County of El Dorado

Mental Health Services Act (MHSA)

Three-Year Plan

Covering Fiscal Years 2013-14 (upon Plan Approval), 2014-15 and 2015-16

Health and Human Services Agency

Mental Health Division

December 10, 2013

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 participated in the Mental Health Services Act (MHSA) Community Planning Process. The new MHSA programs were 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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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) has held community planning meetings to gather information from consumers, their families, providers, and community members throughout the County.

MHSA General Standards

Services provided under MHSA must integrate the following General Standards:[1]

(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."[2]

(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.

[1] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3320, General Standards.
[2] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3200.060, Community Collaboration.

(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.

(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."[3]

(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."[4]

(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."[5]

(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."[6]

(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."[7]

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

MHSA Plan Requirements

In November 2012, the Mental Health Services Oversight and Accountability Commission (MHSOAC) issued instructions for the Fiscal Year (FY) 2013-14 MHSA Plans.[8] The instructions summarized MHSA Plan requirements found within the MHSA and the Welfare and Institutions Code, including the stakeholder process (community planning process), public review, and information to include regarding programs, 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, deleted or amended, changes in revenues 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.

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)
  - 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.

[8] Mental Health Services Oversight and Accountability Commission, *FY 2013-2014 MHSA Annual Update Instructions*. November 2012. http://www.mhsoac.ca.gov/docs/FY%2013-14%20MHSA%20Annual%20Update%20Instructions%20FINAL.pdf.

Needs Assessments

Original MHSA Plans

The original MHSA Plans developed for El Dorado County identified specific areas of need within our communities. The initial assessments identified underserved populations within the Latino and Native American populations. From this, the PEI Health Disparities program developed. In more recent years, including during the community planning process for this FY 2013-14 MHSA Plan, additional unserved or underserved populations have drawn the focus of the community, including transitional age youth and older adults.

Within WET, the 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. A new El Dorado County Public Mental Health System Workforce Needs Assessment will be performed in the coming months and the results will be included in the FY 2014-15 MHSA Plan.

The 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 webpage.[9]

Barton Health

Barton Health completed its Community Health Needs Assessment (CHNA) Report for the South Lake Tahoe and surrounding communities in 2012. This CHNA identified "Mental Health & Mental Disorders" as one of the health priorities for the Barton Health service area, and "Mental Health" was identified as the top community health concern among community key informants.[10] The main issues discussed included shortage of psychiatrists and treatment facility options, stress management, stigma associated with mental illness, and individuals living with disabilities.[11] More information about the Barton Health CHNA, along with the complete report, can be accessed from http://www.bartonhealth.org/main/community-health.aspx.

Marshall Medical Center

As of the date of the draft MHSA Plan publication, Marshall Medical Center had not yet released its 2013 Community Health Needs Assessment Report for the West Slope of El Dorado County.

[9] El Dorado County, MHSA Plans Archive. http://www.edcgov.us/MentalHealth/MHSA_Plans.aspx.
[10] Professional Research Consultants, Inc. for Barton Health. *2012 PRC Community Health Needs Assessment Report.* 2012, pp. 12-13.
[11] *Ibid.* p. 41.

Demographics

El Dorado County encompasses a large geographic area (1,708 square miles, of which approximately 51% is U.S. Forest Service land[12]), with two incorporated cities (South Lake Tahoe and Placerville) and twelve unincorporated Census-Designated Places (CDPs)[13].

According to the 2010 census,[14] the population within the county is 181,058, which represents a 15.8% increase since the 2000 census. 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 (e.g., transportation to services, outreach to residents, and public awareness relative to available services).

Location	2010 Census Population[15]	Percent of County	Persons per Square Mile[15]
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

[12] Retrieved from http://www.fs.usda.gov/main/eldorado/about-forest, March 7, 2013.
[13] Retrieved from http://www.dof.ca.gov/research/demographic/state_census_data_center/census_2010/documents/2010Census_DemoProfile1.xls, June 25, 2013.
[14] 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.
[15] Retrieved from http://www.dof.ca.gov/research/demographic/state_census_data_center/census_2010/documents/2010Census_DemoProfile1.xls, June 25, 2013.

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).[16] Veterans represent approximately 9.8% of the population.

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:[17]

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).

[16] Gender distributions from U.S. Census Bureau data and compiled by Sacramento Area Council of Governments (SACOG).

[17] Age distributions from U.S. Census Bureau data and compiled by Sacramento Area Council of Governments (SACOG).

Poverty Levels in El Dorado County

The median household income in El Dorado County is $68,815.[18] However, economic disparities are evident across the county:

Place of Residence within the County	Median Household Income[19]	Percent of Individuals Below the Poverty line[20]
El Dorado Hills	$115,121	2.7%
Cameron Park	$72,562	4.3%
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%

A February 2012 report[21] to the California Department of Health Care Services (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 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 below the 200% poverty level, the need increases to approximately 19.5%.

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.[22] 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.[23]

[18] Median household income, U.S. Census Bureau 2007-2011 American Community Survey 5-Year Estimates. http://factfinder2.census.gov/.
[19] Median household income, U.S. Census Bureau 2007-2011 American Community Survey 5-Year Estimates. http://factfinder2.census.gov/.
[20] People of all ages in poverty - percent, U.S. Census Bureau 2007-2011 American Community Survey 5-Year Estimates. http://factfinder2.census.gov/
[21] Technical Assistance Collaborative, *California Mental Health and Substance Use System Needs Assessment* (February, 2012) at http://www.dhcs.ca.gov/provgovpart/Pages/BehavioralHealthServicesAssessmentPlan.aspx.
[22] 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.
[23] 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/.

Poverty Status in the Past 12 Months
2007-2011 American Community Survey 5-Year Estimates[24]

Includes All or Portion of Area	Includes All or Portion of Zip Code[25]	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
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

[24] 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.
[25] 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[25]	2007-2011 Population	% Population Below Poverty Level	Population Below Poverty Level
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

Community Planning Process

The general public and stakeholders were invited to participate in multiple MHSA community planning meetings in 2013 to contribute to the development of the County's FY 2013-14 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.

Public Meetings

A series of public meetings were held to discuss the MHSA Plan:

Date	Location	Topic
4/23/13	Greenwood - Community Center 4401 Highway 193	MHSA – Legislation, Funding, Annual Plans, Next Steps, General Questions

Date	Location	Topic
4/24/13	Placerville - Health and Human Services Agency (HHSA), Emergency Medical Services (EMS) Conference Room 415 Placerville Drive, Suite K	MHSA – Legislation, Funding, Annual Plans, Next Steps, General Questions
4/25/13	Cameron Park - Library 2500 Country Club Drive	MHSA – Legislation, Funding, Annual Plans, Next Steps, General Questions
4/26/13	El Dorado Hills - Library 7455 Silva Valley Parkway	MHSA – Legislation, Funding, Annual Plans, Next Steps, General Questions
4/26/13	South Lake Tahoe - Library 1000 Rufus Allen Boulevard	MHSA – Legislation, Funding, Annual Plans, Next Steps, General Questions
4/29/13	Somerset - Pioneer Park Community Center, 6740 Fair Play Road	MHSA – Legislation, Funding, Annual Plans, Next Steps, General Questions
5/2/13	Placerville - HHSA, EMS Conference Room 415 Placerville Drive, Suite K	Community Services and Supports (CSS)
5/6/13	Somerset - Pioneer Park Community Center, 6740 Fair Play Road	CSS
5/7/13	Greenwood - Community Center 4401 Highway 193	CSS
5/9/13	Cameron Park - Library 2500 Country Club Drive	CSS
5/10/13	El Dorado Hills - Library 7455 Silva Valley Parkway	CSS
5/10/13	South Lake Tahoe - Library 1000 Rufus Allen Boulevard	CSS
5/14/13	Greenwood - Community Center 4401 Highway 193	Prevention and Early Intervention (PEI)
5/15/13	Cameron Park - Fire Department 3200 Country Club Drive	PEI
5/16/13	Placerville - HHSA, EMS Conference Room 415 Placerville Drive, Suite K (morning and afternoon meetings)	PEI
5/17/13	South Lake Tahoe - Library 1000 Rufus Allen Boulevard	PEI
5/20/13	El Dorado Hills - Library 7455 Silva Valley Parkway	PEI
5/20/13	Somerset - Pioneer Park Community Center, 6740 Fair Play Road	PEI
5/22/13	Placerville - HHSA, EMS Conference Room 415 Placerville Drive, Suite K	Innovation (INN)
5/24/13	South Lake Tahoe - Library 1000 Rufus Allen Boulevard	INN

Date	Location	Topic
5/28/13	Greenwood - Community Center 4401 Highway 193	INN
5/29/13	Somerset - Pioneer Park Community Center, 6740 Fair Play Road	INN
5/30/13	Cameron Park - Library 2500 Country Club Drive	INN
5/31/13	El Dorado Hills - Library 7455 Silva Valley Parkway	INN
6/3/13	El Dorado Hills - Library 7455 Silva Valley Parkway	Workforce Education and Training (WET)
6/3/13	Somerset - Pioneer Park Community Center, 6740 Fair Play Road	WET
6/4/13	Greenwood - Community Center 4401 Highway 193	WET
6/5/13	Cameron Park - Fire Department 3200 Country Club Drive	WET
6/6/13	Placerville - HHSA, EMS Conference Room 415 Placerville Drive, Suite K	WET
6/7/13	South Lake Tahoe - Library 1000 Rufus Allen Boulevard	WET
6/12/13	Greenwood - Community Center 4401 Highway 193	Capital Facilities and Technology Needs (CFTN) and review of previous topics if requested
6/13/13	Cameron Park - Fire Department 3200 Country Club Drive	CFTN and review of previous topics if requested
6/17/13	El Dorado Hills - Library 7455 Silva Valley Parkway	CFTN and review of previous topics if requested
6/17/13	Somerset - Pioneer Park Community Center, 6740 Fair Play Road	CFTN and review of previous topics if requested
6/19/13	Placerville - HHSA, EMS Conference Room 415 Placerville Drive, Suite K	CFTN and review of previous topics if requested
6/20/13	South Lake Tahoe - Library 1000 Rufus Allen Boulevard	CFTN and review of previous topics if requested
7/22/13	Somerset - Pioneer Park Community Center, 6740 Fair Play Road	Proposed PEI Programs
7/23/13	Greenwood - Community Center 4401 Highway 193	Proposed PEI Programs
7/24/13	Placerville - HHSA, EMS Conference Room 415 Placerville Drive, Suite K	Proposed PEI Programs
7/25/13	South Lake Tahoe - Library 1000 Rufus Allen Boulevard	Proposed PEI Programs
7/26/13	El Dorado Hills - Library 7455 Silva Valley Parkway	Proposed PEI Programs

Each public meeting consisted of two parts. During the first part of the meeting, attendees were provided with an overview of the identified topic (e.g., CSS, PEI) from an MHSA project team member, including a review of the component requirements, current programs, and anticipated revenues and expenditures. The second part was a discussion format where attendees could ask questions and receive answers, provide input on existing programs and expenditures, and identify potential new programs. Although turnout was relatively low for these meeting, they opened discussion with the community regarding MHSA and paved the way for future planning efforts to expand participation.

