employees to assist with the integration of clients and/or family members of clients into the public mental health system workforce; (5) staff necessary to support activities in multiple WET funding categories when the staff time is not included in the budget for any other funding category; and (6) the WET Coordinator.[143]

WET funds may be used to:

(1) Educate the Public Mental Health System workforce on incorporating the MHSA general standards of (1) community collaboration, (2) cultural competence, (3) client driven services, (4) family driven services (5) wellness, recovery, and resilience focused, and (6) integrated service experiences for clients and their families.

(2) Increase the number of clients and family members of clients employed in the Public Mental Health System through activities such as:

(A) Recruitment;

(B) Supported employment services;

(C) Creating and implementing promotional opportunities; or

[141] CCR, Title 9, Division 1, Chapter 14, Section 3843, Residency and Internship Programs Funding Category.
[142] CCR, Title 9, Division 1, Chapter 14, Section 3844, Financial Incentive Programs Funding Category.
[143] CCR, Title 9, Division 1, Chapter 14, Section 3845, Workforce Staffing Support Funding Category.

(D) Creating and implementing policies that promote job retention.

(3) Conduct focused outreach and recruitment to provide equal employment opportunities in the Public Mental Health System for individuals who share the racial/ethnic, cultural and/or linguistic characteristics of clients, family members of clients and others in the community who have serious mental illness and/or serious emotional disturbance.

(4) Recruit, employ and support the employment of individuals in the Public Mental Health System who are culturally and linguistically competent or, at a minimum, are educated and trained in cultural competence.

(5) Provide financial incentives to recruit or retain employees within the Public Mental Health System.

(6) Incorporate the input of clients and family members of clients and, whenever possible, utilize them as trainers and consultants in public mental health WET programs and/or activities.

(7) Incorporate the input of diverse racial/ethnic populations that reflect California's general population into WET programs and/or activities.

(8) Establish Regional Partnerships.

(9) Coordinate WET programs and/or activities.

(10) Staff time spent supervising interns and/or residents who are providing direct public mental health services through an internship or residency program may be funded.

Workforce Education and Training funds may not be used to:

(1) Address the workforce recruitment and retention needs of systems other than the Public Mental Health System, such as criminal justice, social services, and other non-mental health systems.

(2) Pay for staff time spent providing direct public mental health services.

(3) Off-set lost revenues that would have been generated by staff who participate in Workforce Education and Training programs and/or activities. [144]

Mental Health Workforce

El Dorado County is longer designated as a Mental Health Professional Shortage Area (MHPSA) by the U.S. Department of Health and Human Services, Health Resources and Services Administration. A MHPSA is an area that has a been designated as having a shortage of professionals in the mental health industry. Designation as a MHPSA provides jurisdictions with specific benefits, such as additional Medicare payments to providers, education loan relief for

[144]CCR, Title 9, Division 1, Chapter 14, Section 3810. General Workforce Education and Training Requirements. Full requirements for the WET program can be found in CCR, Title 9, Division 1, Chapter 14, Sections 3810 through 3856.

medical service providers, and waiver of certain J-1 visa requirements related to temporary employment in certain specialty occupations.

Census information is used for this determination and is provided to the federal government from each state. Based on the data, El Dorado County does not meet the criteria to qualify for a MHPSA designation due to the County's poverty level being lower than required poverty level and having more psychiatrists in our area than the criteria allows.[145] The data does not look at the number of psychiatrists practicing in the public mental health system or the type of insurance (if any) accepted by those psychiatrists, but rather the overall number of psychiatrists.[146]

The County has struggled to recruit and retain qualified Mental Health staff, especially Psychiatrists, Nurses, Mental Health Clinicians and bilingual staff. El Dorado County will be engaging in a workforce needs assessment in FY 2014-15. The last workforce needs assessment, published in 2008, identified similar needs.

WET in El Dorado County

The previous WET Plans detailing the origins of the WET programs and the Workforce Needs Assessment may be found on the County's MHSA web page.[147] The results of the next Workforce Needs Assessment will be incorporated into the FY 2014-15 MHSA Plan. The WET programs will be re-evaluated at that time to determine their applicability to the outcomes of the new Workforce Needs Assessment and explore how the WET funds may be utilized to better develop a staff recruitment and retention program.

WET Budget

MHSA no longer provides funding for WET activities. The County has been operating this program through funds previously received and remaining as a fund balance. As of the beginning of FY 2014-15, the remaining WET fund balance from previous fiscal years is $151,076. There is no risk of WET fund reversion in FY 2014-15.

After FY 2014-15, it is estimated there will be no remaining fund balance. Therefore, per WIC §5892(b), counties may use a portion of their CSS funds for WET, CFTN, and the Prudent Reserve. The total amount of CSS funding used for this purpose may not exceed 20% of the total average amount of funds allocated to that County for the previous five years. El Dorado County will transfer CSS funds to the WET component starting in FY 2014-15 as follows:

[145] These two specific issues were identified during a telephone conversation with Health Resources and Service Administration and the National Health Service Corps, February 2014.
[146] More information about the MHPSA designation requirements and data can be found at http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsaoverview.html, http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/mentalhealthhpsacriteria.html and http://arf.hrsa.gov/arfdashboard/HRCT.aspx.
[147] El Dorado County, MHSA Plans Archive. http://www.edcgov.us/MentalHealth/MHSA_Plans.aspx.

Fiscal Year	Amount
FY 2014-15	$35,361
FY 2015-16	$166,000
FY 2016-17	$156,000

For additional information regarding MHSA allocations and expenditures, please see Attachment E.

WET Programs

Program/Project	Training and Technical Assistance	Residency and Internship Programs	Workforce Staffing Support	Mental Health Career Pathways Programs	Financial Incentive Programs	FY 14-15 Expenditures	FY 15-16 Expenditures	FY 16-17 Expenditures
Revenues:								
Fund Balance						$151,076	$0	$0
Transfer from CSS						$35,361	$166,000	$156,000
Available Revenues						**$186,437**	**$166,000**	**$156,000**

Expenditures:								
Program 1: Workforce Education and Training (WET) Coordinator	✓		✓			$11,037	$15,000	$15,000
Program 2: Workforce Development	✓		✓			$49,825	$50,000	$50,000
Program 3: Psychiatric Rehabilitation Training						Realigned under Program 2	Realigned under Program 2	Realigned under Program 2
Program 4: Early Indicators of Mental Health Issues			✓			$50,000	$45,000	$40,000
Program 5: Suicide Education and Training			✓			$50,000	$45,000	$40,000
Program 6: Consumer Leadership Academy			✓	✓		$600	$1,000	$1,000
Program 7: Crisis Intervention Team Training			✓			$20,000	$0	$0
Administrative Costs						$4,975	$10,000	$10,000

Program/Project	Training and Technical Assistance	Residency and Internship Programs	Workforce Staffing Support	Mental Health Career Pathways Programs	Financial Incentive Programs	FY 14-15 Expenditures	FY 15-16 Expenditures	FY 16-17 Expenditures
Total WET Expenditures						**$186,437**	$166,000	$156,000

Anticipated Year-End Fund Balance						**$0**	**$0**	**$0**

Program Name: Workforce Education and Training (WET) Coordinator I

Funding Categories:	☒ Training and Technical Assistance ☐ Residency and Internship Programs ☒ Workforce Staffing Support	☐ Mental Health Career Pathways Programs ☐ Financial Incentive Programs
Objective	Coordinate WET programs and activities and serve as the liaison to the State. This position is required by the MHSA.[148]	
Target Audience	☒ Public Mental Health System Employees ☒ Contractors ☒ Volunteers	☒ Consumers and Family Members ☐ Law Enforcement ☐ Teachers/Education
Service Location(s)	Countywide	
Project Duration	Ongoing	
Activities Performed	1) Coordinate WET activities. 2) Participate in regional partnerships. 3) Address the priority need of improving the linguistic and cultural capacity of our public mental health workforce. 4) Provide leadership for the implementation of the locally identified WET funding priorities. 5) Develop goals of the workforce development program, expand capacity, and identify career enhancement opportunities.	
Services Provided By	☐ Contracted Vendor ☐ Volunteers ☒ County Staff The MHSA Program Manager is designated as the WET Coordinator for El Dorado County. However, support for this position is provided by various MHSA Project Team members.	
Procurement Method	Services provided by HHSA staff.	

[148] CCR, Title 9, Division 1, Chapter 14, Section 3810, General Workforce Education and Training Requirements.

Program Name: Workforce Education and Training (WET) Coordinator I

Program Goals	• Increase participation in regional partnerships. • Identify career enhancement opportunities and variety of promotional opportunities for existing public mental health system workforce. • Increased utilization of WET funding for local trainings. • Increase number of bilingual / bicultural public mental health workforce staff. • Increase number and variety of employment and/or volunteer opportunities available to consumers and their families who want to work in the mental health field.
Outcome Measures	Measurement 1: Increase the number of training opportunities for the mental health workforce. Measurement 2: Increased number of bilingual / bicultural mental health workforce employed within the public mental health system.
Number of Services / Quantity of Service	Coordinator will work to expand capacity and identify career enhancement opportunities for current County mental health staff as well as consumers. It is estimated that at least four trainings opportunities occur in FY 2014-15. WET programs will continue to expand in future years.
Budget	Approximately $11,037 annually. Costs include WET coordinator, support staff, administration and overhead.

Program Name: Workforce Development 2

Funding Categories:	☒ Training and Technical Assistance ☐ Residency and Internship Programs ☒ Workforce Staffing Support	☐ Mental Health Career Pathways Programs ☐ Financial Incentive Programs
Objective	Workforce Development includes education and training programs and activities for prospective and current public mental health system employees, contractors and volunteers.	
Target Audience	☒ Public Mental Health System Employees ☒ Contractors ☒ Volunteers	☐ Consumers and Family Members ☐ Law Enforcement ☐ Teachers/Education
Service Location(s)	Countywide	
Project Duration	Ongoing	
Activities Performed	Activities under this program include, but are not limited to: 1) Identify training opportunities for the public mental health system staff to improve mental health practices, including cultural and linguistic competency. 2) Provide a web-based training system to provide clinical and health education training, including a comprehensive library of online courses (currently contracted with Relias Learning). 3) Identify ways to improve retention rates for current staff. 4) Identify opportunities to recruit new staff into the mental health workforce. 5) As part of this program, prepared food (including, but not limited to snacks, lunch, beverages) may be purchased through MHSA funds and provided for attendees of WET trainings. 6) Upon development of the necessary policies and procedures and execution of an agreement, eligible members of the public mental health system (beyond just County staff and volunteers) may receive reimbursement for training costs, including registration fees, travel to training, lodging, meals and training materials, when attendance at training is received in advance and pursuant to the policies and procedures and the agreement. An online survey to gather input on the training preferences for El Dorado County was distributed at the end of August and remained open	

	through September 4, 2013. The purpose of this survey was to gauge public input on the types and formats of workforce development training that should occur. Only nine responses were received, therefore the results from this survey are rather limited in identifying public preferences related to the Workforce Development program. Respondents were asked: "On a scale of 1 to 5, with 5 being the highest need, please prioritize each of the following Workforce Education and Training (WET) trainings topics and training formats." On a scale of 1 to 5, with 5 being the highest, these were the priorities identified: Evidence-Based Practices for Transitional Age Youth.....4.63 Evidence-Based Practices for Adults.....4.38 Evidence-Based Practices for Youth.....4.38 Youth Development and Youth Assets.....4.25 Co-Occurring Substance Use/Abuse and Mental Illness.....4.13 Recognizing Signs of Mental Illness.....4.13 Crisis Intervention Techniques (CIT).....3.88 Recovery and Resiliency.....3.88 Shared Training Opportunities (multiple organizations at one training).....3.88 Strength-Based Supervision and Leadership.....3.88 Suicide Prevention.....3.88 Healthcare Reform (Affordable Care Act).....3.75 Integrated Service Delivery Models.....3.63 Outcome Measures.....3.63 Post-Traumatic Stress Disorder (PTSD).....3.63 Stigma and Discrimination with Mental Illness.....3.63 Parenting/Step-Parenting Programs.....3.38 Cultural Competency.....3.00 DSM-5.....3.00 Electronic Health Records Systems.....2.75 Additionally, respondents were given the opportunity to identify other training topics, and they identified the following: • Employment/Education for Consumers • Consumers in the Workforce • School Outreach/SDR • Co-occurring use/abuse mental illness • Integrated services

Program Name: Workforce Development 2

	• Mindfulness Based Stress Reduction (MBSR) training program The MHD has purchased other training materials, including but not limited to: • Psychiatric Rehabilitation Training These topics and training formats will be the primary focus during the term of this Plan, however other relevant training topics supporting the General Standards of MHSA and the MHSA projects identified in this Plan will also be available.
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Relias Learning for access to and maintenance of web-based training system. Other vendors as needed to provide training. County staff and/or volunteers to provide and/or attend training.
Procurement Method	Services of contracted vendors will be arranged in compliance with the County's Procurement Policy.
Program Goals	1) Increase the number of training opportunities for the public mental health system workforce. 2) Identify career enhancement opportunities for existing mental health workforce. 3) Increase the retention rates for current mental health workforce staff. 4) Increase the number of new staff recruited into the mental health workforce. 5) Increase the number of bilingual / bicultural mental health workforce staff available to serve clients. 6) Increase the number and variety of positions available to consumers and their family members who want to work in the mental health field.
Outcome Measures	Measurement 1: Increase the number of training opportunities for the public mental health system workforce, including staff, contractors, volunteers and consumers. Measurement 2: Increased number of bilingual / bicultural public mental health workforce system staff in the County.
Number of Services / Quantity of Service	All current public mental health system workforce staff, including County employees, contractors and volunteers, as well as consumers and their family members interested in working in the mental health field may be eligible.
Budget	Approximately $49,825 annually. Costs include, but are not limited to, staff, administration, overhead, training materials, training fees (e.g., contracted vendor costs,

	registration fees, lodging, meals, travel), equipment purchase and repairs, prepared food, household supplies (e.g., disposable plates, utensils). Staff will generally record their time to attend Workforce Development trainings to "indirect" rather than to this project.

Program Name: Psychiatric Rehabilitation Training 3

This program will be moved under Program 2: Workforce Development effective with the implementation of the FY 2014-15 MHSA Plan. Rather than being a separate program, it will become one of many options for training opportunities funded through the Workforce Development program.

Funding Categories:	☒ Training and Technical Assistance ☐ Residency and Internship Programs ☒ Workforce Staffing Support	☒ Mental Health Career Pathways Programs ☐ Financial Incentive Programs
Objective	To provide evidence based independent living life skills training in conjunction with the Consumer Leadership Academy.	
Target Audience	☒ Public Mental Health System Employees ☒ Contractors ☒ Volunteers	☒ Consumers and Family Members ☐ Law Enforcement ☐ Teachers/Education
Service Location(s)	South Lake Tahoe and West Slope outpatient clinics	
Project Duration	Ongoing	
Activities Performed	The Psychiatric Rehabilitation training package, client workbooks, guides for program leaders, and curriculum materials were purchased from Boston University in June, 2010. Since these materials have been purchased and implementation of the program requires staff to access the materials as a training program, this program will be rolled under Program 2: Workforce Development effective with the implementation of the FY 2014-15 MHSA Plan. Participants, including public mental health staff and volunteers, have an opportunity to learn direct skills teach through class development, role-playing, and developing coaching skills. Participants will be able to learn individual-focused behavioral skills including; goal setting, problem solving, interpersonal skills, how to share emotions, job interview skills, identifying and overcoming barriers, time management skills, creating support systems and achieving a more stable living situation. Skills learned will be applied to group sessions and everyday situations.	
Services Provided By	☐ Contracted Vendor ☒ Volunteers ☒ County Staff	
Procurement Method	None. Services provided by HHSA staff, volunteers and interested consumers.	

Program Name: Psychiatric Rehabilitation Training 3

Program Goals	• Improved teaching and group facilitation skills. • Improved social interaction between group facilitators, consumers and their friends/family. • Participants are able to identify and overcome barriers.
Outcome Measures	Measurement 1: Pre- and post-participation surveys.
Number of Services / Quantity of Service	Training materials are available.
Budget	$0 as a standalone program; incorporated into Program 2: Workforce Development.

Program Name: Early Indicators of Mental Health Issues 4

Funding Categories:	☐ Training and Technical Assistance ☐ Residency and Internship Programs ☒ Workforce Staffing Support	☐ Mental Health Career Pathways Programs ☐ Financial Incentive Programs
Objective	Increase the number of education staff trained to identify early indicators of mental issues. EDCOE will identify and/or develop online training modules and resources that will be made available to all educators and, to the extent allowed by licensing, community partners working with children and youth (e.g., Boys and Girls Club, Big Brothers Big Sisters)	
Target Audience	☒ Public Mental Health System Employees (Secondary) ☒ Contractors (Secondary) ☒ Volunteers (Secondary)	☐ Consumers and Family Members ☐ Law Enforcement ☒ Teachers/Education (Primary)
Service Location(s)	Countywide	
Project Duration	Through June 30, 2017.	
Activities Performed	EDCOE will identify a menu of SAMHSA approved evidenced-based programs that may be selected for implementation. This will allow for the selection of programs that most specifically meet the need of their students, beyond existing programs. To the extent allowed by licensing and provided there is no additional cost incurred to do so, these programs will also be available to educators and community partners working with children and youth. To identify potential SAMHSA-approved programs, EDCOE may facilitate a needs assessment or other information gathering approach to guide the selection of the appropriate model program. EDCOE will develop an implementation plan, monitor and support implementation, and evaluate effectiveness.	
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Support	
Procurement Method	Sole Source to EDCOE	

Program Name: Early Indicators of Mental Health Issues 4

Program Goals	• Identify or develop online training and resources for educators and community partners working with children and youth to increase awareness of mental illness and help them better identify the early signs and risk factors of mental illness. • Increase appropriate referrals to mental health professionals for individuals and families in need of services at earlier opportunities. • Implement a mental illness awareness campaign within the school districts Countywide. • Promote positive attitudes among youth regarding living with mental illness. • Share messages of wellness, hope and recovery.
Outcome Measures	Measurement 1: Survey community partners and educators to determine the number of participants that have completed the training. Measurement 2: Success will be measured by interviews and surveys about the training. Measurement 3: Outcome measurement tools utilized by the individual evidence-based programs selected. Measurement 4: Referrals from schools to mental health professionals.
Number of Services / Quantity of Service	This training program will be available to all school districts within El Dorado County.
Budget	Up to $50,000 in FY 2014-15, $45,000 in FY 2015-16 and $40,000 in FY 2016-17 on a reimbursement basis. WET funds would be utilized for purchase of program materials, staff training, implementation costs (including but not limited to web site development and video production costs), and ongoing program support. EDCOE will commit ongoing in-kind contributions of administrative oversight, staff time to attend and implement the programs, technology hosting, and resources to support this WET program.

Program Name: Suicide Education and Training 5

Funding Categories:	☐ Training and Technical Assistance ☐ Residency and Internship Programs ☒ Workforce Staffing Support	☐ Mental Health Career Pathways Programs ☐ Financial Incentive Programs
Objective	Equip all educators to identify suicide warning signs and make appropriate referrals.	
Target Audience	☒ Public Mental Health System Employees (Secondary) ☒ Contractors (Secondary) ☒ Volunteers (Secondary)	☐ Consumers and Family Members ☐ Law Enforcement ☒ Teachers/Education (Primary)
Service Location(s)	Countywide	
Project Duration	Through June 30, 2017	
Activities Performed	EDCOE will identify and/or develop online training modules and resources that will be made available to all educators. To the extent allowed by licensing and provided there is no additional cost incurred to do so, these programs will also be available to educators and community partners working with children and youth. The training will be designed to empower educators to identify warning signs and risk factors for suicide and refer students to clinical staff. Potential training options include QPR and Teen Screen. 1) Identify evidence-based programs (including but not limited to SAMHSA Model Programs). 2) Develop and implement online training modules. 3) Train at least ten suicide prevention trainers within the County. 4) Have at least one suicide prevention trainer / specialist at each high school (to the extent possible a licensed or intern clinician). 5) Implement suicide prevention public awareness campaign. 6) Include suicide prevention training with annual staff information sharing and/or training. 7) Place at least one suicide prevention trainer / specialist at each school site. This program links with the Suicide Prevention and Stigma Reduction program under the PEI component.	

Program Name: Suicide Education and Training 5

Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Support
Procurement Method	Sole Source to EDCOE
Program Goals	• Identify/develop online training modules and resources for educators. • Increase awareness of mental illness and suicide warning signs for educators. • Increase referrals to clinical staff and other resources. • Reduce the number of suicides of school-aged children and youth to zero. • Implement suicide prevention public awareness campaign Countywide. • Have at least one suicide prevention trainer / specialist at each school site. • Promote positive attitudes and reduce stigma associated with living with mental illness. • Share messages of wellness, hope and recovery.
Outcome Measures	Measurement 1: Survey each school district to determine the number of educators that have completed the training. Measurement 2: Interviews and surveys about the training. Measurement 3: Specific outcome measures utilized by the selected evidence-based trainings. Measurement 4: The number of students referred for suicide prevention services. Measurement 5: The number of youth who are prevented from committing suicide and the number of youth who commit suicide.
Number of Services / Quantity of Service	All staff working in the El Dorado County public school system.
Budget	Up to $50,000 in FY 2014-15, $45,000 in FY 2015-16 and $40,000 in FY 2016-17 on a reimbursement basis. WET funds would be utilized for purchase of program materials, staff training, implementation costs (including but not limited to web site development and video production costs), and ongoing program support. EDCOE will commit ongoing in-kind contributions of administrative oversight, staff time to attend and implement the programs, technology hosting, and resources to support this WET program.

Program Name: Suicide Education and Training 5

Program Name: Consumer Leadership Academy 6

Funding Categories:	☐ Training and Technical Assistance ☐ Residency and Internship Programs ☒ Workforce Staffing Support	☒ Mental Health Career Pathways Programs ☐ Financial Incentive Programs
Objective	The Consumer Leadership Academy provides educational opportunities to inform and empower consumers to become involved in meaningful participation in the broader community. The academy includes peer-training, peer supportive skills training, job skill training, and training related to consumer leadership in the community.	
Target Audience	☒ Public Mental Health System Employees ☐ Contractors ☒ Volunteers	☒ Consumers and Family Members ☐ Law Enforcement ☐ Teachers/Education
Service Location(s)	South Lake Tahoe and West Slope Wellness Centers	
Project Duration	Ongoing	
Activities Performed	This program will include a Consumer Leadership Academy providing educational opportunities designed to inform and empower consumers in relationship to meaningful participation in the broader community. A meaningful role in the community may serve to be one of the most effective preventive measures to relapse to illness. This program begun as a grassroots effort with very favorable response from participants. Participants identified a need for support related to transportation assistance, funding for food during activities, and training resources and fees. In addition, establishment of a stipend program to address costs incurred for participants will be pursued. Training will also be pursued through sources such as the California Institute for Mental Health (CIMH), regional MHSA WET funds and local MHSA funds. Peer counselor training may also be included. Staff support for a range of these events will be provided. Mental Health staff and volunteers on both slopes will collaborate with consumers on this project. Individuals who complete the Consumer Leadership Academy will be eligible to receive support in locating potential work and/or volunteer opportunities in the public mental health system. To the extent necessary, MHD staff may provide on-going vocational support for a period of up to two years from the date of hire or start date for volunteering to assist with the vocational needs of clients.	

Program Name: Consumer Leadership Academy 6

	To the extent possible, this program will partner with services provided through the County's Connections-One Stop Americas Job Center of California, or successor, or other programs including by not limited to the California Department of Rehabilitation.
Services Provided By	☐ Contracted Vendor ☒ Volunteers ☒ County Staff Support[149]
Procurement Method	None. Services provided by HHSA staff.
Program Goals	• Increase consumer awareness of skills necessary to seek employment and/or volunteer opportunities within the public mental health system. • Increase employment and/or volunteer opportunities for mental health consumers.
Outcome Measures	Measurement 1: Number of graduates of the consumer leadership academy. Measurement 2: Number of organizations identified for employment and/or volunteer opportunities. Measurement 3: Number of consumers who receive employment and/or volunteer opportunities after completion of the Consumer Leadership Academy and duration of their employment and/or volunteer position.
Number of Services / Quantity of Service	Approximately two Consumer Leadership Academies per year with up to 10 participants per academy session.
Budget	Approximately $600 annually. Costs include but are not limited to staff, administration, overhead, speakers, transportation, prepared food for meetings, household supplies (e.g., disposable plates, utensils), stipends, training resources, training costs (e.g., registration, travel, lodging, meals, parking), material fees, equipment, and equipment repairs. Staff will generally charge their time to one of the adult CSS projects for provision of the curriculum and support of clients enrolled in this project.

[149] County staff will be utilized to perform tasks such as: administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this project. Costs will be applied to these projects either directly (such as through direct recording of time from time card) or indirectly (such as through County cost applied charges).

Program Name: Crisis Intervention Team Training 7

Funding Categories:	☐ Training and Technical Assistance ☐ Residency and Internship Programs ☒ Workforce Staffing Support	☐ Mental Health Career Pathways Programs ☐ Financial Incentive Programs
Objective	De-escalate crisis situations of individual with mental health challenges through crisis intervention training workshops.	
Target Audience	☒ Public Mental Health System Employees ☒ Contractors ☒ Volunteers	☒ Consumers and Family Members ☐ Law Enforcement ☒ Teachers/Education
Service Location(s)	Unknown at this time (either West Slope or South Lake Tahoe)	
Project Duration	On-going until funding utilized.	
Activities Performed	Crisis Intervention Team Training "programs are local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises. They are built on strong partnerships between law enforcement, mental health provider agencies and individuals and families affected by mental illness."[150] CIT training is generally provided to law enforcement, but it can be applicable to other first responders or front-line staff who may come into contact with individuals in a mental health crisis. Training provides increased knowledge of available community resources, tools and skills to manage and de-escalate crisis situations. Course objectives include increasing the ability of attendees to recognize an individual with mental illness, increase empathy of attendees for individuals with a mental illness, provide techniques for de-escalating tense situations, increase proficiency in non-violent crisis intervention techniques. The course also provides an overview of major mental disorders, dual diagnosis and developmental disabilities, and hosts a panel of consumers who provide personal insight.	
Services Provided By	☒ Contracted Vendor ☐ Volunteers ☐ County Staff	

[150] NAMI. *Crisis Intervention Teams (CIT).* Retrieved from http://www.nami.org/template.cfm?section=cit2.

Program Name: Crisis Intervention Team Training 7

Procurement Method	Sole source to the individual/organization utilized by the El Dorado County Sheriff's Office for CIT training. Funds may be paid directly to the El Dorado County Sheriff's Office or the training provider on a reimbursement basis.
Program Goals	• Increase the ability of attendees to recognize an individual with mental illness. • Increase empathy of attendees for individuals with a mental illness. • Provide techniques for de-escalating tense situations. • Increase proficiency in non-violent crisis intervention techniques. • Increase basic knowledge and understanding of various presentations of mental illness. • Increase understanding of how a person with mental illness will respond to different approaches. • Increase ability to recognize dual diagnosis situations. • Increase knowledge of available community resources.
Outcome Measures	Measurement 1: Reduction in negative outcomes between law enforcement and individuals with a mental illness. Measurement 2: Increase in respectful treatment of individuals with a mental illness. Measurement 3: From course surveys, gauge the knowledge gained by the participants.
Number of Services / Quantity of Service	It is anticipated that one or more trainings will be funded through MHSA WET funds.
Budget	Up to $20,000 for the term of the MHSA Plan. Funds may be utilized in whole or in part in any fiscal year. Once funding is utilized in whole or in part, additional funding may be added to this program through the MHSA community planning process if funding is available.

Discontinued WET Programs/Projects

There are no WET programs/projects to be discontinued under the FY 2014-15 MHSA Plan.

Realigned WET Programs/Projects

Program 3: Psychiatric Rehabilitation Program will be moved under Program 2: Workforce Development effective with the implementation of the FY 2014-15 MHSA Plan. Rather than being a separate program, it will become one of many options for training opportunities funded through the Workforce Development program.

Capital Facilities and Technology (CFTN)

Component Definition

"Capital Facilities and Technology" are items necessary to support the development of an integrated infrastructure and improve the quality and coordination of care that will transform the mental health system and support the goals of MHSA.

Capital Facilities and/or Technological Needs Projects must support the goals of the MHSA and the provision of MHSA services. The planned use of the Capital Facilities and Technological Needs funds should produce long-term impacts with lasting benefits that move the mental health system towards the goals of wellness, recovery, resiliency, cultural competence, prevention/early intervention, and expansion of opportunities for accessible community-based services for clients and their families which promote reduction in disparities to underserved groups.

These efforts include development of a technological infrastructure for the mental health system to facilitate the highest quality, cost-effective services and supports for clients and their families. The foundation for an integrated information systems infrastructure is an Electronic Health Record (EHR) system, which is a secure, real-time, point-of-care, client-centric, information resource for service providers. It is this system in which El Dorado County has focused its CFTN funding.

CFTN in El Dorado County

The programs included in this Plan are based upon the original foundation of the CFTN program. During the initial development of the CFTN Plan for El Dorado County, an assessment of the CFTN needs to support the efficient implementation of the MHSA and transformation to a recovery and resiliency-focused service delivery system in El Dorado County indicated that while there is community interest to use these funds for Capital Facilities expenditures, the challenges associated with a Capital Facilities project were not feasible at the time. Instead, technological improvements that supported the development of an integrated infrastructure that would transform the mental health system and support the goals of the MHSA were identified for the CFTN funds.

It was determined that El Dorado County would dedicate CFTN funds to the development of an integrated information system infrastructure that includes the establishment of an EHR system; electronic clinical assessment and outcome measurement tools for children and adults, telepsychiatry (also known as "telehealth"), an electronic care pathways, and related training and administrative/technical support.