MHSA staff attended other meetings or individual/small group meetings to discuss the MHSA Plan, gather input on the mental health needs of our community, or discuss specific programs/projects. These groups/meetings included:

- Commission on Aging
- El Dorado County Office of Education
- El Dorado County Health and Human Services Agency, Mental Health Division, Adult Services and Children's Services
- Multidisciplinary Adult Services Team (MAST)
- El Dorado County Continuum of Care
- Community Strengthening Coalition / First 5
- El Dorado County Veteran Affairs
- El Dorado County Health and Human Services Agency, Child Welfare Services
- El Dorado County Health and Human Services Agency, Public Health, Public Health Nurses Team
- El Dorado Hills Community Vision Coalition Executive Advisory Committee
- Health Connections Advisory Board
- Diamond Springs El Dorado Community Advisory Committee
- Barton Health Community Advisory Committee

During the course of the community planning process, emails and notices about the MHSA process and events were also distributed, advising the recipients of new postings on the MHSA webpage, upcoming meetings, news and events, and publication of documents.

Discussion at the public, collaborative and individual meetings, and subsequent feedback received, revealed the following community priorities:

- Services for children;
- Services for older adults;
- Locally provided services;
- Suicide prevention;
- Stigma and discrimination reduction;
- Comprehensive resource bank development (including promotion of the available information); and
- Community-based coordination of mental health resources and services.

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 over 600 individuals on the email distribution list who received notifications regarding the community planning process and MHSA updates.

Input from these stakeholder groups was received during the community planning process, either through attendance at one or more of the public meetings, collaborative meetings, individual meetings, survey response, or via telephone calls. The majority of the participants at the public meetings were families of consumers, education and providers of services (primarily mental health and alcohol and drug service providers). Consumers were primarily involved in the community planning process through survey instruments. Participation by each stakeholder group included:

- adults and seniors with severe mental illness – public meetings, surveys.
- families of children, adults and seniors with severe mental illness – public meetings, surveys, emails, one-on-one meetings.
- providers of services – public meetings, surveys, emails, meetings.
- law enforcement agencies – one-on-one discussion.
- education – public meetings, surveys, emails, meetings.
- social services agencies – public meetings, surveys, emails, one-on-one discussions.
- veterans – public meetings, one-on-one discussion.
- representatives from veterans organizations – one-on-one discussion.
- providers of alcohol and drug services – public meetings, surveys, emails, one-on-one discussions.
- health care organizations – public meetings, surveys, small group meetings.
- other interested individuals – public meetings, surveys, one-on-one meetings.

MHSA Surveys

During the community planning process, four surveys were distributed. The surveys can be found in Attachment B.

Older Adults Survey

This survey was distributed between May and early July 2013, to the El Dorado County Commission on Aging, the El Dorado Hills and Placerville Senior Centers, and to the recipients of home-delivered meals throughout the County. One hundred sixty-two (162) surveys were returned to the MHSA Program Team. The survey revealed transportation and cost were two key considerations for older adults in seeking mental health services. Other concerns identified were impact to others, not knowing where to start and the stigma associated with mental health. Older adults indicated they would prefer to receive information about mental health in a doctor's office, at a community center, via mail or in their home, whereas they would prefer to receive mental health services in their home, at a doctor's office or at a community center, primarily through individual appointments. The full results of this survey are included in Attachment B.

Wellness Center Survey

This survey was distributed in June 2013, to the Wellness Centers in South Lake Tahoe and Placerville. Thirty-six (36) responses were received, of which 53% were women and 47% were men. Of the 35 responses to the attendance question, a majority of the respondents (18 individuals/51%) indicated attendance at least three or four days per week. Activities of interest included:

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

Activity	% of Respondents Who Would Participate
Games	53%
Relationship Skills	53%

The full results of this survey are included in Attachment B.

Prevention and Early Intervention (PEI) Proposed Programs

In July 2013, the Prevention and Early Intervention Proposed Programs survey was distributed. There is approximately $1,000,000 available annually for PEI programs, the actual amount of which varies slightly from year to year. Through the community planning process, approximately $2,500,000 in proposed PEI programs was identified. To help identify the highest need within our community, the PEI Proposed Programs survey was developed to assist in gathering input. Public meetings were also held to gather additional input.

Individuals who wished to respond to the PEI proposed programs were not required to utilize the survey, and some did not, but through the survey, 57 responses were received. An additional four individuals/organizations submitted specific comments via email, one individual submitted general questions that were answered during a public meeting, and there were

numerous emails received indicating support for having the Children 0-5 and Their Families project implemented through the Infant-Parent Center.

For each proposed PEI project, the public was asked to comment on:

- Should this program be funded under PEI?
- Should the funding level be different than proposed? If so, what should it be?
- Other than funding level, do you have any suggested changes to this proposed program or should this program be combined with another program to maximize funding and services?

Based on the information received through this survey, emails and the public meetings, the PEI projects to be included with this Plan were identified and their descriptions refined. These programs are identified under the PEI component below.

Workforce Development Survey

This survey 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 eight responses were received (one from El Dorado Hills, five from Placerville and two from South Lake Tahoe). Responses came from a cross-section of stakeholders, with the following stakeholder groups having one respondent each: Consumer; Family of Consumer; Education; Social Services Agency; Mental Health Provider; Alcohol and Other Drugs (AOD) Provider; Health Care Provider; and one identified as Other. No responses were received from stakeholders from Law Enforcement, Veterans, or Veteran Organizations. Highest ratings were received for:

Training / Format	Scale of 1-5 (with 5 being highest)
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

Public Notification of the Draft FY 2013-14 MHSA Plan

HHSA provided notification of the Draft FY 2013-14 Plan publication as follows:

- **FY 2013-14 Plan and Public Hearing:** The Draft FY 2013-14 MHSA Plan was posted on the County's website on September 30, 2013 for a 30-day review period. Emails were sent on September 30, 2013 to the MHSA distribution list, the Mental Health Commission members, the Chief Administrative Office (CAO), the Board of Supervisors' offices, and the Mental Health Division staff advising recipients that the Draft FY 2013-14 MHSA Plan was posted and available for public comment, and that a public hearing is scheduled for October 30, 2013. Press releases were distributed during the week of September 30, 2013, to

various media outlets, including the Tahoe Daily Tribune, Mountain Democrat, Georgetown Gazette, Sacramento Bee, Village Life and El Dorado Hills Telegraph.

- **El Dorado County Board of Supervisors:** This Plan will be presented to the El Dorado County Board of Supervisors for adoption on December 10, 2013. Notification of the date was posted on the MHSA web page[26] and will be included on the Board of Supervisors agenda for December 10, 2013.

- **California Mental Health Services Oversight and Accountability Commission (MHSOAC):** Within 30 days of the Board of Supervisors' approval of the FY 2013-14 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.	*Comment:* How long is this MHSA Plan active? Can it be amended?
	Response: 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, deleted or amended, changes in revenues 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. The above information has been incorporated into the "MHSA Plan Requirements" section. The community planning process for the FY 2014-15 MHSA Plan Update will begin in January 2014, with an anticipated implementation date of July 1, 2014. During that process, project outcomes will be reviewed, new projects may be identified, and existing projects may be changed or eliminated.
2.	*Comment:* In order to implement this plan, the ability to recruit and retain quality staff will be a determining factor in its success.
	Response: Adequate staffing levels within the public mental health system is key to a strong mental health system. As noted in the "Staffing Levels" section, projects and activities will be implemented to the extent that trained and licensed staff are available. Staff retention continues to be an area of focus for HHSA, and HHSA is moving forward with recruiting critical staff to provide services provided through the Mental Health

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

	Division.
3.	*Comment:* Please break out the results of the Wellness Center survey by slope.
	Response: The survey results have been updated to reflect the West Slope, South Lake Tahoe and both slopes combined in Attachment B.
4.	*Comment:* I have seen an increase in the number of students at our school, who need mental health intervention at an earlier age. As an educator I cannot teach a child until that child feels safe, and mentally secure in their school environment. We have numerous students who are coming from split families, dysfunctional home environments and possible drug use of either or both parents. These students have behavior issues which in turn detract from their learning and disrupt our classroom environment.
	Response: MHSA cannot fund all mental health needs within a county, nor is MHSA designed to fill that role. MHSA is not "the mental health system", but rather plays a supporting role through the development and funding of certain projects. The El Dorado County Office of Education is a key partner in providing services for children, as are primary care physicians, community health clinics and other faith- and community-based service providers who receive their funding though a multitude of funding sources. Addressing issues within the family unit as early as possible, even before starting school, was identified in the community planning process as a priority need. Two new PEI programs have been added for this reason: • Children 0-5 and Their Families: Provided through the Infant-Parent Center in Cameron Park, this program will provide families with children in the 0-5 age-range (perinatal to five years) living in El Dorado County with services. • Mentoring for 3-5 Year Olds: Provided through Big Brothers Big Sisters on the west slope and in the Tahoe Basin via a provider to be determined through a competitive procurement process, this program is designed to recruit, screen and train adults and older adults to mentor at-risk, unserved, and underserved children living in El Dorado County. In three communities, children in kindergarten through third grade may be able to participate in the Primary Intervention Project. However, school age children experiencing mental health issues should be directed to their schools and their health care providers for referrals to other appropriate service providers based upon the unique needs of each child.
5.	*Comment:* The premise of the plan is that lower income people suffer more mental illness, which is inaccurate.
	Response: 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 as described within each

	project. However, research has shown that there is a higher prevalence of mental illness in households that are considered low-income.[27] 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 over twice the poverty level."[28]
General – Location of Service Provision	
6.	*Comment:* I oppose the Mental Health Services Act (MHSA) plan for 2013-16 and insist that it be revised to include services to El Dorado Hills and Cameron Park.
	Response: The FY 2013-14 Three-Year Plan includes services for residents who may meet project criteria, including residents in El Dorado Hills, Cameron Park and all other areas of the County. MHSA staff attempted to learn from the commenter which portion of the MSHA Plan excluded El Dorado Hills and Cameron Park, but did not receive a response. MHSA staff could not identify any text in the MHSA Plan that stated those communities were excluded from participation in the MHSA Plan. The eligibility criteria for each project is specified within the project's description. Eligibility for participation in a project is different than where services for a project will be delivered. 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 comment (e.g., NAMI training on the west slope only); 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). MHSA does not fund projects based on County-wide population dispersal rates. 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. PEI Programs are available in the following locations:

[27] 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." Psych Central.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.

[28] 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.