Technology funds were requested and received for systems development to improve the quality and coordination of care, establish the means for the effective use of client assessments and measurements data, and provide for the exchange of information between County providers and community health partners. El Dorado County also requested and received funds for the expansion and improvement of telepsychiatry and videoconferencing capabilities, and an electronic care pathway implementation.

El Dorado County's CFTN Plan also funded relevant training for each of these projects, software to support project management and reporting needs, as well as funds for updating/upgrading equipment, including but not limited to local and remote desktop computers, server equipment, scanning equipment, and signature pad devices needed to further the goals of the MHSA and the expansion of mental health services.

The previous CFTN Plans detailing the origins of the CFTN programs may be found on the County's MHSA web page.[151]

CFTN Budget

MHSA no longer provides CFTN funding. The County has been operating this program through funds previously received and remaining as a fund balance. As of the beginning of FY 2014-15, the remaining CFTN fund balance from previous fiscal years is $428,398.

It is anticipated there will be an adequate CFTN fund balance to continue to operate the CFTN programs in FY 2014-15. In FY 2015-16, it is anticipated that approximately $136,176, and in FY 2016-17 approximately $232,473, in CSS funds will need to be reallocated to CFTN in accordance with WIC §5892(b) that allows counties to use a portion of their CSS funds for CFTN. The total amount of CSS funding used for this purpose may not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

There is no risk of CFTN fund reversion during the term of this Plan.

For additional information regarding MHSA allocations and expenditures, please see Attachment E.

[151] El Dorado County, MHSA Plans Archive. http://www.edcgov.us/MentalHealth/MHSA_Plans.aspx.

CFTN Programs

Program/Project	FY 14-15 Expenditures	FY 15-16 Expenditures	FY 16-17 Expenditures	FY 14-15 % of Expenditures
Revenues:				
Fund Balance	$428,398	$96,297	$0	
Transfer from CSS	$0	$136,176	$232,473	
Available Revenues	$428,398	$232,473	$232,473	
Expenditures:				
Program 1: Electronic Health Record System Implementation				
Project 1a: Avatar Clinical Workstation	$180,686	$185,000	$185,000	54%
Project 1b: Electronic Outcome Measurement Tools	$5,000	$5,000	$5,000	2%
Program 2: Telehealth (formerly Telemedicine)	$129,000	$25,000	$25,000	39%
Program 3: Electronic Care Pathways	$5,900	$5,900	$5,900	2%
Administrative Costs	$11,515	$11,573	$11,573	3%
Total CFTN Program Expenditures	$332,101	$232,473	$232,473	
Anticipated Year-End Fund Balance	$96,297	$0	$0	

Project Name: Avatar Clinical Workstation 1a

Objective	Successful implementation of an EHR system for the MHD's two outpatient clinics, as well as the PHF. The EHR enables Mental Health staff to safely and securely access a client's medical record. The use of electronic mental health records will enhance communication between treating health care professionals, thus promoting coordination of mental and physical health care needs. With an EHR, providers spend less time repeatedly documenting client information, which will allow providers to spend more time delivering services.
Service Location(s)	El Dorado County HHSA Mental Health outpatient clinics, Placerville and South Lake Tahoe and the PHF in Placerville. Community-based use via laptop computers.
Project Duration	The project was initiated in September 2011, and the "go live" implementation was completed for all units May 6, 2013. There will continue to be a need for system support, including maintenance, modifications and reporting, and equipment purchases. Additionally, there will be an ongoing need for training for new staff and annual software licenses.
Activities Performed	A contract was signed with Netsmart for the customization and development of Avatar's Clinical Workstation (CWS), including an upgrade to the *My Avatar* system, as well as client assessment tools that provide a common language and establish standards to make meaningful recommendations to meet the needs of each individual client. The project team developed many County-specific forms and reports for use with the new system. Staff members moved data from the old computer system to CWS. After successful testing of the system, procedures and training guides were created and staff were provided with training on how to navigate the CWS system. The "go live" implementation was staggered by unit, and the CWS system implementation was successfully completed on May 6, 2013. The EHR system also includes InfoScriber (e-Prescribing), which is a secure, web-based prescribing and medication management system. Benefits of e-Prescribing include enhanced patient safety, increased physician productivity, reduction in pharmacy call backs and adherence to security and confidentiality standards. The e-Prescribing system improves the quality of care and reduces medication errors. The electronic creation and transmission of medication orders from the psychiatrist's computer to the pharmacy reduces the possibility of a misread prescription by a pharmacist. El Dorado County has a centralized Information Technologies (IT) Department providing technical assistance for all general computer issues including department computer and network problems. The IT department also provides CWS programming. IT services are billed to

Project Name: Avatar Clinical Workstation 1a

	the MHD at an hourly rate.
Services Provided By	☒ Contracted Vendor ☒ County Staff
Procurement Method	The vendor for this project, Netsmart, was selected in compliance with the County Procurement Policy.
Current Year Goals	• Standardized scheduling of appointments within the MHD, adjusted as needed to address any scheduling issues that may arise with the relocation of the South Lake Tahoe and/or West Slope out-patient clinics. • The Quality Improvement (QI) unit will utilize weekly, monthly and quarterly reports to audit charts, identify potential program challenges (e.g., service delays), standardize procedures, and provide information to the management team. • Develop program changes to addresses identified challenges and implement changes. • Maintenance of the EHR and continued training.
Outcome Measures	Measurement 1: Implementation of EHR throughout the MHD. – *Completed May 2013.* Measurement 2: Ability to provide centralized, electronic appointment scheduling. – *Completed May 2013.* Measurement 3: Updated and standardized business procedures and assessments, resulting in practices that are more efficient. – *Ongoing.* Measurement 4: Improved reporting capabilities (to audit charts and provide information relevant to program development). – *Ongoing.* Measurement 5: Successful maintenance of the EHR and continued training. – *Ongoing.*
Budget	Approximately $180,686 in FY 2014-15 and 185,000 in FY 2015-16 and FY 2016-17. Costs include but are not limited to staff, administration, overhead, licensing, equipment purchase and repair, peripheral equipment purchase and repair, software and other hardware purchases, hosting, programming support and maintenance agreements.

Program Name: Electronic Outcome Measurement Tools 1b

Objective	Implement tools that can be utilized to develop client treatment plans, support quality improvement efforts, and monitor outcomes.
Service Location(s)	El Dorado County HHSA Mental Health outpatient clinics, Placerville and South Lake Tahoe and the PHF in Placerville. Also within the community when services are provided locally.
Project Duration	Ongoing.
Activities Performed	HHSA MHD identified the client assessment tool of LOCUS for adults, and the CALOCUS for children. The LOCUS for adults and the CALOCUS for children are quantifiable measures to guide assessment, level of care placement decisions, and service packages. These tools provide a common language and establish standards to make judgments and recommendations meaningful and sufficiently sensitive to distinguish appropriate needs and services for each individual client. The collaboration between the clinician and the client to accomplish the input will develop services and processes that will facilitate recovery. The initial Three-Year Program and Expenditure Plan identified the outcome measurement tool for adults as the CIOM (Clinically Informed Outcomes Management) and the Y-OQ® software package for children. The CIOM is client completed and reports their perception of functional progress and service satisfaction and Y-OQ® will assist clinicians to track the actual change in the client's functioning based upon normative data. However, the electronic versions of these outcome measurement tools were not available electronically at that time. HHSA MHD has now identified the CANS and ANSA tools for use within its service provision. Although The Praed Foundation (http://www.praedfoundation.org) maintains the copyright on the CANS and ANSA tools, The Praed Foundation makes these tools available at no cost through the open domain. "The Child and Adolescent Needs and Strengths (CANS) is a multi-purpose tool developed for children's services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. Versions of the CANS are currently used in 25 states in child welfare, mental health, juvenile justice, and early intervention applications."[152] "The Adult Needs and Strengths Assessment (ANSA) is a

[152] The Praed Foundation. *About the CANS.* Retrieved from http://www.praedfoundation.org/About%20the%20CANS.html. September 28, 2013.

	multi-purpose tool developed for adult's behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services. The ANSA is currently used in a number of states and Canada in applications hospitals, emergency departments, psychosocial rehabilitation programs, and ACT programs."[153] The CANS and ANSA will be administered at regular intervals during the course of treatment provided to clients, the results of which will be utilized to develop client treatment plans, support quality improvement efforts, monitor client-level outcomes, and determine appropriate discharge of services.
Services Provided By	☒ Contracted Vendor ☒ County Staff Contracted vendors will be asked to utilize the CANS and ANSA tools for clients referred through the MHD.
Procurement Method	The CANS and ANSA are available at no cost through the open domain.
Goals	• Train staff on use of the CANS and ANSA. • Implement use of the CANS and ANSA.
Outcome Measures	Measurement 1: Quantifiable data to identify continuing client needs and/or barriers to improvements. Measurement 2: Identify growing strengths of clients, which show improvement in life functions, that result from service delivery. Measurement 3: Identify program changes that may be needed based on identified outcomes.
Budget	Approximately $5,000 annually. These costs include but are not limited to staff, administrative and overhead costs, as well as licensing fees and programming support, if needed.

[153] The Praed Foundation. *About the CANS*. Retrieved from http://www.praedfoundation.org/About%20the%20ANSA.html. September 28, 2013.

Program Name: Telehealth 2

Objective	Expand psychiatric services to clients who are either unable to travel or who live in remote areas of the County and utilize video conferencing to further the public mental health system within El Dorado County.
Service Location(s)	El Dorado County HHSA Mental Health South Lake Tahoe and West Slope outpatient clinics.
Project Duration	Ongoing
Activities Performed	Telemedicine allows psychiatrists to provide psychiatric services using video conferencing technology, allowing clients and psychiatrists to see and hear one another through a secure network. This provides clients who are unable to travel to the psychiatrist's office or who live in areas not staffed by a psychiatrist to obtain needed psychiatric service. Additionally, providers are able to share general system development and health practice training via video conferencing to help improve the public mental health system within our County. The County's large geographic area makes it difficult to provide face-to-face services in some remote areas of our County. To help address this issue, El Dorado County began providing psychiatry services using a telehealth format in 2009. Telehealth allows psychiatrists to provide psychiatric services using videoconferencing technology, allowing clients and psychiatrists to see and hear one another through a monitor. This provides clients who are unable to travel to the psychiatrist's office or who live in areas not staffed by a psychiatrist to obtain needed psychiatric service. The original approved project included two sets of video conferencing equipment, one for the West Slope clinic and one for the South Lake Tahoe clinic. In February of 2012, the South Lake Tahoe HHSA Mental Health office relocated into a County-owned building, which has adequate video conferencing equipment. Therefore, in the previous MHSA Plan Update, the video conferencing equipment for South Lake Tahoe was removed from the program description. However, the South Lake Tahoe clinic will be relocating to a building without the video conferencing equipment, and therefore, the system is being added back into the this program.
Services Provided By	☒ Contracted Vendor ☒ County Staff
Procurement Method	Some telehealth equipment was provided through grant funding for various health providers in El Dorado County, including the MHD. Purchase of additional video conferencing equipment will be done in compliance with the Board of Supervisors' Procurement Policy.

Program Name: Telehealth 2

Goals	• Purchase video conference systems for both the Placerville and South Lake Tahoe outpatient clinics. • Expand telemedicine to other remote areas of the County.
Outcome Measures	Measurement 1: Increase the number of clients served in remote areas of the County through use of telemedicine. Measurement 2: Utilization of the video conference equipment for general system development and health practice training
Budget	Approximately $129,000 in FY 2014-15. Approximately $25,000 in FY 2015-16 and FY 2016-17. Costs include but are not limited to staff, administration, overhead, licensing, equipment purchase and repair, peripheral equipment purchase and repair, software and other hardware purchases, hosting, programming support and maintenance agreements.

While telehealth can be quite successful for some clients, others can find it difficult due to specific symptoms associated with their mental health diagnosis. The MHD continues recruitment efforts for psychiatrists, but use of telehealth technology will continue to be utilized.

In calendar years 2011 and 2012, more than 125 unique clients were served via telehealth, primarily from the South Lake Tahoe location.

Program Name: Electronic Care Pathways 3

Objective	An Electronic Care Pathway facilitates linkage between mental health and primary health care providers for persons with mental illness, chronic disease issues and/or co-occurring substance abuse.
Service Location(s)	El Dorado County HHSA Mental Health South Lake Tahoe and West Slope outpatient clinics and partnering agencies in El Dorado County.
Project Duration	Ongoing
Activities Performed	A Care Pathway is a set of standardized rules for inter-agency shared case management that connects clients to health care services, facilitates the sharing of information and provides clarity to providers in client transitions between agencies. The initial phase of this program, prior to the wide-spread implementation of electronic health records, focused on the development, design and implementation of a series of bi-directional, paper-based Care Pathways to facilitate inter-agency linkage for adults and children faced with mental health distress and co-occurring substance abuse or chronic disease issues, and/or who are at risk of homelessness. The ACCEL program automated this process throughout the system utilizing the iReach system. ACCEL is a collaborative of health care providers, including Barton Hospital, Marshall Hospital, El Dorado Community Health Care, Tribal Health and El Dorado County. There is currently one Electronic Care Pathway available through ACCEL, that being the Pediatric Mental Health Consults Care Pathway. Although it was anticipated that an Adult Mental Health Care Pathway would be developed for iReach, it was determined in the community planning process that doing so would result in duplicate data entry and tracking beyond what providers currently enter in their electronic health records. Therefore, the Adult Mental Health Care Pathway will not be developed and providers will continue to use the current referral processes.
Services Provided By	☒ Contracted Vendor ☒ County Staff Infocom Systems Services or other IT support services engaged through ACCEL.
Procurement Method	For iReach system support, sole source to ACCEL, whose costs are shared by participating agencies. Evaluation will be performed by MHD staff.

Program Name: Electronic Care Pathways 3

Outcome Measures	Measurement 1: Increase number of referrals to and from primary care providers for individuals with a mental illness. Measurement 2: Increase linkage to services for clients who are homeless or are at risk of homelessness. Measurement 3: Continue and increase inter-agency collaboration between our community partners.
Budget	$5,900 annually ($900 for IT support of the iReach system to ACCEL; $5,000 for Mental Health program evaluation by MHD staff).

Between June 1, 2008 and July 31, 2013, 248 children have been referred to the MHD through the ACCEL program via the Pediatric Mental Health Consults Care Pathway. This represents 5% of the total referrals made through all ACCEL Care Pathways.

Discontinued CFTN Programs/Projects

There are no CFTN programs/projects to be discontinued under the FY 2014-15 MHSA Plan.

Innovation (INN)

Component Definition

An Innovation project is defined as one that contributes to learning rather than a primary focus on providing a service. By providing the opportunity to "try out" new approaches that can inform current and future practices/approaches in communities, an Innovation project contributes to learning.

Innovation projects must address one of the following purposes as its primary purpose:

(A) Increase access to underserved groups;
(B) Increase the quality of services, including measurable outcomes;
(C) Promote interagency and community collaboration; and/or
(D) Increase access to services;

and support innovative approaches by doing one of the following:

(A) Introducing new mental health practices or approaches, including, but not limited to, prevention and early intervention;
(B) Making a change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community; or
(C) Introducing a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.[154]

If an innovative project has proven to be successful and a County chooses to continue it, the project shall transition to another category of funding.[155]

Innovation projects may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges, including, but not limited to, any of the following:

(1) administrative, governance, and organizational practices, processes, or procedures;
(2) advocacy;
(3) education and training for service providers, including nontraditional mental health practitioners;
(4) outreach, capacity building, and community development;
(5) system development;
(6) public education efforts; or
(7) research.
(8) Services and interventions, including prevention, early intervention, and treatment.[156]

[154] WIC §5830(b).
[155] WIC §5830(d).
[156] WIC §5830(c).

Innovation plans must be approved by the MHSOAC prior to the expenditure of funds in this component.[157] The Innovation Plan will be developed, and submitted through the approval process including approval of the Innovation Plan by the MHSOAC.

Future INN Regulations

The MHSOAC is in the process of developing regulations for INN.[158] The proposed regulations have several steps to complete prior to adoption and implementation.[159]

The next steps are publication of the proposed INN regulations and receiving of public comment by the MHSOAC. More information about this process and other MHSOAC activities may be found on their website (http://mhsoac.ca.gov/).

Innovation Budget

Of the total MHSA funding received by the County for CSS and PEI, five percent (5%) of the funding is allocated to Innovation. The fund balance at the beginning of FY 2014-15 for INN is $1,318,641 and anticipated revenues are $328,000. A portion of the Innovation funds received in prior years may be subject to reversion. The Innovation budget will be discussed in greater detail in the Innovation Plan that will be developed and published separately from this document.

Program/Project	FY 14-15 Expenditures	FY 15-16 Expenditures	FY 16-17 Expenditures	FY 14-15 % of Expenditures
Revenues:				
Fund Balance	$1,318,641	$1,626,033	$571,944	
Revenues (MHSA)	$329,392	$323,260	$323,260	
Available Revenues	$1,648,033	$1,949,293	$2,249,553	
Expenditures:				
Innovation Program(s) – TBD through separate planning process	TBD	TBD	TBD	
Administrative Costs	$22,000	$23,000	$23,000	100%
Total INN Program Expenditures	$22,000	$23,000	$23,000	
Anticipated Year-End Fund Balance	$1,626,033	$1,949,293	$2,226,553	

[157] WIC §5830(c).
[158] The proposed INN regulations, as of September 18, 2013, can be found at http://mhsoac.ca.gov/Meetings/docs/Meetings/2013/INN_09192013_Regs.pdf.
[159] For more information about the regular rulemaking (regulation) process, see http://www.oal.ca.gov/Regular_Rulemaking_Process.htm.

For additional information regarding MHSA allocations and expenditures, please see Attachment E.

Innovation Projects

Through the community planning process, the public submitted ideas for Innovation projects. After discussion with the MHSOAC representative for El Dorado County and a review of the proposed Innovation projects by the MHSA project team, the following Innovation projects are under consideration:

- Occupational Mental Health Training: Would providing training to individuals in occupations that frequently interact with individuals through the provision of personal or professional services (e.g., house cleaners, hair dressers, electricians, plumbers) increase identification of potential mental health concerns and access (referrals) to mental health services?
- Mini-Grants: Can a single program focus and/or message be effectively implemented County-wide through mini-grants to local communities to tailor the message to their needs and unique characteristics, thus promoting interagency and community collaboration.
- REACH: Responsive Engagement and Awareness for Children at Home: Would partnering with programs providing direct linkage in underserved/unserved neighborhoods decrease the stigma associated with seeking treatment for mental health related issues and change early intervention services from behaviorally manifested to developmentally-based?
- High School Theater Arts and Mental Health Services: Would a program to provide direct integration between an evidence-based practice normally applied in a clinical setting and apply its principles to a Theater Arts program to engage youth involved in the juvenile justice and/or mental health programs result in a reduction of juvenile justice and/or mental health interventions?

A separate community planning process will commence to review these projects, receive stakeholder input, and determine which will become part of the El Dorado County MHSA Innovation Plan. Through the Innovation community planning process, other projects may be identified.

No Innovation projects are proposed for implementation within this Plan.

Discontinued INN Programs/Projects

There are no INN programs/projects to be discontinued under the FY 2014-15 MHSA Plan. The previous INN program was discontinued in FY 2012-13.

Glossary

AB	Assembly Bill
AB 109	Public Safety Realignment 2011
ANSA	Adult Needs and Strengths Assessment
AOD	Alcohol and Other Drugs
AOT	Assisted Outpatient Treatment
ARF	Adult Residential Facility
ART	Aggression Replacement Therapy
CalMHSA	California Mental Health Services Authority
CALOCUS	Child/Adolescent Levels of Care Utilization System
CANS	Child and Adolescent Needs and Strengths
CAO	Chief Administrative Office
CAS	Community Access Site
CBO	Community-Based Organization
CBT	Cognitive Behavioral Therapy
CCR	California Code of Regulations
CDBG	Community Development Block Grant
CDP	Census-Designated Place
CFR	Code of Federal Regulations
CFTN	Capital Facilities and Technology
CHNA	Community Health Needs Assessment
CIMH	California Institute for Mental Health
CIOM	Clinically Informed Outcomes Management
CIT	Crisis Intervention Techniques
County	El Dorado County
CPRT	Child Parent Resource Team
CSS	Community Services and Supports
CSS-Housing	Community Services and Supports – Housing
CWS	Clinical Workstation
DBT	Dialectical Behavior Therapy
DHCS	California Department of Health Care Services

DSM	Diagnostic and Statistical Manual of Mental Disorders
EDCOE	El Dorado County Office of Education
EFC	Extended Foster Care
EHR	Electronic Health Record
EMDR	Eye Movement Desensitization Reprocessing
ESL	English as a Second Language
FSP	Full Service Partnership
FY	Fiscal Year
GSD	General System Development
HHSA	Health and Human Services Agency
HOME	Home Investment Partnership Program
ICC	Intensive Care Coordination
ICM	Intensive Case Management
IEP	Individualized Education Program
IHBS	Intensive Home-Based Services
INN	Innovation
ISSP	Individual Services and Supports Plan
IT	Information Technologies
KET	Key Event Tracking
LGBTQ	Lesbian, Gay, Bisexual, Transgender, Questioning
LOCUS	Levels of Care Utilization System
MAST	Multidisciplinary Adult Services Team
MBSR	Mindfulness Based Stress Reduction
MHD	Mental Health Division of HHSA
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission
NAMI	National Alliance on Mental Illness
NMD	Non-Minor Dependents
OE	Outreach and Engagement
ORS	Outcome Rating Scale
PCIT	Parent-Child Interactive Therapy
PEI	Prevention and Early Intervention

PEI-TTACB	Prevention and Early Intervention - Training, Technical Assistance and Capacity Building
PFLAG	Parents, Families, Friends of Lesbians and Gays
PHF	Psychiatric Health Facility
PIP	Primary Intervention Project
PMHP	Primary Mental Health Project
PSA	Public Service Announcement
PSC	Personal Service Coordinator
PTSD	Post-Traumatic Stress Disorder
QI	Quality Improvement
RCL	Rate Classification Level
RFP	Request for Proposals
SAMHSA	Substance Abuse and Mental Health Services Administration
SARB	School Attendance Review Board
SB	Senate Bill
SDR	Stigma and Discrimination Reduction
SED	Seriously Emotionally Disturbed
TAY	Transitional Age Youth
TBS	Therapeutic Behavioral Services
TFC	Therapeutic Foster Care
TLC	Therapeutic Lifestyle Changes
TTACB	Training, Technical Assistance and Capacity Building (TTACB)
UMDAP	Uniform Method of Determining Ability to Pay
WET	Workforce Education and Training
WIC	Welfare and Institutions Code
WMS	Walker-McConnell Scale

County Certification Forms

Please see attached certification forms.

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: El Dorado County

☐ Three-Year Program and Expenditure Plan
☒ Annual Update

Local Mental Health Director	Program Lead
Name: Don Ashton	Name: Joe Harn
Telephone Number: (530) 642-7300	Telephone Number: (530) 621-5487
E-mail: don.ashton@edcgov.us	E-mail: joe.harn@edcgov.us
Local Mental Health Mailing Address: El Dorado County Health and Human Services Agency, Mental Health Division 768 Pleasant Valley Road, Suite 201 Diamond Springs, CA 95619	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on August 26, 2014.

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

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

Don Ashton
Local Mental Health Director (PRINT)

Signature

Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: El Dorado County

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Don Ashton	Name: Joe Harn
Telephone Number: (530) 642-7300	Telephone Number: (530) 621-5487
E-mail: don.ashton@edcgov.us	E-mail: joe.harn@edcgov.us
Local Mental Health Mailing Address: El Dorado County Health and Human Services Agency, Mental Health Division 768 Pleasant Valley Road, Suite 201 Diamond Springs, CA 95619	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

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

Don Ashton _____ _____
Local Mental Health Director (PRINT) Signature Date

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

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

Joe Harn _____ _____
County Auditor Controller / City Financial Officer (PRINT) Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

Attachment A
Fiscal Year 2013-14 MHSA Annual Update Instructions

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Title

FY 2014-2015 through FY 2016-2017
MHSA Three-Year Program and Expenditure Plan Instructions

Background

Welfare and Institutions Code Section (WIC) § 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan (Plan) and Annual Updates for Mental Health Service Act (MHSA) programs and expenditures.

Plans and Annual Updates must be adopted by the county Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after Board of Supervisor adoption.

WIC § 5848 states the mental health board shall conduct a public hearing on the draft three-year program and expenditure plan at the close of the 30-day comment period.

These are instructions for the MHSA Fiscal Year (FY) 2014-2015 through FY 2016-2017 Three-Year Program and Expenditure Plan. These instructions are based on WIC and the California Code of Regulations Title 9 (CCR) in effect at the time these instructions were released.

WIC § 5891 states that MHSA funds may only be used to pay for MHSA programs.

Purpose

The purpose of these instructions is to:

- Assist counties and their stakeholders in developing the FY 2014-2015 through FY 2016-2017 Three-Year Plan to include all the necessary elements as required by law and regulation.
- Provide the essential elements necessary by law in preparing a plan for a county Board of Supervisor approval. Counties retain every right to include more in their stakeholder process, Plan, or Annual Update than the statutory minimum.
- Provide the MHSOAC the information it needs for oversight to track, evaluate, and communicate the statewide impact of the MHSA.
- Provide the MHSOAC the information it needs to approve new or amended Innovation program (INN) plans per the established threshold for changes requiring MHSOAC approval issued by the MHSOAC on August 3, 2012.

These instructions often refer to WIC or CCR, which remain the authority on requirements. These instructions do not negate the MHSOAC's authority, pursuant to WIC Section 5845(d)(6), to obtain additional data and information from state or local entities that receive MHSA funds for the MHSOAC to utilize in its oversight, review, training and technical assistance, accountability, and evaluation capacity regarding projects and programs supported with MHSA funds.

What is a Three Year Plan?

WIC § 5847 and **CCR § 3310** state that a Three Year Program and Expenditure Plan shall address each MHSA component: Community Services and Supports (CSS) for children and youth, transition age youth, adults, and older adults (WIC § 5800 and § 5850); Capital Facilities and Technology Needs (CFTN) (WIC § 5847); Workforce Education and Training (WET) (WIC § 5820); Prevention and Early Intervention (PEI) (WIC § 5840); and Innovative Programs (INN) (WIC § 5830). This shall be one plan, incorporating all these elements, and making expenditure projections for each component per year.

How is a Three Year Plan different from an Annual Update?

CCR § 3310 states that a county shall update the Plan annually. An Annual Update includes an update to the Plan addressing the elements that have changed and that year's expenditure plan. In FY 2015-2016 and FY 2016-2017 counties will complete Annual Updates to the FY 2014-2015 through FY 2016-2017 Three Year Program and Expenditure Plan.

Who Should be Involved in the Stakeholder Process?

WIC § 5848 states that each Plan shall be developed with local stakeholders, including:

- Adults and seniors with severe mental illness
- Families of children, adults, and seniors with severe mental illness
- Providers of services
- Law enforcement agencies
- Education
- Social services agencies
- Veterans
- Representatives from veterans organizations
- Providers of alcohol and drug services
- Health care organizations
- Other important interests.

CCR § 3300 further includes:

- Representatives of unserved and/or underserved populations and family members of unserved/underserved populations, as defined in CCR § 3200.300 and CCR § 3200.310
- Stakeholders that reflect the diversity of the demographics of the county, including but not limited to, geographic location, age, gender, and race/ethnicity.
- Clients with serious mental illness and/or serious emotional disturbance, and their family members.

What Should be Included in the Stakeholder Process?

WIC § 5848 states that counties shall demonstrate a partnership with constituents and stakeholders throughout the process that includes meaningful stakeholder involvement on:

- Mental health policy
- Program planning
- Implementation
- Monitoring
- Quality improvement
- Evaluation
- Budget allocations.

CCR § 3300 states that involvement of clients and their family members be in all aspects of the community planning process and that training shall be offered, as needed, to stakeholders, clients, and client's family who are participating in the process.

What Standards Should be Used for the Stakeholder Process?

CCR § 3320 states that Counties shall adopt the following standards in planning, implementing, and evaluating programs:

- Community collaboration, as defined in CCR § 3200.060
- Cultural Competence, as defined in CCR § 3200.100
- Client Driven, as defined in CCR § 3200.50
- Family Driven, as defined in CCR § 3200.120
- Wellness, recovery, and resilience focused, as described in WIC § 5806 and § 5813.5
- Integrated service experiences for clients and their families, as defined in CCR § 3200.190, which is defined as when the client, and when appropriate the client's family, accesses a full range of services provided by multiple agencies, programs and funding sources in a comprehensive manner.

Public Review

WIC § 5848 states that a draft Plan shall be prepared and circulated for review and comment for at least 30 days to representatives of stakeholder interests and any interested party who has requested a copy.

Additionally, the mental health board shall conduct a public hearing on the draft Plan at the close of the 30-day comment period. It should also review the adopted Plan and make recommendations for revisions.