Program/Project	Service Delivery Location
Program 1: Youth and Children's Services	
Project 1a: Children 0-5 and Their Families	Cameron Park, or other locations if facilities available
Project 1b: Mentoring for 3-5 Year Olds	Countywide based on available facilities and location of volunteers
Project 1c: Incredible Years	At least one class in each of the six regional areas of the County based on demand
Project 1d: Primary Intervention Project (PIP)	Specific schools in the El Dorado Hills, Georgetown Divide, and South Lake Tahoe area
Project 1e: SAMHSA Model Programs	County-wide in schools
Program 2: Community Education Project	
Project 2a: Mental Health First Aid	County-wide based on requests and facility availability
Project 2b: National Alliance on Mental Illness Training	West slope based on requests and facility availability
Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education	County-wide based on requests for materials
Project 2d: Community Information Access	County-wide through internet site
Project 2e: Suicide Prevention and Stigma Reduction	County-wide
Project 2f: Foster Care Continuum Training	County-wide based on demand and results of competitive procurement process
Project 2g: Community Outreach and Resources	County-wide
Program 3: Health Disparities Program	
Project 3a: Wennem Wadati - A Native Path to Healing	Placerville, schools and other community-based sites that are accessible to the Native American population on the west slope
Project 3b: Latino Outreach	South Lake Tahoe and west slope throughout local communities

Program 4: Wellness Outreach Program for Vulnerable Adults	
Project 4a: Wellness Outreach Ambassadors and Linkage to Clubhouse Membership	South Lake Tahoe and Diamond Springs
Project 4b: Senior Peer Counseling	Placerville, clients' homes and other community meeting places on the west slope; future plans include exploring how services may be expanded to or developed for the Tahoe basin
Project 4c: Older Adult Program	County-wide based on demand
Program 5: Community-Based Services	
Project 5a: Community-Based Mental Health Services	County-wide based on demand
Project 5b: Community Health Outreach Worker	County-wide based on demand and results of competitive procurement process

CSS projects are available in the following locations:

Program/Project	Service Delivery Location
Program 1: Youth and Family Strengthening Program	
Project 1a: Youth and Family Full Service Partnership	Countywide based on clients' location and needs
Project 1b: Family Strengthening Academy	Countywide based on clients' location and needs, service provider location, and available facilities
Project 1c: Foster Care Enhanced Services	Countywide based on clients' location and needs
Program 2: Wellness and Recovery Services	
Project 2a: Wellness Centers	South Lake Tahoe and Diamond Springs
Project 2b: Adult Full Service Partnership	Countywide based on clients' location and needs
Project 2c: Older Adults Program (Partner program to PEI Older Adults Program)	Countywide based on clients' location and needs

	Program 3: Transitional Age Youth (TAY) Services	
	Project 3a: TAY Engagement, Wellness and Recovery Services	Countywide based on clients' location and needs
	Program 4: Community System of Care	
	Project 4a: Outreach and Engagement Services	Countywide
	Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)	Countywide based on clients' location and needs
	Project 4c: Resource Management Services	Countywide
7.	*Comment:* There is a huge need in El Dorado Hills. There have been three suicides at Oak Ridge High School and several kids since that have attempted suicide. There is currently nowhere in El Dorado Hills to send these kids to receive help.	
	Response: Please see response to comment 26 relative to suicide prevention. As is common with many rural counties, services may not be located in each community, or if services are provided locally, they may require out-of-pocket payments or insurance co-payments. Many other communities in El Dorado County, and in fact most rural counties, face this situation, but the business locations selected by services providers cannot be directed by the MHSA. There are trained therapists in El Dorado Hills and other areas of the County who provide mental health services, but they may elect to do so through insurance networks or private pay arrangements, which is beyond the scope of MHSA. "The MHSA addresses a broad continuum of prevention, early intervention and service needs and provides funding for the necessary infrastructure, technology and training elements that will effectively support the local mental health system."[29] MHSA is not "the mental health system." It is not a substitute for services that may be available through primary care physicians, referrals for specialty mental health services, or insurance networks. For MHSA-funded projects, the focus is on locally provided services. Please see response to comment 7 for more information about service location for MHSA-funded projects. No matter where an individual lives, all appropriate avenues of services and support should be pursued, whether through schools, primary care physicians, community health clinics, faith- or community-based services, MHSA projects, or other service providers.	
8.	*Comment:* There are many children dealing with very traumatic issues who never received counseling, even though their parents may have had the means. There is a great unmet need in El Dorado Hills.	
	Response: Please see the response to comments 6 and 7 relative to service locations.	

[29] 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.

	MHSA is not a substitute for services that may be available through primary care physicians, referrals for specialty mental health services, or insurance networks. Parents must be active participants in supporting and addressing a child's mental health needs. A key element in encouraging individuals to seek mental health treatment, whether for themselves or for their children, is addressing the stigma long associated with mental illness, and a required element of PEI projects is stigma reduction. Additionally, the Statewide MHSA PEI Stigma and Discrimination Reduction program also works to reduce stigma. Once mental illness becomes more understood as a medical issue and historical stigma is reduced, those in need of services will hopefully be more willing to seek services.
General – Stakeholder Process	
9.	*Comment:* I recommend that the El Dorado County MHSA Coordinator work with the El Dorado Hills Community Vision Coalition and its partners to revise the plan to ensure these universally needed services are funded equitably throughout our county.
	Response: Working solely with one organization to develop the MHSA Plan is contrary to the direction of the MHSA. The MHSA requires input from stakeholders representing varying interests. As defined in California Code of Regulations, Title 9, Division 1, Chapter 14, Section § 3200.270: "Stakeholders" means individuals or entities with an interest in mental health services in the State of California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families. During the community planning process prior to publication of the draft MSHA Plan, and during the 30-day comment period and public hearing on the draft MHSA Plan, the public was encouraged to provide input on the projects to be provided through MHSA, including the funding to be allocated, the types of services, the eligibility criteria, and the service delivery locations for the projects. The El Dorado Hills Community Vision Coalition participated in the community planning process, submitted four PEI project proposals, submitted written comments, and spoke at the public hearing. Additionally, the MHSA Program Manager attended multiple Executive Advisory Committee meetings of the El Dorado Hills Community Vision Coalition. All input was considered as part of the community planning process. Of the four PEI projects submitted by the El Dorado Hills Community Vision Coalition, three were incorporated into the MHSA Plan, either as individual projects or within the scope of other projects. One PEI project proposal submitted by the El Dorado Hills Community Vision Coalition, along with eight other PEI project proposals submitted through the community planning process, was unable to be included in the MHSA Plan due to lack of funding.

10.	*Comment:* The process for decision-making and writing the MHSA Plan was unfair, inequitable, and did not include adequate representation from El Dorado Hills' residents, stakeholders, parents, youth, community organizations, schools, local government, and local mental health professionals familiar with the needs of El Dorado Hills. The County MHSA input meetings were not adequate and did not obtain the input needed from a large cross section of people. The meetings were held at the wrong times, mostly at 10 am, and very few people attended. MHSA staff should tell us how many people attended each meeting and what sector of the community they represented.
	Response: Please see the section "Public Meetings" for a list of public meetings offered and other meetings attended by MHSA staff. In addition to the public meetings, MHSA staff attended meetings hosted by other organizations or individual/small group meetings to discuss the MHSA Plan, gather input on the mental health needs of our community, or discuss specific programs/projects. While turnout for the MHSA public meetings was low, as has been identified in this MHSA Plan, representatives from the required stakeholder groups had the opportunity to provide input into the MHSA Plan and the information learned from this year's community planning process can be applied to the next community planning process to increase participation rates. In addition to the input received from El Dorado Hills Community Vision Coalition on behalf of its members, other input received from El Dorado Hills identified the need for services for older adults and one individual identified service support for Veterans as a potential need. Additionally, individuals from the Senior Center in El Dorado Hills participated in a survey to provide input on the service barriers and preferred service locations for Older Adults. It is important to remember that input may be received from a variety of sources, not just at a public meeting or through a single organization. Notification regarding the community planning process was released via a press release, distributed via the MHSA email distribution list to over 600 individuals, and posted on the MHSA web page. Flyers were developed and posted on the MHSA web site to allow community partners to distribute them to their networks. There were 91 attendees who signed in at the public meetings (56 unique individuals), representing a cross-section of the required stakeholder groups. Where there was no stakeholder group representation at the public meetings, individuals representing those interests were sought out by MHSA staff and met with on an individual or small group basis. The "Stakeholder Representation" portion of the plan identifies how each stakeholder group participated in the community planning process as follows: • adults and seniors with severe mental illness – public meetings, surveys. • families of children, adults and seniors with severe mental illness – public meetings, surveys, emails, one-on-one meetings. • providers of services – public meetings, surveys, emails, meetings. • law enforcement agencies – one-on-one discussion. • education – public meetings, surveys, emails, meetings. • social services agencies – public meetings, surveys, emails, one-on-one discussions. • veterans – public meetings, one-on-one discussion. • representatives from veterans organizations – one-on-one discussion.

	• providers of alcohol and drug services – public meetings, surveys, emails, one-on-one discussions. • health care organizations – public meetings, surveys, small group meetings. • other interested individuals – public meetings, surveys, one-on-one meetings Additionally, the public was notified of the opportunity to comment on the proposed PEI projects through emails from HHSA to over 600 individuals and a posting on the County's News and Hot Topics web page that resulting in over 1,100 individuals receiving an email notification of the opportunity to comment. Despite these notifications and postings, only 61 individuals elected to respond to the request for comments on the PEI proposed projects, of which 34% came from the El Dorado Hills/Cameron Park area. **Location of Residence — Total** Cameron Park....6 Camino....2 Cedar Grove....1 Coloma....1 Cool....1 Diamond Springs/El Dorado....2 El Dorado Hills....15 Garden Valley....2 Georgetown....4 Greenwood....3 Grizzly Flats....1 Placerville....11 Pleasant Valley....2 Rescue....1 Shingle Springs....2 Somerset....2 South Lake Tahoe....2 Other Unincorporated Area....1 Out of County / Work in County....1 Out of County / Work Location Unknown....1 **Total....61**
11.	*Comment:* Input from El Dorado Hills and the El Dorado Hills Community Vision Coalition was ignored and not reflected in the MHSA plan. Community members from all sectors of El Dorado Hills gave input and recommendations to MHSA staff. The MHSA staff heard the input first hand, such as: 1. A parent of a teen who committed suicide who spoke at one meeting, school counselors and assistant principals who spoke at other meetings stating there is high need for MHSA services in El Dorado Hills. Myrna Harp, Counselor at Marina Village Middle School, and Michelle Witt, MFT for the PIP program for Elementary Schools spoke about the needs in El Dorado Hills. 2. Our coalition said there are too many teen suicides in El Dorado Hills.