What to Include in the Plan About the Stakeholder Process

CCR § 3315 states this section of the Plan shall include:

- A description of the local stakeholder process including date(s) of the meeting(s) and any other planning activities conducted
- A description of the stakeholders who participated in the planning process in enough detail to establish that the required stakeholders were included

What to Include in the Plan About the Stakeholder Process (cont)

- Description of how stakeholder involvement was meaningful
- The dates of the 30 day review process
- Methods used by the county to circulate for the purpose of public comment the draft of the plan to representatives of the stakeholder's interests and any other interested party who requested a copy of the draft plan
- The date of the public hearing held by the local mental health board or commission
- Summary and analysis of any substantive recommendations received during the 30-day public comment period
- A description of substantive changes made to the proposed plan

What to Include in the Plan About Programs

WIC § 5847 states the Plan shall describe the following programs:

- Services to children, including a wrap-around program (exceptions apply), that shall include services to address the needs of transition age youth ages 16 to 25 and foster youth. The number of children served by program and the cost per person must be included. The standards for these services are defined in WIC § 5851.
- Services to adults and seniors, including services to address the needs of transition age youth ages 16 to 25. The number of adults and seniors served by program and the cost per person must be included. The standards for these services are defined in WIC § 5806. WIC § 5813.5 states that Plans shall consider ways to provide services similar to those established pursuant to the Mentally Ill Offender Crime Reduction Grant Program. Funds shall not be used to pay for persons incarcerated in state prison or parolees from state prisons.
- Prevention and Early Intervention programs designed to prevent mental illnesses from becoming severe and disabling. The standards for these programs are defined in WIC § 5840. Please describe programs and program components/activities for Prevention versus Early Intervention separately.
- INN in accordance with WIC § 5830
- CFTN
- Identification of shortages in personnel and the additional assistance needs from education and training programs
- Prudent Reserve

In addition to the required elements above, counties should include the following information as part of the Plan:

- A description of county demographics, including but not limited to size of the county, threshold languages, unique characteristics, age, gender, and race/ethnicity.
- The number of children, adults, and seniors to be served in each PEI and INN program that provide direct services to individuals/groups.
- The cost per person for PEI (separated out by Prevention versus Early Intervention) and INN programs that provide direct services to individuals/groups.

What to Include in the Plan About INN

WIC § 5830 states that Counties shall expend funds for their INN programs upon approval by the MHSOAC and details INN requirements. Plans should include sufficient information about a new or changed INN program so that the MHSOAC may determine if the program meets statutory requirements and can be approved. INN programs shall meet the criteria described in WIC § 5830.

If an INN project has proven successful and the county chooses to continue it, the project work plan shall transition to another category of funding as appropriate.

What to Include in the Plan About Performance Outcomes

WIC § 5848 states that Plans shall include reports on the achievement of performance outcomes for MHSA services. Please include the results of any evaluations or performance outcomes the county has for CSS services and PEI programs (separated out by Prevention versus Early Intervention when possible). Counties shall also provide evaluation or performance outcomes for INN programs. Please specify the time period these performance outcomes cover.

What to Include in the Plan About County Compliance Certification

WIC § 5847 states that certification by the county mental health director, which ensures that the county has complied with all pertinent regulations, laws, and statutes of the Mental Health Services Act, including stakeholder participation and nonsupplantation requirements must be included in the Plan.

Please use the MHSA County Compliance Certification form included with these instructions.

What to Include in the Plan About County Fiscal Accountability Certification

WIC § 5847 states that certification by the county mental health director and the county auditor-controller that the county has complied with any fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the MHSA shall be included in the Plan.

Please use the MHSA County Fiscal Certification form included with these instructions.

What to Include in the Plan About Board of Supervisor Adoption

WIC § 5847 states that the county mental health program shall prepare a Plan adopted by the county Board of Supervisors. Please include evidence that the Board of Supervisors adopted the Plan and the date of that adoption.

What to Include in the Plan About An Expenditure Plan

WIC § 5847 states that each county shall prepare an expenditure plan for the Plan based on available unspent funds, estimated revenue, and reserve amounts.

Please complete the Expenditure Plan Funding instructions and forms included with these instructions.

In addition, please include the budgeted amount to be spent on:

- Full Service Partnerships, as defined in CCR § 3620, which should be at least 50% of CSS funds
- General System Development, as defined in CCR § 3630
- Outreach Engagement, as defined in CCR § 3640
- PEI by program or component so that Prevention and Early Intervention program/component costs are listed separately (20% of MHSA funds distributed to a county)
- INN by project (5% of CSS funds and 5% of PEI funds distributed to a county)
- WET
- CFTN
- Prudent Reserve

When the Plan Should be Submitted to the MHSOAC

Per **WIC § 5847** please submit your FY 2014-2015 MHSA Plan to the MHSOAC within 30 days of adoption by the Board of Supervisors.

Attachment B
Fiscal Year 2011-12
Revenue and Expense Report

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2011-12

County: **El Dorado** **Date:** 10/15/2013

Community Services and Supports Component	Total (Gross) Mental Health Expenditures
FSP Programs	
1 WP1 - Youth and Family Strengthening Wraparound	$247,052
2 WP2 - Adult Wellness & Recovery/Assertive Community Tre	$500,545
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	
Subtotal FSP Programs	$747,597
Non-FSP Programs	
1 CSS Non-FSP	$3,211,615
2	
3	
4	
5	
6	
7	
8	
Subtotal Non-FSP Programs	$3,211,615
Total FSP and Non-FSP Programs	$3,959,212
CSS Evaluation	
CSS Administration	$514,939
CSS MHSA Housing Program Assigned Funds	
Total CSS Expenditures	$4,474,151

Updated: 09/05/2013

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2011-12

County: El Dorado **Date:** 10/15/2013

	Prevention and Early Intervention Component	(A) Total (Gross) Mental Health Expenditures
PEI Programs		
1	Early Intervention Program for Youth	$110,785
2	Primary Intervention Project (PIP)	$202,792
3	Incredible Years	$66,445
4	Community Education Project	$34,706
5	Wennem Wadati	$141,814
6	Wellness Outreach Program for Vulnerable Adul	$163,044
7	Health Disparities Initiative	$262,857
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
Total PEI Programs		$982,443
PEI Evaluation		
PEI Administration		$107,699
Total PEI Expenditures		$1,090,142

Updated: 09/05/2013

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2011-12

County: El Dorado **Date:** 10/15/2013

Innovation Component	(A) Total (Gross) Mental Health Expenditures
Innovation Programs	
1 Closing the Gap	$412,691
2 Planning	$18,146
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
16	
17	
18	
19	
20	
21	
22	
23	
24	
25	
Total INN Programs	$430,837
Innovation Evaluation	
Innovation Administration	$48,725
Total Innovation Expenditures	$479,562

Updated: 09/05/2013

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2011-12

County: El Dorado **Date:** 10/15/2013

Workforce Education and Training Component	(A) Total (Gross) Mental Health Expenditures
WET Funding Category	
Workforce Staffing Support	$4,663
Training and Technical Assistance	$7,413
Mental Health Career Pathways Programs	$10,778
Residency and Internship Programs	$705
Financial Incentive Programs	$705
Total WET Programs	$24,264
WET Administration	$8,178
Total WET Expenditures	$32,442

Updated: 09/05/2013

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2011-12

County: El Dorado **Date:** 10/15/2013

Capital Facility/Technological Needs Projects	(A) Total (Gross) Mental Health Expenditures
Capital Facility Projects	
1 Electronic Health Records (Clinical Work Station	$198,808
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
Total CF Projects	$198,808
Capital Facility Administration	$23,379
Total Capital Facility Expenditures	$222,187
Technological Needs Projects	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
Total TN Projects	$0
Technological Needs Administration	$0
Total Technological Needs Expenditures	$0
Total CFTN Expenditures	$222,187

Updated: 09/05/2013

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2011-12

County: El Dorado **Date:** 10/15/2013

	(A) Total (Gross) Expenditures
PEI Training, Technical Assistance and Capacity Building	$21,574
WET Regional Partnerships	$0
PEI Statewide Projects	$65,976

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2011-12
Identification of Unspent Funds

County: El Dorado **Date:** 10/15/2013

PEI Statewide Project funds have been assigned to CalMHSA? (YES or NO) YES

	Fiscal Year 2011-12	(A) Community Services and Supports	(B) Prevention and Early Intervention	(C) Innovation	(D) Workforce Education and Training	(E) Capital Facilities and Technological Needs	(F) TTACB	(G) WET Regional Partnerships	(H) PEI Statewide Projects Funds	(I) Prudent Reserve	(K) Total-All Components
1	**MHSA Unspent Funds Available from Prior Fiscal Years**										
	a FY 2006-07 Funds										$0
	b FY 2007-08 Funds										$0
	c FY 2008-09 Funds				$18,104						$18,104
	d FY 2009-10 Funds				$340		$11,250				$11,590
	e FY 2010-11 Funds	$1,822,128	$1,014,691	$1,031,694	$391,004	$1,628,851	$32,690		$428,249		$6,349,307
	f Total MHSA Unspent Funds Available from Prior Fiscal Years	$1,822,128	$1,014,691	$1,031,694	$409,448	$1,628,851	$43,940	$0	$428,249		$6,379,001
2	**Local Prudent Reserve**										
	a Balance as of June 30, 2011									$1,898,284	$1,898,284
3	**Funds Posted to Local MHS Fund during FY 2011-12**[1]										
	a Transfer of funds from the Local Prudent Reserve										$0
	b Funds received from State MHS Fund[2]										
	1 FY 2006-07 Funds										$0
	2 FY 2007-08 Funds										$0
	3 FY 2008-09 Funds										$0
	4 FY 2009-10 Funds										$0
	5 FY 2010-11 Funds										$0
	6 FY 2011-12 Funds	$3,117,380	$649,420	$198,100			$21,700		$145,200		$4,131,800
	c Interest Income Posted to Local MHS Fund	$8,560	$4,767	$4,846	$1,923	$7,652	$206		$695		$28,649
	d Total Funds Posted	$3,125,940	$654,187	$202,946	$1,923	$7,652	$21,906	$0	$145,895	$0	$4,160,449
4	**MHSA FY 2011-12 Fund Sources**[3]										
	a FY 2006-07 MHSA Funds										$0
	b FY 2007-08 MHSA Funds										$0
	c FY 2008-09 MHSA Funds				$18,104						$18,104
	d FY 2009-10 MHSA Funds				$340		$11,250				$11,590
	e FY 2010-11 MHSA Funds	$1,822,128	$1,014,691	$479,562	$13,997	$222,187	$10,324				$3,562,889
	f FY 2011-12 MHSA Funds	$1,813,761	$65,956						$65,976		$1,945,693
	g Federal Financial Participation	$772,108	$2,552								$774,660
	h 1991 Realignment										$0
	i Behavioral Health Subaccount										$0

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2011-12
Identification of Unspent Funds

County: El Dorado **Date:** 10/15/2013

PEI Statewide Project funds have been assigned to CalMHSA? (YES or NO) YES

	Fiscal Year 2011-12	(A) Community Services and Supports	(B) Prevention and Early Intervention	(C) Innovation	(D) Workforce Education and Training	(E) Capital Facilities and Technological Needs	(F) TTACB	(G) WET Regional Partnerships	(H) PEI Statewide Projects Funds	(I) Prudent Reserve	(K) Total-All Components
	j Other	$66,153	$6,943								$73,096
	k Total MHSA Fund Sources	$4,474,150	$1,090,142	$479,562	$32,441	$222,187	$21,574	$0	$65,976		$6,386,032
	l Total Program Expenditures	$4,474,151	$1,090,142	$479,562	$32,442	$222,187	$21,574	$0	$65,976		$6,386,034
5	**Transfers from CSS to Prudent Reserve, WET, CFTN[4]**										
	a FY 2009-10										$0
	b FY 2010-11										$0
	c FY 2011-12										$0
6	**MHSA Funds Reverted[5]**										
	a FY 2008-09 Funds[6]			$0			$0		$0		$0
	b FY 2009-10 Funds	$0	$0	$0			$0		$0		$0
	c Total Funds Reverted	$0	$0	$0			$0		$0		$0
7	**Total MHSA Unspent Funds[7]**										
	a FY 2006-07 Funds				$0						$0
	b FY 2007-08 Funds				$0	$0					$0
	c FY 2008-09 Funds				$0	$0		$0			$0
	d FY 2009-10 Funds				$0	$0		$0			$0
	e FY 2010-11 Funds	$0	$0	$552,132	$377,007	$1,406,664	$22,366	$0	$428,249		$2,786,418
	f FY 2011-12 Funds	$1,312,179	$588,231	$202,946	$1,923	$7,652	$21,906	$0	$79,919		$2,214,756
	g Total MHSA Unspent Funds	$1,312,179	$588,231	$755,078	$378,930	$1,414,316	$44,272	$0	$508,168		$5,001,174
8	**Prudent Reserve Balance**									$1,898,284	

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2011-12
Identification of Unspent Funds

END NOTES:

[1] For purposes of reporting on the RER, revenues should be recognized in the accounting period in which they become available and measurable. (Accounting Standards and Procedures for Counties, State Controller's Office, May 2003)

[2] Funds received include funds delegated by the County to CalMHSA in FY 2011-12 that were not deposited into the local MHS Fund.

[3] Fund sources for each component must equal the total program expenditures as reported on the Component Summary Worksheets.

[4] WIC Section 5892(b) permits a County to use up to 20 percent of the average amount of funds allocated to the county for the previous five years to fund technological needs and capital facilities, human resource needs, and a prudent reserve. The amount of funds transferred from CSS should be reported in the CSS column as a negative amount. The funds transferred into WET, CFTN, or Prudent Reserve should be reflected as a positive amount. For each year reported, the amount transferred from CSS should equal zero when added to the funds transferred into WET, CFTN, or Prudent Reserve.

[5] The amount of CSS, PEI, INN, TTACB, or PEI Statewide Project funds that reverted on June 30, 2012 auto populates. The amount of CSS, PEI, and INN funds that are subject to reversion may change when calculated per Information Notice 11-15.

[6] Information Notice 08-07 identifies criteria that must be met for funds to be considered available and to trigger the beginning of the reversion period. For FY 08/09, the criteria was not met, thus allowing counties an additional year to expend certain funds.

[7] Total MHSA Unspent Funds will auto populate for each Fiscal Year.

Attachment C
Public Meeting Survey

Mental Health Services Act (MHSA)
Community Planning Process Survey
December 27, 2013 – January 17, 2014

Where do you live?		
Answer Options	**Response Percent**	**Response Count**
Cameron Park	6.3%	2
Camino	3.1%	1
Cedar Grove	--	--
Coloma	3.1%	1
Cool	3.1%	1
Diamond Springs/El Dorado	--	--
Echo Lake	--	--
El Dorado Hills	15.6%	5
Fairplay	--	--
Garden Valley	6.3%	2
Georgetown	3.1%	1
Greenwood	3.1%	1
Grizzly Flats	--	--
Kyburz	--	--
Lotus	--	--
Meyers	--	--
Mosquito/Swansboro	--	--
Mt. Aukum	--	--
Pilot Hill	--	--
Placerville	31.3%	10
Pleasant Valley	6.3%	2
Pollock Pines	3.1%	1
Rescue	3.1%	1
Shingle Springs	3.1%	1
Somerset	--	--
South Lake Tahoe	3.1%	1
Tahoma	--	--
Twin Bridges	--	--
Other (please specify):	6.3%	2
answered question		**32**

What area(s) do you represent relative to mental health issues? (check all that apply)		
Answer Options	**Response Percent**	**Response Count**
Consumer	9.4%	3
Family of Consumer	28.1%	9
Veteran	--	--
Veteran Organization	--	--
Law Enforcement	--	--
Student	3.1%	1
Parent of Student	9.4%	3
Education Provider	28.1%	9
Mental Health Provider	21.9%	7
Health Care Provider	3.1%	1
AOD Provider	3.1%	1
Social Services Agency	25.0%	8
General Interest in Mental Health Issues	25.0%	8
Other (please specify):	28.1%	9
answered question		**32**

The best days of the week to have public meetings are: (check all that apply)		
Answer Options	**Response Percent**	**Response Count**
Monday	29.0%	9
Tuesday	**71.0%**	**22**
Wednesday	**51.6%**	**16**
Thursday	**51.6%**	**16**
Friday	16.1%	5
Saturday	19.4%	6
Sunday	12.9%	4
answered question		**31**

On weekdays (Monday through Friday), the best times to start public meetings are: (check all that apply)		
Answer Options	**Response Percent**	**Response Count**
7:00 am	--	--
8:00 am	6.3%	2
9:00 am	21.9%	7
10:00 am	**37.5%**	**12**
11:00 am	25.0%	8
12:00 pm	25.0%	8
1:00 pm	18.8%	6
2:00 pm	18.8%	6
3:00 pm	21.9%	7
4:00 pm	15.6%	5
5:00 pm	12.5%	4
6:00 pm	**43.8%**	**14**
7:00 pm	18.8%	6
8:00 pm	6.3%	2
Other (please specify)	3.1%	1
answered question		**32**

On weekends (Saturday and Sunday), the best times to start public meetings are: (check all that apply)		
Answer Options	**Response Percent**	**Response Count**
7:00 am	0.0%	0
8:00 am	0.0%	0
9:00 am	21.7%	5
10:00 am	**60.9%**	**14**
11:00 am	**47.8%**	**11**
12:00 pm	17.4%	4
1:00 pm	26.1%	6
2:00 pm	21.7%	5
3:00 pm	13.0%	3
4:00 pm	13.0%	3
5:00 pm	13.0%	3
6:00 pm	4.3%	1
7:00 pm	4.3%	1
8:00 pm	4.3%	1
Other (please specify)	4.3%	1
answered question		**23**

Attachment D
Summary of Public Meetings and Comment Form Input

Mental Health Services Act (MHSA)
Input from Public Meetings
FY 2014/15 Community Planning Process

Discussion Topic	Cool	DFD (GT)	EDH	EDH VC	GV	NAMI	PP	PVL	SLT	SLT FRC
Action First Before a Tragedy							x			
Assistance in Developing a Local Plan	x									
Benefits • Coordinate Benefits Eligibility • SSI/SSDI Outreach, Access and Recovery (SOAR)						x				
Better Technology to Help With • Transportation • Tele-Health • Infrastructure ▪ No Home Computers ▪ More Public Access to Computers • Local Support • Webinars		x								
Case Management • Caseworker for Follow-Up Case Management									x	
Change the Perception • "Don't Tattle-Tale" • "Every 15 Minutes" Program for Mental Health • "Guilt by Association" - If activity done by one, done by all/others • Change the Culture • Focus on the "Wellness" -- Not on the "Illness" • Myth-Busting about Mental Illness • Mental Health is as Important as Physical Health • Role Playing Program ▪ Ongoing ▪ Collaborative with Existing Groups	x			x					x	x

DFD (GT) = Drug-Free Divide (Georgetown)
EDH = El Dorado Hills
EDH VC = El Dorado Hills Vision Coalition
GV = Garden Valley
NAMI = National Alliance on Mental Illness
PP = Pollock Pines
PVL = Placerville
SLT = South Lake Tahoe
SLT FRC = South Lake Tahoe Family Resource Center

Discussion Topic	Cool	DFD (GT)	EDH	EDH VC	GV	NAMI	PP	PVL	SLT	SLT FRC
Children • Increasing Levels of Emotionally Disturbed Children • Children's Shelter - Homeless, Runaway Youth • Cutting • Need for Coping Skills • Difficult to Talk with Children Regarding Issues Such as Bullying • Increase in Children Not Meeting 5150 Criteria, but not able to go home • Runaways • Special Needs Clients/Children • Youth Incarcerations • How to Manage Stress and Family Stress, and Reach out to Others • Needs of Non-IEP Children	x	x	x	x				x		x
Crisis • After Crisis Care • Adequate Follow-Up • Unmarked Vehicles for Law Enforcement Follow-Up • Crisis Staff Stationed at ER • Drop-In Crisis Center • Families in Crisis				x	x	x		x		
Culture • Cultural Differences • Accepted Practices, Traditions, Roles										x
Education • Parents Regarding Impact of Expectations on Children • New Parents - Bonding, Attachment Positive Relationships • Teachers, Parents and Children								x		x
Empowerment • Start Young • Students (e.g., Girls Talk) • Health and Wellness			x	x						x
Engagement in Services • Encouraging Participation in Mental Health Services • Early Intervention - Young Children						x	x		x	
Facilities • Step-Down Facility • PHF Step-Down and Intensive Services • Detox Facility						x			x	

Discussion Topic	Cool	DFD (GT)	EDH	EDH VC	GV	NAMI	PP	PVL	SLT	SLT FRC
Families • Breakdown in Families • Divorce, Busy Schedules • "Latch Key" Children • Communication Between Children and Parents - Make it Good and Regular • Cross-Generational Opportunities	x		x							x
Gathering Places • Local Gathering Places / Central Meeting Places • Build on Natural Gathering Places • Need for a Safe Place to go • Fire Station Safe Sites	x			x	x					
Getting the Word out about Services/Mental Wellness • Lack of Knowledge of What Services are Available • Get the Word Out About What's Available and Where to go for Services • Letting Marshall Hospital Know What's Available • Libraries, Doctor Offices, Grocery Stores, Central Information Points, Community Service Districts, Chambers of Commerce, Service Organizations, Schools, Churches, Community Resource Center, Social Media, Teen Centers • Business Card for Reference Phone Numbers • Public Awareness • Wellness Events - Regularly Scheduled • Wellness Worker • Community Outreach and Awareness • Couple Mental Health with Other Topics • Not Knowing How to Access Services • Not Knowing Where To Go • Project List - Where Projects are Operating • Resource Binder • Schools newsletters/website/texts ▪ hints ▪ short messages	x		x	x	x		x		x	
Grief and Loss Services • Loss, Death, Health, Jobs, Pets • Ongoing With Regular Schedule • All Ages			x							
Home Visitor • With a Specialty in Mental Health Issues or a Non-Mental Health Home Visitor with Cross-Training in Mental Health				x						

Discussion Topic	Cool	DFD (GT)	EDH	EDH VC	GV	NAMI	PP	PVL	SLT	SLT FRC
Homeless • Families / Increase in Family Homelessness • Stigma • Need for Affordable Housing • "Pathways to Success" Program • Runaways			x	x	x	x		x		
Housing • Affordable Housing • Post Release from Facilities • Transitional Housing • Crisis Residential Treatment • Board and Cares • Vouchers • Short-Term Crisis Housing						x		x	x	
How to Get People Involved • Personal Phone Calls				x						
Integration/Partnerships with Physical Health Care	x						x			
Isolation • Geographic • Self Isolation • Older Adult Isolation	x				x		x			
Jail / Incarcerations • Discharge Planner/Navigator • Discharges • In-House Pharmacy • Upon Release, Meeting Jail Releases • Notification of Upcoming Releases • Services for Incarcerated Youth in a Culturally Competent Manner ▪ Including Mental Health Services and Mentoring								x	x	x
Law Enforcement Officers to Partner with Mental Health (Dedicated Officers)								x		
Local "Anonymous Clubs" / Blog Sites			x							
Local Services • Access to Care • Regular Basis • Lack of Local Services / Services in Remote Areas • Lack of Services in Western County: ▪ Youth Shelter ▪ County Services ▪ Sliding Fee Schedules	x	x	x	x	x	x	x	x		
Medicare • Mental Health Services • Lack of Providers • Psychiatrists			x					x		

Discussion Topic	Cool	DFD (GT)	EDH	EDH VC	GV	NAMI	PP	PVL	SLT	SLT FRC
Medication • Access to Prescriptions (Getting to Pharmacy) • Cost / Assistance with Cost • How to Obtain Refills • Linkage with Pharmacy Upon Release from Jail or the PHF • Quick Access to / Emergency Medications • Jail Discharges • System-wide Cost Savings When Individuals Remain on Medications	x							x	x	
Mental Health First Aid • Adults, Youth • English and Spanish		x							x	x
MHSA Plan / Implementation / Funding • Program Flexibility (how written in MHSA Plan) • Start-up Workshop for Vendors • Be Smart About Leverages • CSS Funding Not in El Dorado Hills • Quick Access to Funds for Supportive Services and Client Needs		x		x				x	x	
Navigators / Mental Health Outreach Worker	x			x		x				
Nutrition • Garden									x	
Parenting Classes / Programs • Including Parenting Older Children • All Age Groups • Variety of Models (PEI) • Parenting Classes with Onsite Child Care ▪ Incredible Years, Parent Project		x					x	x	x	x
Parents • Get Them Involved • Parents Attitudes • Parents not Addressing Behavior Issues • Parent Phone Line or Webinars • Parental Struggles • Maternal Depression • Peri-natal Services • Schedules - Too Busy to Devote Time ▪ Important to Make Time	x	x		x			x	x		x
People Make Choices				x						
Prevention and Early Intervention (PEI) • Expand Mental Health to Serve More People Under PEI • Services for Mild to Moderate Mental Illness • Short-Term Counseling ▪ Maybe up to 10 Sessions ▪ All Ages ▪ Triage Mechanism ▪ Self Assessments			x			x		x		

Discussion Topic	Cool	DFD (GT)	EDH	EDH VC	GV	NAMI	PP	PVL	SLT	SLT FRC
Programs • Turning Point Program (Full Service Partnership) • Transitional Age Youth Programs • PCIT in Tahoe • Art Therapy • Dina Dinosaur Incredible Years Program ▪ Child Focused ▪ Anti-Bullying • Primary Intervention Program - Expand • SafePlace Model • Social Skills and Independent Living Skills • Programs at the Library ▪ Teen Council		x		x	x		x	x	x	
Psychiatrists (Lack of)			x							
Referrals to Higher Level of Care				x						
School • Input from Parents, Students, Yard Duties • "Point Break" Program • School Programs That Involved Parents • School Site Usage for Services • School-Based Services • Services During School Hours • Student Peer Counselors • Stress with Missing Classes to Attend Training • Teachers Reluctant to Talk with Parents About Mental Health Issues • Services in Schools ▪ Marriage and Family Therapists, Interns and Trainees	x	x	x	x						x
Sense of Community is Important			x							
Service Mapping / Access • What are the Needs, What Services are Available, and How to Access Those Services • Data - What Money/Services are Going Where • Access to Services: ▪ Weather ▪ Flexible Hours for Services (not just 8-5) ▪ People are Not Getting Services They Need ▪ Individuals Turned Away at Hospital / ER	x	x			x	x				
Services/Activities Unaffordable										x

Discussion Topic	Cool	DFD (GT)	EDH	EDH VC	GV	NAMI	PP	PVL	SLT	SLT FRC
Services • Latino Older Adults • Job Skills • Latino Outreach - Direct Services on West Slope • Legal Advice/Services/Advocate • Services for Mild to Moderate Mental Health Needs • No or Low-Income • Uninsured • Services for Those not Meeting Specialty Mental Health Criteria, Uninsured or No Mental Health Services Included in Health Plan • Stabilization Support (Includes Jail Releases) • Mentoring			x		x			x	x	x
Staff Reduction	x									
Stigma • Stigma Reduction • About Mental Illness • From Parents • About the Mental Health Division • Homeless and Mental Illness • Fear of Others Knowing	x		x	x	x	x	x	x	x	x
Substance Abuse • Co-Occurring / Dual Diagnosis • Treatment • No Detox Facility in County • Emergency Detox Facility with Staffed Clinicians • Alcohol Awareness Education • Youth Drinking			x		x				x	x
Suicide Prevention • Services • Youth • Older Adults			x	x						
Support / Discussion Groups • Peer Support • Discussion Groups • Grief Group • Support Groups for Parents with Mental Illness Struggling to Parent Their Children			x					x		
Training / Education / Staff Development • How to Access Services • Shelter Volunteers • On Schools' Professional Development Day • Teachers • Parents • Law Enforcement • Awareness, Education	x	x		x	x	x	x		x	x

Discussion Topic	Cool	DFD (GT)	EDH	EDH VC	GV	NAMI	PP	PVL	SLT	SLT FRC
• On-Going Check-Ins/Refreshers • Meetings About Mental Health Not Well Attended • Family Education about Mental Health Diagnosis, Treatments and Medications • Better Trained (i.e., Specialists) in Co-Occurring Disorders • ER Training in Mental Health • Crisis Intervention Team (CIT) Training • Community Education • Student and Adult Education ▪ It's Ok to Tell Someone ▪ Parent Power Night • Cutting Education (Parents) / Prevention (Teens) • Parent Education at Libraries ▪ Family Place Library • Mental Health Awareness for Business Owners										
Transitional Age Youth • Linkage/Access ▪ Social Security Office ▪ Cost of Documents/Services ▪ Obtaining Birth Certificates • Lack of Correct Paperwork/Documentation • Lifeskills Training									x	
Transportation • "How do I get there?" • Access to Transportation • Disabled Access • To Wellness Center from Outlying Areas • Bus Service Lacking • No Transportation to New Morning Youth & Family Services Children's Shelter from Outlying Areas	x	x	x	x	x	x	x	x		
Underlying Causes of and Issues Related to Mental Illness • Substance Abuse / Self-Medication • Poverty • Dysfunctional Families • Level of Education • Unemployment • Anxiety and Stress ▪ Isolation ▪ Not Like Others ▪ Parental Stress on Youth • Bullying • Depression • Peer Pressure • Self-Worth Judged by Others • Lack of Role Models • Challenge: Identifying Reasons for Mental Health Issues and Who Those Individuals Are		x	x	x			x			x

Discussion Topic	Cool	DFD (GT)	EDH	EDH VC	GV	NAMI	PP	PVL	SLT	SLT FRC
Work with Local Community Organizations						x				
Working with Universities Training Teachers • Meeting with universities specifically about training their teachers in mental health • Voluntarily requiring their students to have the training							x			

Mental Health Services Act (MHSA)
Input from Comment Forms
FY 2014/15 Community Planning Process

Mental Health Service Gaps / Needs

- Better education for law enforcement about mental illness and how to treat someone experiencing a mental health crisis.
- Youth are under extreme stress to succeed in school and they have little access to mental health services other than their parent's health insurance. Youth are reluctant to access those services because 90% of the time it is the parent who is applying the pressure. This is causing many young people to turn to self-medicating techniques and/or suicide ideology.
- Need adequate "housing first" program for our homeless.
- Need more affordable housing.
- Older adults support groups.
- Talking circles from second grade into middle school.
- More education about an individual's culture.
- People in crisis have no urgent care clinic for help.
- Someone/somewhere to contact for aggressive/violent behavior.
- Transportation for mental health services.
- Co-occurring disorders (mental health and substance abuse).
- Consumers in crisis have no services available to them unless they are going to harm themselves or others.
- Programs that are flexible and allow the provider to implement creatively (for example, Incredible Years offered as modules rather than a 10-week class).
- Services for homeless, runaway and in-crisis youth.
- Over the last few years I have noticed a significant increase in drug use among the people I often do business with. If there is a component within MHSA that could help turn people away from drug use I would consider it a real positive contribution to the heath and stability of the community.
- Need more for adults of all ages.
- More to erase stigma.
- The public still doesn't understand MHSA. People don't have computers, just phones, and don't look at the County web sites.
- Tap into local digital media.
- Need more counselors.
- Access to care if you remove present counseling services at the schools.
- Timeliness of counseling services.
- Local access to services.
- Transportation inadequate outside the area.
- Cutting and suicide prevention.
- Anti-bullying (preventative and reactive strategies toward bullying) in K-5, bully prevention classes, etc.