	3. Our Coalition said we want Prevention and Early Intervention programs in El Dorado Hills. 4. Our coalition said we want the PIP program in elementary schools in El Dorado Hills. 5. Our coalition we said we need mental health counselors in middle schools and at Oak Ridge high school in El Dorado Hills for prevention and early intervention. 6. Our coalition said we want community mental health services (community support services) for families in El Dorado Hills, not 20 miles away. 7. Our coalition said we want equity in funding for Board of Supervisors District One and El Dorado Hills. 8. Our coalition was under the impression that El Dorado Hills and Board of Supervisors District One would have an equitable allotment of funding and services compared to the rest of the county and Board of Supervisors districts. It was our impression that our community input would be listened to, and we could decide the best use of those funds for our community. We gathered the input, and received commitments and agreements from our schools and community mental health services providers.
	Response: Input from all communities and stakeholder was considered but as discussed during the meetings and in this MHSA Plan, there is a limited amount of funding available and therefore, not all projects could be funded. Please see response to comment 24 for additional information. Based on the input received during the County-wide community planning process, along with MHSA requirements and the available data, this MHSA Plan includes 18 new projects to address the identified needs. These new projects largely focus on the local provision of services, to the extent possible. Specifically related to the eight items identified in the comment: 1. There is an expressed need for general mental health services throughout the County, not just in El Dorado Hills. However, MHSA is not "the mental health system" nor was it designed to be, but MHSA funding can help support the mental health system. There is limited funding subject to certain restrictions within each component. All other avenues of receiving mental health services should be pursued, including the use of insurance networks, primary care physicians, schools, and faith- or community-based services. 2. There are two new suicide prevention projects included in the MHSA Plan (Suicide Prevention and Stigma Reduction (PEI) and Suicide Education and Training (WET)). Please see response to comment 26 related to suicide prevention. 3. All PEI programs are available to residents of El Dorado Hills, provided they meet the eligibility criteria for those programs. However, where projects require specific facilities, residents of El Dorado Hills and the rest of the County will need to go to those facilities (e.g., Wellness Center is in Diamond Springs) or travel to other regional central points to participate (e.g., Incredible Years classes offered in six regional locations throughout the County). 4. El Dorado Hills is one of only three communities to receive funding for PIP through a competitive procurement process.

	5. Not all PEI projects submitted through the community planning process could be included in the MHSA Plan. As was discussed during the MHSA community planning meetings, there is limited funding available. There was approximately $2,500,000 in PEI projects up for consideration, with only approximately $1,000,000 in annual revenues (supported by an approximate $1,200,000 fund balance that could be utilized for one-time-only projects, initial start-up costs or project that do not require continued funding for sustainability). 6. As is common with many rural counties, services may not be located in each community, or if services are provided locally, they may require out-of-pocket payments or insurance co-payments. Many other communities in El Dorado County, and in fact most rural counties, face this situation, but the business locations selected by services providers cannot be directed by the MHSA. There are trained therapists in El Dorado Hills and other areas of the County who provide mental health services, but they may elect to do so through insurance networks or private pay arrangements, which is beyond the scope of MHSA. However, when services are funded through MHSA, the preference expressed by all communities was to have those services provided locally. Therefore, this MHSA Plan focuses on community-based service provision to the extent possible. For example, for those individuals who meet the criteria to receive services through CSS (and thus qualify for therapeutic interventions), several projects are included in the MHSA Plan that allow for the provision of services in a community-based setting, including: • 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; and • Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services). 7. Funding is allocated by project for those who meet eligibility criteria for the project, regardless of where an individual may live. For those projects that have a geographic component to them, such as the PIP program, that is a result of the competitive procurement process outcome based upon the responses received from service providers interested in delivering the requested services. 8. Please see response to item 7. Additionally, during the community planning process, it was discussed that there is limited MHSA funding and that all projects may not be able to be included in the plan. MHSA services are to address the needs of those who meet eligibility criteria for the project, and funding for services is not allocated based upon general population percentages of any specific area but rather allocated to each project to help those who meet the eligibility criteria.
12.	*Comment:* We were under the impression that funding and services would be equitably allocated for each Board of Supervisors District and our input was needed for how to best use our district allocation.

	That would mean of the $6,000,000 annually that the State gives El Dorado County, a portion of that would go to Board of Supervisors District One, El Dorado Hills, in various categories. A portion would go to District two that includes Cameron Park for various categories. With over $1,000,000 annually for Prevention and Early Intervention, we expect a proportion similar to our population size. We have 25% of the population, so $250,000 per year would be a reasonable expectation for El Dorado Hills. There is still over $750,000 for PEI and $5,000,000 of MHSA funds for the rest of the County.
	Response: The County receives approximately $5,000,000 annually in MHSA funds, with the remaining $1,000,000 received from Medi-Cal reimbursements for MHSA-funded services previously provided through CSS. Allocation of funding by Supervisor Districts was never presented during the community planning process, and has not been the way in which MHSA funding is allocated in El Dorado County. MHSA funds are allocated by target populations through individual projects, not based on overall population rates of a geographic area. The target population for each project is identified based on the needs identified through the community planning process, and it is to those residents meeting the criteria for the projects that services are provided. For example, the budget for the Older Adults project in PEI is $75,000 and $250,000 in CSS. In the County, there are 39,494 individuals age 60+.[30] Any Older Adult who meets the eligibility criteria for the project may access these services. Since 17% of the older adults in the County live in the El Dorado Hills CDP,[4] it could be that 17% of the funding goes toward serving Older Adults in El Dorado Hills CDP. However, it is not mandated that 17% of funding be reserved for the El Dorado Hills CDP. Rather, the funds are used to provide the services to those meeting the eligibility criteria regardless of where they live, which could mean that the El Dorado Hills CDP could receive more than 17% of the funding for that project if demand is high for the services or less if demand for the services is lower. The key is to provide the services to those who need the services, not reserve the funding for a specific area based on a percent of general population.
General – Procurement of Services	
13.	*Comment:* Why do some projects have both the County and the Contracted Vendor box checked? How will we know where the money goes?
	Response: Programs currently operated by County staff may transition to contract providers through a procurement process. In such circumstances, it is generally noted that this may occur in the future. When contracted vendors perform services, the County staff must continue compliance and outcome monitoring, as well as perform other administrative tasks (e.g., contracting, accounting). In such circumstances, it is generally noted as "County Staff Support". Project performance outcomes are reported annually in the MHSA Plan/Update, which will indicate who performed the service.

[30] Retrieved from http://www.dof.ca.gov/research/demographic/state_census_data_center/census_2010/documents/2010Census_DemoProfile1.xls, June 25, 2013.

General – Funding	
14.	*Comment:* The draft plan should not be approved until references recommending funding to only small rural communities and poverty level census tracts are deleted.
	Response: Funding is spread throughout the County based on residents' eligibility for services (as described in the project description) and services are not limited to those living in small rural areas or census tracts with higher poverty levels. Please see the response to comments 6 and 7 relative to service locations throughout the County. County demographics are a required element of the MHSA Plan. Removing demographic information about poverty level within the County would conflict with the instructions provided by the MHSOAC for preparation of an MHSA Plan (see Attachment A). However, to help better understand the data within the demographics section, the Census Tract numbers have been replaced with the community name and the table has been updated to include number of individuals not just percent of individuals.
15.	*Comment:* Over the years, the County has asked for public comment on what the needs of the community are, but then it seems that the money always ends up going back to the County.
	Response: MHSA funding can only be utilized for MHSA programs; MHSA funding is not available for other County programs. Although MHSA funding has not be fully utilized in the past, the remaining revenues become what is called a "fund balance." Fund balances are accessed for all components through this MHSA Plan. Please see Attachment C for more details about the revenues, expenditures and remaining fund balances. MHSA-funded programs will be performed by community-based organizations and the County Mental Health Division, along with volunteers for both types of organizations. The entity to provide the services is identified in each project description. During the FY 2013-14 community planning process, the public identified the following needs: • services for children; • services for older adults; • locally provided services; • suicide prevention; • stigma and discrimination reduction; • comprehensive resource bank development (including promotion of the available information); and • community-based coordination of mental health resources and services. It is believed that the FY 2013-14 MHSA Plan incorporates projects to address these needs. Services will either be delivered via community-based organizations or the County as noted within the description for each project.
16.	*Comment:* Can money shift between programs once a MHSA Plan has been approved?
	Response: There is 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 to be addressed. The amount of funding able to be shifted depends

	upon the component and is determined on a case-by-case basis to verify the shift complies with the requirements set forth in Information Notice 10-04.[31] Shifting funding within a component in excess of the amount allowed by Information Notice 10-04 or between components, to the extent allowed by the MHSA, requires a community planning process and Plan Update. Per Welfare and Institutions Code Section 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. Funds may not be transferred into PEI. This MHSA Plan includes shifting funds from CSS to WET and CFTN in FY 2014-15 and FY 2015-16.
17.	*Comment:* What is the impact to CSS programs in FY 14-15 and FY 15-16 when money is proposed to be moved from CSS to WET and CFTN?
	Response: There is no anticipated impact to CSS services because there is a significant CSS fund balance. Based upon the expenditures identified in this plan, there will be in excess of $2,000,000 in CSS fund balance remaining at the end of FY 2015-16.
18.	*Comment:* Attachment C reflects $130,000 in "Off-setting Expenditures (Medi-Cal, Insurance, Private Payor)" under CFTN. Is that correct?
	Response: There are no offsetting expenditures in CFTN. The error has been corrected in Attachment C.
Prevention and Early Intervention - General	
19.	*Comment:* Prevention and Early Intervention (PEI) funds should provide for ALL socioeconomic areas and be made available in centers of highest population in order to serve the most people.
	Response: PEI projects are designed to address the preventative and early mental health needs of individuals and families, provided those individuals/families meet the project's eligibility criteria, whether they live in a population center or in a sparsely populated area of the County. Focusing funding in an area of higher population does not necessarily mean more people will receive services because individuals must meet eligibility criteria to receive services. PEI projects are designed to be community-based, when feasible, and provided to individuals/families based on eligibility criteria, not based on population centers. Please see response to comment 6 for more information about service location.
20.	*Comment:* The MHSA plan does not adequately give data about the need for prevention and early intervention for the school age population. The Report to Congress from the U.S. Department of Health and Human Services, Center for Mental Health Services states that "half of all lifetime cases of diagnosable mental illness begin by age 14, and three fourths by age 24. Focusing promotion and prevention efforts on children and their parents or other care givers increase the

[31] California Department of Health Care Services, MHSD Information Notice 10-04, page 3. March 16, 2010. http://www.dmh.ca.gov/prop_63/mhsa/Publications/Notices.asp.