- Finding more extra-curricular activities after school for our youth (many parents in our community work when kids get home and spend many hours alone).
- Services and activities on the Divide (there are some services on the Divide)
- Transportation to services and activities in Placerville.
- Job coaching.
- Counseling services.
- Issues around gay/lesbian mental health needs, especially geared towards members of the Latino community.
- Mental health MFTIs and trainees supervised by MFTs in middle schools and high schools through PEI funds for prevention and early intervention.
- Suicide prevention among youth 11-18 and older adults 45-55.
- Housing, including housing on the Divide for those with a mental illness.
- Addressing stigma of mental illness.
- Individuals with a mental illness speaking at high schools.
- Older adult in home assessments and follow up services.
- More access to providers for teens.
- Schools need more resources at school.
- Services not available when needed.
- School-based mental health services.

Recommendation(s) / What is Needed

- Nearly impossible to get treatment for an adult if he/she is not considered a danger to himself/herself or others; often results in the individual breaking laws.
- Services I schools in particular where students can easily access mental health providers in the form of brief therapy. If these kids could have someone to talk to that is a therapist is can act as a bridge to eventually contacting the parents and get more intensive treatment.
- Mental health services in juvenile hall.
- Mental health awareness for every new law enforcement officer/deputy.
- A program like the "Blue Skies" support group from Merced County.
- Services on the Divide or transportation to Placerville.
- Talking circles, including from second grade into middle school.
- Transportation to services.
- Mental health urgent care clinic.
- Something similar to the Dental Van, but with a mental health focus, for outreach to all communities.
- Caltrans has unused funding available for Native American services.
- Counselors private phone number.
- More activities that include multiple generations, including more for Native Americans.
- Emergency detox facility (this should not be done in the jails).
- Non-acute drop-in facilities (one on each slope).

- Ability to positively impact those suffering in breaks from reality even if they are not going to harm themselves or others.
- Start-up workshop for new vendors/programs.
- It is hard to propose ideas and updates to the MHSA Plan if we don't know all the current funded programs.
- Funding for homeless youth program.
- More outreach to local groups such as Rotary or Soroptimist.
- An easy to read sheet with early symptom of behavior that may indicate mental illness.
- Families don't know about early indicators of mental illness. More education.
- Need dual diagnosis treatment.
- There are many individuals needing mental health services and few counselors.
- More education programs provided in Garden Valley/Georgetown area for access to care. Large population without funds to drive distance for programs outside the area.
- Early intervention at school sites.
- Continue Primary Intervention Program (PIP) at the elementary schools.
- Cutting prevention for teens.
- Suicide prevention for teens.
- Drug use prevention for teens.
- Anti-bullying for kids and teaching parents how to respond to your child (whether it be the bully or the one being bullied - warning signs.
- Housing – board and care homes in the County, more transitional housing, group homes, apartments, supervised, daily check-in.
- Mental health services on the Divide.
- Transportation to services/activities in Placerville.
- Engage the Latino community.
- Issues around gay and lesbian in the Latino community.
- Mental health professionals in schools; early intervention program for youth in middle schools and high schools are high need areas.
- WET for law enforcement, hospitals, emergency personnel and community volunteers (especially those who work with homeless).
- After crisis care.
- Navigator to work with individuals with a mental illness and their family members to get on Medi-Cal, SSI, etc.
- More mental health professionals in the County.
- Gero-psych team.
- Older adult services for in home assessments and follow up services.
- Oak Ridge needs more counseling and help when a family feels they have a student who needs help.
- All high school counselors should attend a community forum for the documentary "A New State of Mind: Ending the Stigma of Mental Illness".
- Need individuals who come into the home when a mental illness is diagnosed.
- MFT Interns in middle and high school.

What's Working

- Behavioral Health Court has helped tremendously, giving the mentally ill the chance to reduce or expunge their criminal record.
- Trying to meet with youth at school. Most youth and parents are more comfortable dealing with issues, especially initially, on a school site.
- Talking circles.
- Group events and activities, including on the weekends.
- Shingle Springs Tribal Health mental health services are very approachable.
- The Wennem Wadati program provides an inviting and supportive environment that makes it easier to learn and to have support.
- Senior Peer Counseling.
- Collaboration.
- New Morning Youth and Family Services Youth Shelter.
- NAMI Family-to-Family.
- South Lake Tahoe Family Resource Center programs are working well. There are just too many people in need of help and have to wait until there is space.
- People/parents feeling empowered in groups.
- Parent training within Family Resource Center is very effective.
- Dedicated staff.
- Turning Point program.
- Offering services at locations where consumers feel safe and welcomed (for instance, non-profits in our community).
- Community organizations, non-profit organizations, and community coalitions.
- Public meetings very good.
- Current programs look good.
- The present mental health service plan appears to offer very little to meet the needs of older adults in El Dorado County.

What's Not Working

- Punishing the mentally ill.
- Referring parents to outside resources.
- Unless they are danger to themselves or others, children are often released before the issue is dealt with.
- There is hesitation to hospitalize youth.
- Transportation.
- Ability for family to obtain medical information needed to help consumer family member.
- State funding of traditional mental health services.
- When the MHSA plan is submitted to the County Board of Supervisors, the Board should carry recommendation that they lobby the State for traditional mental health funding.
- Lack of flexibility.

- Money is not flowing freely to community partners – a lot of funding stay with County.
- Too much money is going to schools. The DSM states the first break is at 21 years. If we give funding to schools, it should go to community colleges.
- Perhaps because of downsizing there are not enough counselors.
- Lack of follow through from parents.
- Communication between parents and children – it's torn.
- Not enough extra-curricular/healthy activities for our youth in our community, thus they resort to bad habits and substance/alcohol abuse.
- Jail, incarceration of the mentally ill (repeatedly).
- Lack of housing.
- Lack of access to services and activities on the Divide.
- Transportation to services and activities in Placerville.
- Support for family members.
- Too much of the budget is going to Latino outreach and Native American outreach under PEI and more needs to go to youth early intervention, PIP and general outreach to mental health and homeless populations.
- Not sure if all the available funds are really be used effectively within County – has not in the past but it is changing now.
- My son is not able to participate in afternoon activities at the Wellness Center because there is no transportation available from the more rural areas to Diamond Springs.
- Jail time for the mentally ill, interventions.
- The criteria of "medical necessity" rules out services to the majority of older adults with unmet mental health needs.
- Jail and court.

Any Other Comments about MHSA or mental health needs and services?

- There is a need for mental health therapists on school sites to work with the youth who won't go to outside resources or whose parents won't take them.
- Schools with school counselors often get left out, but school counselors are not therapists.
- The MHSA El Dorado program appears to be very comprehensive.
- More youth leadership opportunities.
- Does not extend to the Divide communities.
- A complicated program like MHSA benefits from having staff to explain.
- Sorry you don't get a better turnout.
- Create flexibility whenever possible.
- Not many members of the public at the meetings; vendors or education are attending.
- Get an attorney to help expunge felony records after five years so they can get a job.
- I would like to have more information about MHSA as this program helps the community.
- Thank you for your funding.

- Support and psycho-educational groups specifically geared towards men and the mental health issues men experience (or rather the different manifestations of mental health issues in men).
- I would like to see more activities for my son so that he is not so isolated.

Did this meeting meet your expectations; if no, why not, and any other comments about the meeting.

- Of the comment forms that answered this question, all responses were "yes". Additional comments:
- Great opportunity to listen to other's concerns and needs.
- This was my introduction meeting. Would like to attend more regarding resources.

Mental Health Services Act (MHSA)
Input from One-on-One or Small Group Meetings
FY 2014/15 Community Planning Process

Suicide prevention is needed.

Substance/alcohol abuse prevention is needed.

Navigators to assist individuals through the process of seeking mental health services or upon release from the PHF.

Create a flow chart on where to go for help/who to see.

How to get the word out about the MHSA community planning process and available programs?

- electronic street signs
- local magazines (Around Here, Style)
- newspapers
- Community Service District class magazine
- school newsletters/postings
- parent organizations
- community concerts / events (booth with information and incentives, face painting)
- granges
- grocery stores
- churches
- natural gathering places

CASA services for youth receiving mental health services.

Collaboration between EDCOE and community providers for the WET programs.

Mental Health Clinicians providing 1-2 hours of continuing education to volunteer organizations.

Mobile mental health van.

Training for consumers to lead support groups in the outlying areas of the County.

Worksite wellness campaign.

More intensive engagement services for those who frequently access services through the emergency rooms.

Pursue hospital grants.

Offering PEI programs in the libraries.

Development screening for children in childcare.

Need to reach children in isolated areas.

Attachment E
MHSA Funding Summary and Expenditure Plan

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan Funding Summary and Plan Instructions

General: Round all amounts to the nearest whole dollar.
Heading: Enter the County name and the date the worksheet is completed.

Component Worksheets:

General: Each individual component worksheet has three sections, one for each of the three fiscal years covered by the Expenditure Plan. The top section is for FY2014/15, the middle section for FY2015/16 and the bottom section for FY2016/17.

Column A represents the total estimated program expenditures for each program and represents the sum of the funding sources for the program. Counties should do their best to estimate the funding from the sources identified so as to reflect the estimated expenditures of the entire program.

Definitions:

Medi-Cal FFP represents the estimated Medi-Cal Federal Financial Participation to be received by the program based on Medi-Cal Certified Public Expenditures (CPE) incurred by the County.

1991 Realignment represents the estimated 1991 Realignment to be used to fund the program.

Behavioral Health Subaccount represents the estimated funding from the Behavioral Health Subaccount used to fund the program. This would generally represent some of the matching funds for EPSDT programs.

Estimated Other Funding represents the any other funds used to fund the program, which could include, but is not limited to, County General Fund, grants, patient fees, insurance, Medicare.

Community Services and Supports Worksheet:

The County should identify CSS programs as either those with Full Service Partnership (FSP) expenditures and those without FSP expenditures (i.e., any program with a FSP expenditure would be reported under the FSP program section). Enter the program names on a line in the appropriate section. The line number does not need to correlate with the program number.

Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.

Enter the estimated funding for CSS Administration in columns B through F. Total estimated CSS Administration is automatically calculated as the sum of columns B through F.

Enter the estimated funding for CSS MHSA Assigned Housing Funding in columns B through F. Total estimated CSS MHSA Assigned Housing Funding is automatically calculated as the sum of columns B through F.

Total CSS estimated expenditures and funding is automatically calculated.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan Funding Summary and Plan Instructions

FSP Programs as a percent of total is automatically calculated as the sum of total estimated FSP program expenditures divided by the sum of CSS funding. Counties are required to direct a majority of CSS funding to FSP pursuant to California Code of Regulations Section 3620.

Prevention and Early Intervention Worksheet:

The County should identify PEI programs as either those focused on prevention or those focused on early intervention. Enter the PEI program names on a line in the appropriate section. The line number does not need to correlate with the program number.

Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.

Enter the estimated funding for PEI Administration in columns B through F. Total estimated PEI Administration is automatically calculated as the sum of columns B through F.

Enter the estimated funding for PEI Assigned Funds in columns B through F. PEI Assigned Funds represent funds voluntarily assigned by the County to CalMHSA or any other organization in which counties are acting jointly. Total estimated PEI Assigned Funds is automatically calculated as the sum of columns B through F.

Total PEI estimated expenditures and funding is automatically calculated.

Innovations Worksheet:

The County should enter the INN program names on a line in the appropriate section. The line number does not need to correlate with the program number.
Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.
Enter the estimated funding for INN Administration in columns B through F. Total estimated INN Administration is automatically calculated as the sum of columns B through F.
Total INN estimated expenditures and funding is automatically calculated.

Workforce, Education and Training Worksheet:

The County should enter the WET program names on a line in the appropriate section. The line number does not need to correlate with the program number.
Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.
Enter the estimated funding for WET Administration in columns B through F. Total estimated WET Administration is automatically calculated as the sum of columns B through F.
Total WET estimated expenditures and funding is automatically calculated.

Capital Facilities/Technological Needs Worksheet:

The County should identify CFTN projects as either capital facilities projects or technological needs projects. Enter the CFTN program names on a line in the appropriate section. The line number does not need to correlate with the program number.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan Funding Summary and Plan Instructions

Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.

Enter the estimated funding for CFTN Administration in columns B through F. Total estimated CFTN Administration is automatically calculated as the sum of columns B through F.

Total CFTN estimated expenditures and funding is automatically calculated.

Funding Summary Worksheet:

General: The Funding Summary worksheet has three sections for each of the three fiscal years covered by the Expenditure Plan. The County should report estimated available funding and expenditures for each fiscal year and by each component. The estimated unspent funds are automatically shown as available funding in the next fiscal year. The County should use available forecasts of estimated MHSA funding to try and determine new available MHSA funding for each fiscal year.

Sections A, C and E

Line 1 Enter the estimated available funding from the prior fiscal years for FY 2014/15 in Section A. This amount is automatically calculated in for FY 2015/16 in Section C and for FY2016/17 in Section E.

Line 2 Enter the estimated new funding for each fiscal year for each component. The County should reduce the amount of estimated distributions by any estimated prior year reverted funding assuming the reverted funds will be offset against new distributions.

Line 3 Enter the amount of funds requested to be transferred from CSS to CFTN, WET and/or the Local Prudent Reserve. Funds requested to be transferred to CFTN, WET and/or the Local Prudent Reserve will be subtracted from the Estimated Available CSS Funding for the relevant fiscal year and the amount is automatically calculated in Column A (CSS). Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

Line 4 Enter the requested amount to be accessed from the Prudent Reserve for either CSS or PEI. The total is automatically summed in Column F (Prudent Reserve).

Line 5 This amount is automatically calculated and represents the estimated available funding for each component for each fiscal year.

Sections B, D and F

This amount is automatically transferred from the CSS, PEI, INN, WET, and CFTN worksheet.