	likelihood that mental health problems in children will be addressed early, before they can evolve into full-blown mental illnesses, including substance abuse." The plan should focus "Prevention and Early Intervention" funding on children and youth in schools, fairly and equitably, in each Board of Supervisors District.
	Response: 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: • 45% is allocated to projects addressing the needs of children (from birth through age 18) or children and their families; • 8% is allocated to projects specifically designed to address the needs of older adults (age 60+); • 32% is allocated to programs that may benefit all ages in the community; and • 15% is allocated to projects to educate the community and provide resource linkage (e.g., Suicide Prevention, Mental Health First Aid, Community Outreach and Resources). These PEI projects are available to eligible residents throughout the County, except where limited geographically due to the outcome of a competitive procurement process (e.g., PIP). There are also two countywide WET programs that focus specifically on the mental health needs of children by training educators about early identification of mental illness and suicide prevention. Educators are with children on a daily basis, and although contracted vendors have staff already trained in mental health, they are with the children on a limited basis. Training educators in the identification of risk factors and warning signs, and when to make a referral to a mental health professional, is key to early identification of mental health issues, and the mental health professionals can then focus on providing treatment to the children.
21.	*Comment:* The County Office of Education should work with rural schools, not schools in major population centers. This is the normal way County Offices provide services to rural communities with other State funding. They do not try to provide services in the jurisdiction of major population centers. In El Dorado Hills, Prevention and Early Intervention services should be provided through a local community organization, such as the El Dorado Hills Community Vision Coalition, that has already established Memorandums of Understanding and agreements between schools and mental health providers, and can implement the programs easily, quickly, and effectively. The schools already work directly with our coalition, and the programs are wanted by parents, students, staff, and administrators. In El Dorado Hills, the Coalition has already obtained agreements with parent educators, training sites, and other services that are cost effective, and can be implemented easily, and effectively.
	Response: Of the five PEI projects that specifically address the needs of children and their families, four will be implemented through community-based organizations. The fifth

	project, SAMHSA Model Programs, is to be implemented through the El Dorado County Office of Education (EDCOE) so that there will be an opportunity to access SAMHSA programs with consistent messaging available for all schools. Through this program EDCOE will focus on anti-bullying, reducing substance abuse, and developing positive behaviors in youth to help improve the mental health of school-aged children. If individual community-based organizations were to purchase SAMHSA Model Programs only for those schools they served, there would be higher than necessary costs for organizational-based licenses.
22.	*Comment:* There should be parent education programs equitable in each Board of Supervisors District.
	Response: The Incredible Years project is to be held a minimum of six times annually, with one class occurring in each community region based on demand: • 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).
23.	*Comment:* The El Dorado Hills Community Vision Coalition wants PEI programs in our schools and community including: 1. Primary Intervention Program in elementary schools to prevent and reduce emotional problems of children (PIP). 2. Early Intervention programs for youth at Rolling Hills and Marina Village Middle Schools, and at Oak Ridge High School to prevent and reduce emotional and social health issues and to prevent cutting, thoughts of suicide, and suicide attempts of youth and teens. (Early Intervention for Youth). 3. Parent education for parents to prevent and reduce emotional problems of children, youth, and teens (Incredible Years). 4. Mental Health Counseling for families and adults locally in El Dorado Hills.
	Response: All communities have service priorities, but there is limited funding available. Not all wants and needs can be funded through MHSA, especially with PEI projects. Therefore, even though a community may identify a priority service need, it does not mean that the project will be able to be funded through MHSA. Relative to item 1, please see response to comment 28. Item 2 is identified as the "Early Intervention Program for Youth" project is to continue through June 30, 2014 only. Other community-based projects (Community-Based Mental Health Services (PEI), Suicide Prevention and Stigma Reduction (PEI), Early Indicators of Mental Health Issues (WET), and Suicide Education and Training (WET)) will supplement

	this project effective upon MHSA Plan adoption, and fully replace this project effective July 1, 2014. Item 3, Incredible Years, is included in this MHSA Plan, both in the El Dorado Hills area and other areas in the County. Relative to item 4, please see the response to comment 7 relative to service provider locations. For those individuals who meet the criteria to receive services through CSS (and thus qualify for therapeutic interventions), several projects are included in the MHSA Plan that allow for the provision of services in a community-based setting, including: • 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; and • Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services).
24.	*Comment:* The request from El Dorado Hills Community Vision Coalition for counselors was not included in the MHSA plan.
	Response: Of 27 proposed PEI projects, 19 were able to be funded through the limited PEI funding. The following eight proposed PEI projects were not included in the MHSA Plan: • Community-Based Support Groups • Behavioral Care Manager • Latino Outreach Tahoe Basin Expansion • Stigma and Discrimination Reduction • Mental Health 101 • Parent and Youth Partner Program • Mental Health Professionals in Schools in El Dorado Hills • Community Mental Health Coordinator During the community planning process, participants were encouraged to comment on existing PEI projects and submit new projects that would address the mental health needs of the unserved and underserved populations in the County. All CSS, WET and CFTN projects were able to be funded in the FY 2013-14 Three-Year MHSA Plan due to sufficient funding levels. It was discussed in the public meetings that the County receives approximately $1,000,000 in PEI revenues annually to be utilized for PEI projects that require ongoing funding, and the PEI fund balance could be utilized to fund one-time-only projects, higher start-up costs, or other short-term duration projects. It was also discussed that not all PEI project proposals could be funded if the amount of expenditures for those projects exceeded annual revenues.

	Public input resulted in the identification of 27 proposed PEI projects (nine existing and 18 new), which would have required annual funding in excess of $2.5 million. The 27 proposed PEI projects were posted for public review and comment, and public meetings were held for in-person discussions regarding the proposed PEI projects. The public was notified of the opportunity to comment on the proposed PEI projects through emails from HHSA to over 600 individuals and a posting on the County's News and Hot Topics web page that resulting in over 1,100 individuals receiving an email notification of the opportunity to comment. Although the response level was low, comments generally aligned with the priorities identified during the community planning process. Of the 27 proposed PEI projects, 19 were funded based upon the needs identified during the community planning process, the comments received on the proposed PEI projects, the purpose and intent of MHSA, and the available PEI revenues and fund balance. All projects receiving a positive response of 56% or higher were able to be funded through MHSA and were in line with community priorities and the purpose and intent of the MHSA. One current project that received lower than 56% approval rate was included in the plan due to MHSA requirement to address health disparities within our community, and one new project that received lower than 56% approval was included due to the identified need for increased coordination of services between health care providers and mental health providers, especially in light of the Affordable Care Act. All PEI projects, as well as all other projects within the MHSA Plan, will be re-evaluated during the next community planning process scheduled to begin in January 2014.
25.	*Comment:* Nationally, the highest rate of suicide is in the older adult population. More programs for older adults should be included and Senior Peer Counseling expanded.
	Response: Please see response to comment 26 relative to suicide rates in El Dorado County. This MHSA Plan includes three projects designed to address the specific needs of older adults (age 60+): • Senior Peer Counseling: $35,000 in FY 2013-14, $45,000 in FY 2014-15, $55,000 in FY 2015-16; • Older Adults Project (PEI): $75,000 in FY 2013-14, $80,000 in FY 2014-15, $85,000 in FY 2015-16; and • Older Adults Project (CSS): $250,000 annually. Additionally, older adults may be included in all projects designed for the adult population or the general public, provided they meet the eligibility criteria for the project. Increased funding and/or additional projects to address the needs of older adults can be considered during the FY 2014-15 MHSA Plan Update.
Prevention and Early Intervention – Suicide Prevention	
26.	*Comment:* El Dorado Hills and Cameron Park are being excluded from the plan. There were 3 suicides in 2012 all from Oak Ridge High School. Those suicides have been devastating and have had ripple effects on the kids and adults in the community.
	Response: Please see the response to comments 6 and 7 relative to provision of services in El Dorado Hills and Cameron Park.

	Suicide is a concern across all age ranges within the County and across all areas of the County, and one suicide or suicide attempt is one too many. This Plan includes two suicide prevention projects, and services under these projects are to be provided countywide. PEI – Suicide Prevention and Stigma Reduction: The services under this project are to be provided via various media, public service announcements (PSAs), printed materials, speakers or other methods. Its purpose is to increase awareness and access to services, identify how and when to access mental health services, and reduce stigma in seeking mental health services, with the anticipated outcome of preventing suicide. The messages may be adapted for specific target audiences, such as youth or older adults, but the message of suicide prevention needs to be delivered to all members of El Dorado County. This project will collaborate with the Statewide MHSA Suicide Prevention program. Data from the California Department of Public Health[32] reflects that from 2006 through 2011, El Dorado County experienced 182 deaths due to suicide. **Age Total** **Age Total** 5-14 .....1 55-64 .....35 15-24 .....8 65-74 .....14 25-34 .....18 75-84 .....10 35-44 .....34 85+ .....9 45-54 .....53 TOTAL.....182 More recent data (2012+) is not yet available. WET - Suicide Education and Training: Through this project, El Dorado County Office of Education (EDCOE) will identify and/or develop online training modules and resources that will be designed to empower educators throughout the County to identify early warning signs and risk factors for suicide and refer students to appropriate clinical staff. Educators spend a significant amount of time with children and youth and may become aware of warning signs and risk factors for suicide before parents, other adults or friends become aware.
Prevention and Early Intervention – Primary Intervention Project	
27.	*Comment:* The Request for Proposal issued as a result of the FY 2012-13 MHSA Plan Update included two semesters of PIP. Since the PIP agreements won't be in place to allow two semesters during this fiscal year, can the PIP program be extended through December 30, 2014 to allow for two semesters of PIP to be completed?
	Response: The change has been incorporated into the FY 2013-14 MHSA Plan. There is no net impact to the budgeted expenditures since two semesters of PIP were already anticipated. The only shift is to the PIP implementation time line.
28.	*Comment:* Students have positively benefitted from the PIP program and funding for this program should continue. This program has allowed local schools to identify children

[32] California Department of Public Health, Health Information and Strategic Planning, Vital Statistics Query System. http://www.apps.cdph.ca.gov/vsq/default.asp.

	with mental health issues early and provide them with local services to be successful in school. PIP should be continued, and available in all schools.
	Response: PIP funding will continue through December 30, 2014 and continuation or expansion of PIP beyond December 30, 2014 will be considered during the FY 2014-15 community planning process. In FY 2012-13, PIP averaged approximately $21,000 per school ($192,511 for nine schools). To enable PIP to be in all schools serving grades K-3, it could require in excess of $800,000 annually. While within the revenues received for PEI on an annual basis, the project would consume approximately 80% of the total PEI revenues and would require the majority of other PEI programs be discontinued.
Prevention and Early Intervention - Community Education Projects	
29.	*Comment:* Per NAMI-El Dorado County (South Lake Tahoe), South Lake Tahoe does not want to receive any of the funding that has been proposed for NAMI training.
	Response: The service location for this training is identified as "West slope; in local communities based on demand."
Community Services and Supports	
30.	*Comment:* "Priority shall be given to populations that are unserved." (CSS Adult Full Service Partnership (FSP) Program description). Based on mental illness prevalence rates for El Dorado County with a population of around 181,000, there are approximately 11,000 – 12,000 Adults with a severe mentally illness/seriously emotionally disturbed (6.5%) in our county. As of 9/17/2013, El Dorado County Health and Human Services Agency, Mental Health Division, was serving fewer than 700 adults and children county wide. It would seem our priority should be finding and resolving those barriers that are denying access to so many.
	Response: A variety of mental health providers are located throughout the county and in neighboring counties. The Mental Health Division contracts with the State to provide specialty mental health services, not general mental health services, and primarily serves individuals on Medi-Cal. Individuals with private insurance generally seek mental health services through their insurance networks, and the public and the Mental Health Division would be unaware of the level at which mental health services are accessed. Examples of other methods of accessing mental health services include Medicare providers (for those on Social Security), CMSP providers, primary care physicians, community health clinics, hospitals, schools, faith-based programs, and employee assistance programs. Additionally, it is important to note that absent court involvement, participation in mental health services in voluntary in nature. The California Department of Health Care Services identified that as of October 2011, approximately 20,421 individuals (or 11% of the County's population) was on Medi-Cal, which would indicate that between 939 (4.6%) and 1,817 (8.9%) individuals may be in need of specialty mental health services through the Mental Health Division via Medi-Cal.[33,34]

[33] California Department of Health Care Services, Current Mental Health Information Notices – 2013, MHSD Information Notice No. 13-09, http://www.dhcs.ca.gov/formsandpubs/Pages/Mental_Health-InfoNotices-CY.aspx.

	Those without insurance may also receive medically-necessary services (as determined by a mental health assessment) through the Mental Health Division. A key element in encouraging individuals to seek mental health treatment is addressing the stigma 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 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. The Older Adults Survey (see Attachment B) revealed that the barriers to services within this age group included transportation and cost. Other concerns identified were impact to others, not knowing where to start and the stigma associated with mental health. These issues are important to consider when designing and implementing the MHSA programs, but MHSA funding cannot resolve all barriers.
31.	*Comment:* Stable, affordable, and supportive housing for FSP clients is essential for successful treatment, and lack of housing is a continuing problem that can only be addressed through community and county action. Without stable housing, our ICM programs will have smaller chance of success.
	Response: Affordable housing for FSP clients continues to be a priority. One of the purposes of the resource specialist on the Intensive Case Management (ICM) team is to help identify housing options for FSP clients.
32.	*Comment:* More money should be spent on transitional housing.
	Response: Please see response to comment 31 above. The Mental Health Division greatly appreciates the property owners who provide transitional housing and continues to monitor additional transitional housing opportunities that may arise. This MHSA Plan identifies over $2,000,000 for Adult and Transitional Age Youth FSP services, which may include housing support in addition to clinical services. The FSP programs work closely with clients to achieve recovery and independence, through a "whatever it takes" model. Helping individuals with severe mental illness obtain financial independence, to the extent possible, is in line with the recovery model of service provision, but housing support may be available for FSP clients if necessary. If additional funding is necessary for client transitional housing, it can be considered during the FY 2014-15 MHSA Plan Update.
33.	*Comment:* Under "Outreach and Engagement Services" there is mention of "Graduates of the Consumer Leadership Academy". Is this program discontinued? If so, this paragraph should be eliminated.
	Response: Consumer Leadership Academy has not been discontinued, but was moved from the PEI component to the WET component as Program 6. The Consumer Leadership Academy was expanded in this Plan to include a focus on both life skills and employment readiness, and post-Academy assistance with finding volunteer and/or job

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

	opportunities for Academy graduates. Thus, the project aligned more accurately with the WET component.
34.	*Comment:* Transportation will continue to be a challenge, even more so with the relocation of the West Slope Mental Health Clinic and Wellness Center to Diamond Springs. The Division has shown creativity and determination in trying to meet the needs of clients with the Temporary Shuttle Service, but it remains as a clear barrier to services in areas of our county.
	Response: The County continues to work with El Dorado Transit related to public transportation, not just for Mental Health Division clients, but for all individuals who seek County services and utilize public transportation. Specific to the Mental Health Division, the budget for Outreach and Engagement has been increased to assist clients with initial and continued engagement in services at the Diamond Springs and South Lake Tahoe locations. In Diamond Springs, a new bus stop is under construction, which is anticipated to be installed by the time this Plan is adopted by the Board of Supervisors. Historically, services provided through traditional Mental Health funding have been fairly limited in service provision area due to the nature of the funding. However, through MHSA funding, the provision of services in the community becomes possible, provided there are appropriate, safe and available locations to provide those services, as well as an adequate number of service providers (including the Mental Health Division) and staff to reach all communities. The FY 2013-14 MHSA Plan includes projects in response to public input received during the community planning process that locally provided services are a priority need.

MHSA Funding

MHSA revenues in FY 2013-14 are projected to be consistent with or slightly higher than in FY 2012-13. The revenue and expenditure data contained in this Plan is based upon projections for FY 2013-14. In the event the actual revenues are higher than anticipated, the additional funding may be utilized to support the projects identified in this Plan in the current fiscal year, if necessary, or rolled into the FY 2013-14 fund balance to be utilized on projects identified in the FY 2013-14 Plan. In the event the actual revenues are lower than anticipated, the County will access fund balances remaining from previous years should it be necessary.

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

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

Funding Methodology

On August 7, 2013, DHCS released MHSD Information Notice 13-15, which identifies the "Methodology for Distributions to Local Mental Health Services Fund".[35] 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 2013-14, which is anticipated to be approximately $6,025,786. Additional funding, attributed to the MHSA programs as offsets to expenditures, is available from private payors, Medi-Cal or other insurance reimbursements for services provided through a MHSA program. Interest on funds already received but not yet expended and Public Safety Realignment 2011 (AB109) are identified as additional revenue sources.

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.[36] The annual revenues identified for each MHSA component is based upon revenues received in prior fiscal years and estimated MHSA revenues identified in the State's budget and by the MHSA organizations and their consultants.

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 2011-12 is due to the State by October 25, 2013.[37]

Budgeted Revenues and Expenditures by Component

FY 2013-14 Revenues	CSS[38]	PEI	INN	WET	CFTN
MHSA[39]	$4,660,288	$1,066,068	$299,430	--	--
Public Safety Realignment 2011 (AB109)	$110,000	--	--	--	--
Interest	$30,000	--	--	--	--
Total Revenues	$4,800,288	$1,066,068	$299,430	--	--

MHSA Administration is budgeted to receive an additional $20,893 in Medi-Cal reimbursements in FY 2013-14.

In addition to the FY 2013-14 revenues identified above, 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.

[35] 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.
[36] 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.
[37] California Department of Mental Health, Information Notice 13-17, *MHSA Revenue and Expenditure Report for FY 2011-12*, August 21, 2013. http://www.dhcs.ca.gov/formsandpubs/Pages/Mental_Health-InfoNotices-CY.aspx.
[38] Does not include the CSS-Housing sub-component as those funds have already been transferred to CalHFA.
[39] Health and Human Services Agency Mental Health Division Approved FY 2013-14 Budget.

FY 2013-14 Fund Balance	CSS[40]	PEI[41]	INN	WET	CFTN
Starting Fund Balance	$4,430,880	$1,225,284	$1,065,944	$360,026	$706,901

A summary of expenditures by component is as follows:

FY 2013-14 Expenditures	CSS[42]	PEI	INN	WET	CFTN
MHSA Programs	$6,150,000	$1,552,011	TBD (through separate process)	$305,000	$385,900
Off-setting Expenditures (e.g., Medi-Cal, Insurance, Private Payor)	($1,116,510)	--	--	--	--
Contribution to Prudent Reserve	$601,716	--	--	--	--
Total Expenditures	$5,635,206	$1,552,011	TBD	$305,000	$385,900

For more detail regarding MHSA allocations and expenditures, please see the individual components and Attachment C.

Transfer of Funds Between Components

Welfare and Institutions Code Section 5892(b) allows counties to use a portion of their CSS funds for Workforce Education and Training (WET), Capital Facilities and Technology (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 contribute to the Prudent Reserve in FY 2013-14, 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 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

[40] Does not include the CSS-Housing sub-component as those funds have already been transferred to CalHFA.
[41] Includes $1,203,584 in PEI and $21,700 in PEI-TTACB.
[42] Does not include the CSS-Housing sub-component as those funds have already been transferred to CalHFA.

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 mid-year approval date of this Plan, funds allocated but unspent in FY 2013-14 will roll from FY 2013-14 into FY 2014-15 for new projects. Starting with FY 2015-16, projects that have been in operation for at least one calendar year will maintain at an annual budget amount without any rollover. Existing projects will continue on an annual budget without any rollover.

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

FY 2013-14	$75,000
FY 2014-15	$75,000
FY 2015-16	$75,000

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

FY 2013-14 and FY 2014-15	$150,000 (with FY 2013-14 not to exceed $75,000)
FY 2015-16	$75,000

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. The balance of the County's Prudent Reserve in FY 2013-14 is $1,898,284. It is not anticipated that the County will utilize the Prudent Reserve funds in FY 2013-14. 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 total contribution to the Prudent Reserve, transfer to WET, and transfer to CFTN in a single year may not exceed 20% of the total average amount of funds allocated to that County for the previous five years. The County intends to transfer $601,716 into the Prudent Reserve in FY 2013-14. This represents approximately 16% of the average funds allocated to the County for the previous five years ($3,781,721). This FY 2013-14 contribution will bring the total funding in the Prudent Reserve to $2,500,000.

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.[43]

Staffing Levels

Key to success of this Plan is adequate staffing levels, both within the Health and Human Services Agency Mental Health Division and through our contracted service providers. Projects and activities will be implemented to the extent that adequate staffing is available.

MHSA Components

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

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

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

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. [44]

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.

[44] Welfare and Institutions Code Section 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.[45] The proposed regulations have several steps to complete prior to adoption and implementation.[46] 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 Procedures Act;
- based on the MHSA;
- outcomes-focused; and
- flexible: supports county/community .priorities and wisdom.[47]

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/).

[45] The proposed PEI regulations, as of September 18, 2013, can be found at http://mhsoac.ca.gov/Meetings/docs/Meetings/2013/PEI_091913_Regs.pdf.
[46] For more information about the regular rulemaking (regulation) process, see http://www.oal.ca.gov/Regular_Rulemaking_Process.htm.
[47] 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 2013-14.

Total anticipated annual revenues for PEI are $1,066,068. PEI receives only MHSA funds (i.e., no Medi-Cal reimbursement).

The future level of MHSA funding is unknown, therefore this Plan will anticipated the same revenues annually for the term of this Plan, and will adjust revenues in future Plan Updates as needed.

As of the beginning of FY 2013-14, the remaining PEI fund balance from previous fiscal years is $1,225,284. 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.

For more detail regarding MHSA allocations and expenditures, please see Attachment C.

PEI Programs

Program/Project	FY 13/14 Expenditures[48]	FY 14/15 Expenditures[48]	FY 15/16 Expenditures[48]	FY 13/14 % of Expenditures	0-5	Elementary School	Middle School	High School	Adults	Older Adults	Families	All Ages
Program 1: Youth and Children's Services												
NEW Project 1a: Children 0-5 and Their Families	$125,000	$125,000	$125,000	8.1%	✓						✓	
NEW Project 1b: Mentoring for 3-5 Year Olds	$75,000	$75,000	$75,000	4.8%	✓ 3-5						✓	
Project 1c: Incredible Years	$50,000	$50,000	$50,000	3.2%	✓ 2-5	✓ <12					✓	
Project 1d: Primary Intervention Project (PIP)	$106,350	$106,350	TBD	6.9%		✓ K-3						
NEW Project 1e: SAMHSA Model Programs	$192,500	$100,000	$100,000	12.4%		✓	✓	✓				
Program 2: Community Education Project												
Project 2a: Mental Health First Aid	$35,000	$35,000	$35,000	2.3%				✓ 16+	✓	✓		
Project 2b: National Alliance on Mental Illness Training	$10,000	$10,000	$10,000	0.6%					✓	✓		
Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education	$5,000	$5,000	$5,000	0.3%			✓	✓	✓	✓		
Project 2d: Community Information Access	$10,000	$12,000	$14,000	0.6%				✓	✓	✓		

[48] Expenditures reflect a planned use of the fund balance.