Section G

This amount is automatically calculated and represents the difference between the estimated available funding and the estimated expenditures at the end of fiscal year 2016/17.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan Funding Summary and Plan Instructions

Section H

Enter the estimated Local Prudent Reserve balance on June 30, 2014. The rest of the cells are automatically calculated.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: El Dorado

Date: 7/25/14

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2014/15 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	5,509,074	1,444,071	1,318,641	151,076	428,398	
2. Estimated New FY2014/15 Funding	6,654,552	1,251,689	329,392			
3. Transfer in FY2014/15[a/]	(35,361)			35,361	0	
4. Access Local Prudent Reserve in FY2014/15	0	0				0
5. Estimated Available Funding for FY2014/15	12,128,265	2,695,760	1,648,033	186,437	428,398	
B. Estimated FY2014/15 MHSA Expenditures	9,432,447	2,016,841	22,000	186,437	332,101	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,695,818	678,919	1,626,033	0	96,297	
2. Estimated New FY2015/16 Funding	6,561,346	1,228,387	323,260			
3. Transfer in FY2015/16[a/]	(302,176)			166,000	136,176	
4. Access Local Prudent Reserve in FY2015/16	0	0				0
5. Estimated Available Funding for FY2015/16	8,954,988	1,907,306	1,949,293	166,000	232,473	
D. Estimated FY2015/16 Expenditures	8,756,729	1,664,315	23,000	166,000	232,473	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	198,259	242,991	1,926,293	0	0	
2. Estimated New FY2016/17 Funding	6,561,346	1,228,387	323,260			
3. Transfer in FY2016/17[a/]	(388,473)			156,000	232,473	
4. Access Local Prudent Reserve in FY2016/17	0	0				0
5. Estimated Available Funding for FY2016/17	6,371,132	1,471,378	2,249,553	156,000	232,473	
F. Estimated FY2016/17 Expenditures	8,706,729	1,368,615	23,000	156,000	232,473	
G. Estimated FY2016/17 Unspent Fund Balance	(2,335,597)	102,763	2,226,553	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	1,898,284
2. Contributions to the Local Prudent Reserve in FY 2014/15	0
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	1,898,284
5. Contributions to the Local Prudent Reserve in FY 2015/16	0
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	1,898,284
8. Contributions to the Local Prudent Reserve in FY 2016/17	0
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	1,898,284

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: El Dorado Date: 7/25/14

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Program 1: Youth and Family Strengthening Program	1,250,766	1,038,136	212,630			
2. Program 2: Wellness and Recovery Services	3,846,189	3,127,020	719,169			
3. Program 3: Transitional Age Youth (TAY) Services	342,387	282,887	59,500			
4. Future Potential Project 2d: Assisted Outpatient Treatment	125,000	125,000	0			
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Program 1: Youth and Family Strengthening Program	100,000	79,348	16,252			4,400
2. Program 2: Wellness and Recovery Services	2,171,269	1,798,833	368,436			4,000
3. Program 4: Community System of Care	1,388,411	1,125,002	153,409			110,000
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: El Dorado Date: 7/25/14

14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	208,425	208,425				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	9,432,447	7,784,651	1,529,396	0	0	118,400
FSP Programs as Percent of Total	71.5%					

	Fiscal Year 2015/16					
	A	**B**	**C**	**D**	**E**	**F**
	Estimated Total Mental Health Expenditures	**Estimated CSS Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
FSP Programs						
1. Program 1: Youth and Family Strengthening Program	1,257,969	1,045,339	212,630			
2. Program 2: Wellness and Recovery Services	3,202,500	2,483,331	719,169			
3. Program 3: Transitional Age Youth (TAY) Services	367,500	308,000	59,500			
4. Future Potential Project 2d: Assisted Outpatient Treatment	225,000	225,000	0			
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Program 1: Youth and Family Strengthening Program	52,000	31,348	16,252			4,400
2. Program 2: Wellness and Recovery Services	2,255,500	1,883,064	368,436			4,000

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: El Dorado Date: 7/25/14

3. Program 4: Community System of Care	1,181,250	917,841	153,409			110,000
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	215,010	215,010				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	8,756,729	7,108,933	1,529,396	0	0	118,400
FSP Programs as Percent of Total	71.1%					

	Fiscal Year 2016/17					
	A	**B**	**C**	**D**	**E**	**F**
	Estimated Total Mental Health Expenditures	**Estimated CSS Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
FSP Programs						
1. Program 1: Youth and Family Strengthening Program	1,257,969	1,045,339	212,630			
2. Program 2: Wellness and Recovery Services	3,202,500	2,483,331	719,169			
3. Program 3: Transitional Age Youth (TAY) Services	367,500	308,000	59,500			
4. Future Potential Project 2d: Assisted Outpatient Treatment	175,000	175,000	0			
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: El Dorado Date: 7/25/14

14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Program 1: Youth and Family Strengthening Program	52,000	31,348	16,252			4,400
2. Program 2: Wellness and Recovery Services	2,255,500	1,883,064	368,436			4,000
3. Program 4: Community System of Care	1,181,250	917,841	153,409			110,000
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration	215,010	215,010				
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	8,706,729	7,058,933	1,529,396	0	0	118,400
FSP Programs as Percent of Total	70.9%					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: El Dorado Date: 6/9/14

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Program 1: Youth and Children's Services	471,825	471,825	0	0	0	0
2. Program 2: Community Education Project	237,000	237,000	0	0	0	0
3. Program 3: Health Disparities Program	249,797	249,797	0	0	0	0
4. Program 4: Wellness Outreach Program for Vulnerable Adults	16,500	16,500	0	0	0	0
5. Program 5: Community-Based Services	32,169	32,169	0	0	0	0
6. Proposed Project 2f: Prevention and Early Intervention for Youth in Schools	18,750	18,750				
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Program 1: Youth and Children's Services	471,825	471,825	0	0	0	0
12. Program 3: Health Disparities Program	107,056	107,056	0	0	0	0
13. Program 4: Wellness Outreach Program for Vulnerable Adults	148,500	148,500	0	0	0	0
14. Program 5: Community-Based Services	32,169	32,169	0	0	0	0
15. Proposed Project 2f: Prevention and Early Intervention for Youth in Schools	56,250	56,250				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	175,000	175,000				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	2,016,841	2,016,841	0	0	0	0

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: El Dorado Date: 6/9/14

PEI Programs - Prevention						
1. Program 1: Youth and Children's Services	281,350	281,350	0	0	0	0
2. Program 2: Community Education Project	214,000	214,000	0	0	0	0
3. Program 3: Health Disparities Program	249,797	249,797	0	0	0	0
4. Program 4: Wellness Outreach Program for Vulnerable Adults	18,000	18,000	0	0	0	0
5. Program 5: Community-Based Services	32,631	32,631	0	0	0	0
6. Proposed Project 2f: Prevention and Early Intervention for Youth in Schools	25,000	25,000				
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Program 1: Youth and Children's Services	281,350	281,350	0	0	0	0
12. Program 3: Health Disparities Program	107,056	107,056	0	0	0	0
13. Program 4: Wellness Outreach Program for Vulnerable Adults	162,000	162,000	0	0	0	0
14. Program 5: Community-Based Services	32,631	32,631	0	0	0	0
15. Proposed Project 2f: Prevention and Early Intervention for Youth in Schools	75,000	75,000				
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	185,500	185,500				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,664,315	1,664,315	0	0	0	0

	Fiscal Year 2016/17					
	A	**B**	**C**	**D**	**E**	**F**
	Estimated Total Mental Health Expenditures	**Estimated PEI Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
PEI Programs - Prevention						
1. Program 1: Youth and Children's Services	125,000	125,000	0	0	0	0
2. Program 2: Community Education Project	216,000	216,000	0	0	0	0
3. Program 3: Health Disparities Program	249,797	249,797	0	0	0	0
4. Program 4: Wellness Outreach Program for Vulnerable Adults	19,500	19,500	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: El Dorado Date: 6/9/14

5.	Program 5: Community-Based Services	32,631	32,631	0	0	0	0
6.	Proposed Project 2f: Prevention and Early Intervention for Youth in Schools	25,000	25,000				
7.		0					
8.		0					
9.		0					
10.		0					
PEI Programs - Early Intervention							
11.	Program 1: Youth and Children's Services	125,000	125,000	0	0	0	0
12.	Program 3: Health Disparities Program	107,056	107,056	0	0	0	0
13.	Program 4: Wellness Outreach Program for Vulnerable Adults	175,500	175,500	0	0	0	0
14.	Program 5: Community-Based Services	32,631	32,631	0	0	0	0
15.	Proposed Project 2f: Prevention and Early Intervention for Youth in Schools	75,000	75,000				
16.		0					
17.		0					
18.		0					
19.		0					
20.		0					
PEI Administration		185,500	185,500				
PEI Assigned Funds		0					
Total PEI Program Estimated Expenditures		1,368,615	1,368,615	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: El Dorado

Date: 41799

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1 NONE AT THIS TIME	=SUM(D10:H10)					
2	=SUM(D11:H11)					
3	=SUM(D12:H12)					
4	=SUM(D13:H13)					
5	=SUM(D14:H14)					
6	=SUM(D15:H15)					
7	=SUM(D16:H16)					
8	=SUM(D17:H17)					
9	=SUM(D18:H18)					
10	=SUM(D19:H19)					
11	=SUM(D20:H20)					
12	=SUM(D21:H21)					
13	=SUM(D22:H22)					
14	=SUM(D23:H23)					
15	=SUM(D24:H24)					
16	=SUM(D25:H25)					
17	=SUM(D26:H26)					
18	=SUM(D27:H27)					
19	=SUM(D28:H28)					
20	=SUM(D29:H29)					
INN Administratio	=SUM(D30:H30)	22000				
Total INN Program	=SUM(C10:C30)	=SUM(D10:D30)	=SUM(E10:E30)	=SUM(F10:F30)	=SUM(G10:G30)	=SUM(H10:H30)

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1 NONE AT THIS TIME	=SUM(D37:H37)					
2	=SUM(D38:H38)					
3	=SUM(D39:H39)					
4	=SUM(D40:H40)					
5	=SUM(D41:H41)					
6	=SUM(D42:H42)					
7	=SUM(D43:H43)					
8	=SUM(D44:H44)					
9	=SUM(D45:H45)					
10	=SUM(D46:H46)					
11	=SUM(D47:H47)					
12	=SUM(D48:H48)					
13	=SUM(D49:H49)					
14	=SUM(D50:H50)					
15	=SUM(D51:H51)					
16	=SUM(D52:H52)					
17	=SUM(D53:H53)					
18	=SUM(D54:H54)					
19	=SUM(D55:H55)					
20	=SUM(D56:H56)					
INN Administratio	=SUM(D57:H57)	23000				
Total INN Program	=SUM(C37:C57)	=SUM(D37:D57)	=SUM(E37:E57)	=SUM(F37:F57)	=SUM(G37:G57)	=SUM(H37:H57)

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1 NONE AT THIS TIME	=SUM(D64:H64)					
2	=SUM(D65:H65)					
3	=SUM(D66:H66)					
4	=SUM(D67:H67)					
5	=SUM(D68:H68)					
6	=SUM(D69:H69)					
7	=SUM(D70:H70)					
8	=SUM(D71:H71)					
9	=SUM(D72:H72)					
10	=SUM(D73:H73)					
11	=SUM(D74:H74)					
12	=SUM(D75:H75)					
13	=SUM(D76:H76)					
14	=SUM(D77:H77)					
15	=SUM(D78:H78)					
16	=SUM(D79:H79)					
17	=SUM(D80:H80)					
18	=SUM(D81:H81)					
19	=SUM(D82:H82)					
20	=SUM(D83:H83)					
INN Administratio	=SUM(D84:H84)	23000				
Total INN Program	=SUM(C64:C84)	=SUM(D64:D84)	=SUM(E64:E84)	=SUM(F64:F84)	=SUM(G64:G84)	=SUM(H64:H84)

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: El Dorado Date: 6/9/14

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Program 1: Workforce Education and Training (WET) Coordinator	11,037	11,037				
2. Program 2: Workforce Development	49,825	49,825				
3. Program 3: Psychiatric Rehabilitation Training	0	0				
4. Program 4: Early Indicators of Mental Health Issues	50,000	50,000				
5. Program 5: Suicide Education and Training	50,000	50,000				
6. Program 6: Consumer Leadership Academy	600	600				
7. Program 7: Crisis Intervention Team Training	20,000	20,000				
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	4,975	4,975				
Total WET Program Estimated Expenditures	186,437	186,437	0	0	0	0

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Program 1: Workforce Education and Training (WET) Coordinator	15,000	15,000				
2. Program 2: Workforce Development	50,000	50,000				
3. Program 3: Psychiatric Rehabilitation Training	0	0				

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
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County: El Dorado Date: 6/9/14

4.	Program 4: Early Indicators of Mental Health Issues	45,000	45,000				
5.	Program 5: Suicide Education and Training	45,000	45,000				
6.	Program 6: Consumer Leadership Academy	1,000	1,000				
7.	Program 7: Crisis Intervention Team Training	0	0				
8.		0					
9.		0					
10.		0					
11.		0					
12.		0					
13.		0					
14.		0					
15.		0					
16.		0					
17.		0					
18.		0					
19.		0					
20.		0					
WET Administration		10,000	10,000				
Total WET Program Estimated Expenditures		166,000	166,000	0	0	0	0

	Fiscal Year 2016/17					
	A	**B**	**C**	**D**	**E**	**F**
	Estimated Total Mental Health Expenditures	**Estimated WET Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
WET Programs						
1. Program 1: Workforce Education and Training (WET) Coordinator	15,000	15,000				
2. Program 2: Workforce Development	50,000	50,000				
3. Program 3: Psychiatric Rehabilitation Training	0	0				
4. Program 4: Early Indicators of Mental Health Issues	40,000	40,000				
5. Program 5: Suicide Education and Training	40,000	40,000				
6. Program 6: Consumer Leadership Academy	1,000	1,000				
7. Program 7: Crisis Intervention Team Training	0	0				
8.	0					
9.	0					
10.	0					
11.	0					

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Workforce, Education and Training (WET) Component Worksheet

County: El Dorado Date: 6/9/14

12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	10,000	10,000				
Total WET Program Estimated Expenditures	156,000	156,000	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: El Dorado Date: 6/9/14

	Fiscal Year 2014/15					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Program 1: Electronic Health Record System Implementation	185,686	185,686				
12. Program 2: Telehealth (formerly Telemedicine)	129,000	129,000				
13. Program 3: Electronic Care Pathways	5,900	5,900				
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	11,515	11,515				
Total CFTN Program Estimated Expenditures	332,101	332,101	0	0	0	0

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					

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Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: El Dorado Date: 6/9/14

7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Program 1: Electronic Health Record System Implementation	190,000	190,000				
12. Program 2: Telehealth (formerly Telemedicine)	25,000	25,000				
13. Program 3: Electronic Care Pathways	5,900	5,900				
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	11,573	11,573				
Total CFTN Program Estimated Expenditures	232,473	232,473	0	0	0	0

	Fiscal Year 2016/17					
	A	**B**	**C**	**D**	**E**	**F**
	Estimated Total Mental Health Expenditures	**Estimated CFTN Funding**	**Estimated Medi-Cal FFP**	**Estimated 1991 Realignment**	**Estimated Behavioral Health Subaccount**	**Estimated Other Funding**
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. Program 1: Electronic Health Record System Implementation	190,000	190,000				
12. Program 2: Telehealth (formerly Telemedicine)	25,000	25,000				
13. Program 3: Electronic Care Pathways	5,900	5,900				
14.	0					
15.	0					
16.	0					

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Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: El Dorado Date: 6/9/14

17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	11,573	11,573				
Total CFTN Program Estimated Expenditures	232,473	232,473	0	0	0	0