Program/Project	FY 13/14 Expenditures[48]	FY 14/15 Expenditures[48]	FY 15/16 Expenditures[48]	FY 13/14 % of Expenditures	0-5	Elementary School	Middle School	High School	Adults	Older Adults	Families	All Ages
NEW Project 2e: Suicide Prevention and Stigma Reduction[49]	$30,000	$30,000	$30,000	1.9%								✓
NEW Project 2f: Foster Care Continuum Training	$50,000	$50,000	$50,000	3.2%					✓	✓		
NEW Project 2g: Community Outreach and Resources	$20,000	$10,000	$10,000	1.3%								✓
Program 3: Health Disparities Program												
Project 3a: Wennem Wadati - A Native Path to Healing	$125,725	$125,725	$125,725	8.1%								✓
Project 3b: Latino Outreach	$231,128	$231,128	$231,128	14.9%								✓
Program 4: Wellness Outreach Program for Vulnerable Adults												
Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness[50]	$50,000	$50,000	$50,000	3.2%					✓	✓		
NEW Project 4b: Senior Peer Counseling	$35,000	$45,000	$55,000	2.3%						✓		
NEW Project 4c: Older Adult Program[50]	$75,000	$80,000	$85,000	4.8%						✓		
Program 5: Community-Based Services												
NEW Project 5a: Community-Based Mental Health Services[50]	$75,000	$75,000	$75,000	4.8%								✓

[49] Partners with a Workforce Education and Training (WET) program.
[50] Partners with a Community Services and Supports (CSS) program.

Program/Project	FY 13/14 Expenditures[48]	FY 14/15 Expenditures[48]	FY 15/16 Expenditures[48]	FY 13/14 % of Expenditures	0-5	Elementary School	Middle School	High School	Adults	Older Adults	Families	All Ages
NEW Project 5b: Community Health Outreach Worker	$35,000	$35,000	$35,000	2.3%								✓
Administrative Costs												
Per Department of Mental Health Information Notice 10-01[51]	$216,308	$171,578	$174,128	13.9%								
Total Proposed PEI Programs/Projects (includes planned use of fund balance)	$1,552,011	$1,421,781	$1,334,981									

[51] 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/MentalHealth-InfoNotices.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)	West Slope • Service provider's offices • Client's home • Other venues convenient for clients • Community events, fairs, festivals such as Kids Expo, etc. • Educational settings • Faith-based organizations	
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	

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

	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. **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[52]

[52] 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

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

Procurement Method	Sole source to the Infant-Parent Center.
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

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

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 CPS 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
Number of Services / Quantity of Service	1,400 client contact hours annually. As a new program, there were no results to report from FY 2012-13.
Budget	Up to $125,000 annually on a reimbursement basis. 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 Tahoe Basin - To be identified	
Project Duration	Ongoing	
Activities Performed	**Outreach:** Collaborate with El Dorado County Office of Education (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 (CBO) 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 (BBBS) nationally recognized evidence-based program with parent, teacher, and mentor to target activities that meet the child's	

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

	individual needs. • On the west slope, each individual match (adult / older adult and child) case managed by a BBBS professional staff. • 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. • Mentors and 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
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Support[53] 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.

[53] 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: BBBS Youth Outcomes Survey and Strength of Relationship survey 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. As a new program, there were no results to report from FY 2012-13.
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.

Project Name: Incredible Years 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	The Incredible Years (IY) program, an evidence-based practice, is generally a 12- to 14-week program that offers weekly 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 ☒ Older Adults ☐ All Ages
	Children ages 2-12 and their parents	
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:** The Incredible Years Program is a set of comprehensive, multi-faceted, and developmentally-based curricula targeting 2-12 year old children and their parents. This strategy addresses the role of multiple interacting risk and protective factors in the development of conduct disorders. This intervention strategy thereby serves as a violence prevention strategy. Each program component is designed to work interactively with the others to promote emotional and social competence and prevent, reduce and treat behavioral and emotional problems in young children.	

Project Name: Incredible Years 1c

Services Provided By	☒ Contracted Vendor ☐ Volunteers ☒ County Staff Support[54]
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., El Dorado Hills, North County, South County, Pollock Pines, South Lake Tahoe, Placerville) as necessitated by demand. In FY 2012-13, there were no active contracts for IY services.
Budget	Up to $50,000 annually on a reimbursement basis.

[54] 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)	In fiscal year 2012-13, the following school districts had PIP: • 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. Feedback from those schools that have PIP and the parents whose children have participated in PIP has been positive, however there was concern expressed during the community planning process that students enrolled in PIP may be receiving duplicate mental health services through other programs, that PIP is not an evidence-based practice, that it is only available in limited locations in the county, and that schools with the highest need may not have PIP. It has since been determined that PIP is an evidence-based practice. PIP will be further explored during the FY 2014-15 MHSA community planning process to determine whether it will be continued going forward. Under the FY 2012-13 MHSA Plan Update, PIP was identified as a program to be contracted via a Request for Proposals (RFP), with the resulting contracts having a term through June 30, 2014. The County is in the process of rating and ranking the responses received. Due to the RFP reflecting that PIP would be provided for two semesters, PIP will be	

Project Name: Primary Intervention Project 1d

	included in the MHSA Plan through December 31, 2014, and further explored during the FY 2014-15 MHSA community planning process for continuation beyond that date.
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. **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[55]

[55] 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

Procurement Method	Competitive procurement process The outcome of the competitive procurement process resulted in contracts to be awarded to: • 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
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. The results of the WMS assessments for each school district implementing PIP in FY 2012-13 is available upon request. Overall, the WMS assessments reflected improvement for the majority of the children enrolled in PIP.
Budget	Up to $212,700 in calendar year 2014 on a reimbursement basis.

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	Ongoing	
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[56] El Dorado County Office of Education, and its volunteers
Procurement Method	Sole source to El Dorado County Office of Education (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). As a new program, there were no results to report from FY 2012-13.
Budget	Up to $192,500 in FY 2013-14 on a reimbursement basis. Up to $100,000 in FY 2014-15 and FY 2015-16 annually on a reimbursement basis. EDCOE will commit ongoing in-kind contributions of administrative oversight, staff time, technology, and resources to support this PEI plan.

[56] 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: 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.	
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 12-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. * Mental Health First Aid USA is reducing the training from 12 hours (multiple day of training) to 8 hours (one day of training) per session. This could result in higher demand for the training.

Project Name: Mental Health First Aid 2a

Services Provided By	☒ Contracted Vendor[57] ☒ Volunteers ☒ County Staff Mental Health First Aid Certified Instructors, who are County employees or community volunteers. Currently, there are five County employees and one community volunteer certified in Mental Health First Aid. Contracted vendor staff will be utilized if they are certified Mental Health First Aid instructors.
Procurement Method	Services provided by Health and Human Services Agency 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.
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.

[57] 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

Number of Services / Quantity of Service	Estimated at nine or more Mental Health First Aid courses annually based on community demand, each class providing training to 12 to 30 individuals. Anticipated training level to be approximately 18 sessions per year, resulting in training for approximately 400 individuals, or more, per year. In FY 2012-13, there were 9 classes attended by 166 individuals.
Budget	Annual cost is estimated at $35,000. MHSA funds would be utilized for the following types of expenses: Books $5,000 Staff Time $23,250 Mileage, Supplies, Refreshments $750 Instructor Training $5,000 Equipment $1,000 Total $35,000 Includes: Books: Books for each participant (approximately $20 per person). Staff Time: County 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. Mileage, Supplies, Refreshments: 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). Instructor Training: Cost to certify additional Mental Health First Aid instructors, and/or expanding the certification of current Mental Health First Aid instructors, including but not limited to registration fees, travel, accommodation, and staff time. Equipment: 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. Other costs not identified above may be necessary to effectively implement and monitor the project.

Project Name: National Alliance on Mental Illness Training 2b

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 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.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☒ Adults ☒ Older Adults ☐ All Ages
Service Location(s)	West slope; in local communities based on demand	
Project Duration	Ongoing	
Activities Performed	**Outreach:** Outreach will be accomplished by increasing the awareness of mental health issues through training to the community and providers. **Access and Linkage to Medically Necessary Care:** Training provided by NAMI will provide information to families and caregivers regarding linkage to mental health services available in the community. **Stigma and Discrimination Reduction:** Increasing the dialogue about mental health through training provided to families, caregivers, providers and the community at large will be done in an effort to increase knowledge and understanding about mental illness, which will work towards the reduction of stigma and discrimination. **Activities:** Expansion and diversity in the types of classes provided by NAMI to the community, including increasing capacity by expanding the network of local instructors. Courses include: • Train-the-Trainer • Provider Education Program • Program Training for HHSA Staff and Community Members • Peer-to-Peer Training • NAMI Basics Education • Family-to-Family	

Project Name: National Alliance on Mental Illness Training 2b

	• In Our Own Voice Reimbursements include but are not limited to class registration costs, facilities costs, travel, class preparation costs (including marketing), administrative costs in support of class offerings, refreshments, and stipends for class presenters.
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Support[58]
Procurement Method	Sole source – NAMI
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. • Increase family coping skills, networks and resiliency.
Outcome Measures	Measurement 1: Increased number of NAMI volunteers trained as trainers. Measurement 2: Increased number of parents, caregivers and community providers receiving NAMI training.
Number of Services / Quantity of Service	Anticipated up to four classes annually within contract amount. There were no MHSA funded NAMI trainings in FY 2012-13.
Budget	Up to $10,000 annually on a reimbursement basis.

[58] 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: 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	Parents, Families, Friends of Lesbians and Gays (PFLAG) provides outreach, education and training to mental health providers and interested community members. 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 for improving their knowledge of the subject and to share with their clients. The Mental Health Division 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 Mental Health Division by PFLAG. **Access and Linkage to Medically Necessary Care:** Attendees may self-refer to services. **Stigma and Discrimination Reduction:** Education, in the form of	

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

	presentations/discussions, to the general public regarding sexual orientation. PFLAG raises awareness about mental wellness and stigma and discrimination reduction for the 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. **Activities:** Volunteers will provide the information kits together with a short presentation to the target audience in partnership with community-based organizations.
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	Publication materials ordered in FY 2012-13 included the following booklets: 400 *Safe Schools*, 100 *Faith in our Families*, 100 *Our Daughters and Sons*, 50 Spanish *Our Daughters and Sons*, and 50 Spanish *Be Yourself*. Materials are distributed to community-based partners, including education, as requested.
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 Mental Health Division web site. 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 Community Access Site (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	

Project Name: Community Information Access 2d

	• Workforce skills • Issues related to older adults • 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[59] 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 Mental Health Division continues to work with the vendor on determining the actual number of users and site access frequency.

[59] 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 $10,000 for the first year. Approximately $12,000 for the second year. Approximately $14,000 for the third year. 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[60]
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.
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.

[60] 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

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. As a new program, there were no results to report from FY 2012-13.
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, 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 Protective Services (CPS), foster family agency staff and CPS staff. **Access and Linkage to Medically Necessary Care:** Parents/guardians and foster parents will be provided with information regarding how to obtain services for themselves and their children. **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:** Training of foster parents, families involved with CPS, foster family agency staff and CPS staff to address behaviors linked to the core issues and functions driving child and adult behavior. Teach foster parents, parents/guardians and staff easy but useable behavioral tracking. Training to develop foster parents to be mentors. Training to develop parents/guardians to be mentors.	

Project Name: Foster Care Continuum Training 2f

Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Support[61]
Procurement Method	Competitive procurement process
Short-Term Goals	• Improve accountability of behavior. • Improve foster parent, 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.
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. As a new program, there were no results to report from FY 2012-13.
Budget	Up to $50,000 annually on a reimbursement basis.

[61] 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 List.
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. As a new program, there were no results to report from FY 2012-13.
Budget	Approximately $20,000 in FY 2013-14. Approximately $10,000 in FY 2014-15 and FY 2015-16. Costs include staff, administration, overhead, printing materials, 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 (NARC) 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 youth, 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[62] 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.

[62] 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 a student 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. In FY 2012-13, 317 individuals received services through the Foothill Indian Education Alliance.
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 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
	Latino Children, Adults and Families	
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.	
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. Services in the Tahoe Basin also include, but are not limited to: • The Brief Strategic Family Therapy program is a short-term, problem focused therapeutic intervention targeting children and adolescents and their families that improves youth behavior by eliminating or reducing drug use and its associated behavior problems, and changes the family members' behaviors that are linked to both risk and protective factors related to substance abuse. • The Families and Schools Together is a family strengthening and parent involvement program. It is a multi-component, non-curricular family-strengthening program using multi-family group interaction to build relationships, impart values and norms, and empower parents to become the primary protective agents for their children. • Parabajitos groups cover a variety of topics that improve a child's functioning at his/her highest potential in school, the community and at home. Groups are arranged loosely in age-appropriate configurations, with play and expressive arts modalities liberally employed for the youngest participants, and for the adolescent participants, these groups address any number of intra-psychic and/or interpersonal issues that can make adolescence a challenging and at times, a painful transition. Dialogue, self-reflective activities,

	expressive arts and workshop formats are employed, and summer programs focus on therapeutic and cognitive recreation. • Parent and Child Together/Parent and Child Interactive Literacy Activities- This group focuses on developing the notion of parents as a child's first and most important teacher. Activities focus on parents as primary transmitters of healthy socio-behavior, physical health and nutrition, literacy development, and character building for their children. Parents engage with their children in activities that engender belongingness, attachment, inter-generational respect, curiosity for learning, English Language Learner preschool preparedness activities, and fun and laughter. Parents spend about 20 - 30 minutes reading and doing hands-on activities with their children, and then discuss the process and its applicability in their lives. • Incredible Years (ages 3-8) - In "Los Años Increibles" groups, parents, and group leaders work together to find new ways to help parents relate to their children, manage challenging behaviors, and improve social competence and school readiness. Parents meet with other parents to explore new strategies for interacting with their children. Parents support each other, share ideas, practice new skills, and problem solve together to meet their goals for their families. Parents watch and discuss video vignettes of parent-child interactions, practice new skills in the group and at home, and work with leaders to individualize the program content to their child's goals. Leaders guide the discussion, present new material to the group, and provide parents with information on child development. Parents learn new skills to manage their child's behavior, make new friends with other parents, and help their child be successful at home and school. Groups meet 2 hours weekly for 12-14 sessions. Child care and snacks are provided during group sessions. Groups are geared to parents of children between 3-8 years old. • Cafecitos is school based parent /teacher participation program exposing parents to a broad range of learning opportunities and experiences. Program participants are learning to address issues through open dialog, instead of reverting to isolation. • Kinship Care classes support resilience of families, and has served as a haven to those whose isolation had brought their families to the breaking point emotionally, physically, or economically. It continues to provide a safe place for parents/grandparents, and extended family to learn and grow, and develop their life skills, and share what they have learned with others. 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 • Health and Human Services Agency, 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.

Project Name: Latino Outreach 3b

	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 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[63] Tahoe Basin: South Lake Tahoe Family Resource Center (previously awarded through a competitive procurement process) West Slope: Competitive Procurement Process In Process

[63] 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

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 Health and Human Services Agency, Mental Health Division, 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.
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. In FY 2012-13, 526 individuals received services through this program (388 in South Lake Tahoe and 138 on the West Slope).
Budget	Up to $231,128 annually on a reimbursement basis, consisting of: • Tahoe Basin $135,128 (current contract) • 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 Mental Health Division 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 Placerville (will be Diamond Springs when the Placerville Mental Health office relocates in the Fall)	
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%

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

	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 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 20 individuals who may not meet eligibility for or require specialty mental health services will participate in the Wellness Center activities annually, and approximately 40 family or friends who provide a support system to Wellness Center participants may participate in activities to enhance their supportive role. The Wellness Centers began tracking the number of non-clients in approximately January 2013. During the last half of FY 2012-13, non-client member attendance ranged between 3 and 7 individuals per week for the West Slope Wellness Center. Attendance levels for non-clients in FY 2013-14 are consistent with the numbers from FY 2012-13. These numbers exclude individuals who may attend group activities such as classes.
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 (SPC) provides free confidential individual counseling to adults age 55 and older. SPC 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. SPC 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 SPC counseling is to meet the expressed needs of the individual and provide prevention and early intervention on mental health issues. SPC 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 SPC. 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 Duration	Ongoing	
Activities	**Outreach:** Use publicity (newspapers, senior center announcements,	

Project Name: Senior Peer Counseling 4b

Performed	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 SPC 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. SPC 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. SPC 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[64] Senior Peer Counseling Program, which utilizes volunteers as peer counselors
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

[64] 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).

	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 an SPC 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 TLC's, 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 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

Project Name: Senior Peer Counseling 4b

	proposal a plan is written for expanding SPC 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	In 2013, SPC expects to serve approximately 40 new clients, in addition to maintaining current case loads. The number of clients will be increased based upon program capacity (the number of volunteer Senior Peer Counselors). As a new program, there were no results to report from FY 2012-13.
Budget	Year 1: Up to $35,000 on a reimbursement basis Year 2: Up to $45,000 on a reimbursement basis Year 3: 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 Community Services and Supports (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. 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[65]
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.

[65] 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. As a new program, there were no results to report from FY 2012-13.
Budget	Up to $75,000 in FY 2013-14 on a reimbursement basis Up to $80,000 in FY 2014-15 on a reimbursement basis Up to $85,000 in FY 2015-16 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 Community Services and Supports (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 will be discontinued effective June 30, 2013.
Services Provided By	☒ Contracted Vendor[66] ☐ 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. These services will reach local communities in the county. As a new program, there were no results to report from FY 2012-13.
Budget	Approximately $75,000 annually, when funded in partnership with the CSS program of "Community-Based Mental Health Services". The combination CSS-PEI Community-Based Mental Health Services program will fund the equivalent of a 5.0 FTE staff (Mental Health Clinicians, Workers, Aides), along with supervisory and support staff and overhead, for community-based services. If staffing levels and funding allows, additional resources (e.g., additional Mental Health Clinicians/Mental Health Workers, Psychiatrists) will be allocated to

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

Project Name: Community-Based Mental Health Services 5a

	community-based services. These funds will be leveraged with AB109 funds when services are provided through the Community Corrections Center. If contracted through local providers, expenses will be on a reimbursement basis.

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[67]
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.

[67] 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. As a new program, there were no results to report from FY 2012-13.
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:

- Early Intervention Program for Youth
- Home-Delivered Meals

Project Name: Early Intervention Program for Youth

(under the Youth and Children's Services program)

Discontinued Effective June 30, 2014

Activities performed under this project are now addressed through other PEI projects.

This project was included in the FY 2012-13 MHSA Plan Update and according to direction from the El Dorado County Board of Supervisors, operation of the project was released via an Request for Proposals (RFP). Responses to the RFP are under review and the term of any resulting contract(s) will be through June 30, 2014.

Program 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 Early Intervention Program for Youth provides screening for early identification, assessment and referrals to appropriate PEI Youth and Children's services as well as other Medi-Cal and MHSA funded programs. The purpose of this project is to both increase access and utilization of early intervention services, as appropriate. County Mental Health clinical staff are assigned to participate in a school-based screening team thereby providing for early identification, assessment, and referral to PEI-funded services, such as the PIP, Incredible Years, and other MHSA and Medi-Cal funded program, such as, Teaching Pro-social Skills, and Trauma-focused Cognitive Behavioral Therapy.	
Target Population(s)	☐ 0-5 Years ☒ Elementary School ☒ Middle School ☒ High School	☐ Adults ☐ Older Adults ☐ All Ages
Service Location(s)	El Dorado County schools	
Project Duration	Ongoing	
Services Provided By	☐ Contracted Vendor ☐ Volunteers ☒ County Staff	
Procurement Method	None.	

Project Name: Home Delivered Meals

(under the Wellness Outreach Program for Vulnerable Adults program)

Discontinued Immediately upon Board of Supervisors Approval of the FY 2013-14 MHSA Plan

This project was not well received and the new PEI projects for vulnerable adults are anticipated to better address the needs of older adults in our community.

Program 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	Community-based outreach, engagement and early intervention services targeting the older adult population will be integrated with the existing Home-Delivered Meals program provided by the County. As a result, the ability to provide mental health early detection and intervention to many older adults and caregivers will be greatly enhanced. This program targets a high-risk population for depression and suicide. Older adults were not receptive to having mental health services linked with their home-delivered meal services. These locally-provided services are included into the Older Adults Program.	
Target Population(s)	☐ 0-5 Years ☐ Elementary School ☐ Middle School ☐ High School	☐ Adults ☒ Older Adults ☐ All Ages
Service Location(s)	Countywide No services were provided in FY 2012-13.	
Project Duration	Ongoing	
Services Provided By	☐ Contracted Vendor ☐ Volunteers ☒ County Staff	
Procurement Method	None.	

Realigned PEI Programs/Projects

The following PEI project has been moved to the Workforce Education and Training (WET) component:

- Consumer Leadership Academy

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.

FY 2013-14 Budget

MHSA no longer provides funding for PEI-TTACB activities. The County continues to operate this program through funds previously received and remaining as a fund balance. If actual expenditures in PEI-TTACB do not meet or exceed $21,700 in FY 2013-14, there is a risk for reversion of the difference between $21,700 and actual expenditures.

For more detail regarding MHSA allocations and expenditures, please see Attachment C.

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 Mental Health Division 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 will be utilized to develop a web-based resource guide for the community. The resource guide will be accessed through the County's MHSA webpage. Additionally, providing there is adequate funding available, the development of a mobile phone application will be pursued to allow individuals and providers instant access to the resource information from a smart phone. In the event HHSA is unable to identify the needed mobile application programming skills within the County's IT Department, a competitive procurement process will be undertaken to secure the necessary services.

This project will increase 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.

Discontinued PEI-TTACB Program

The previous PEI-TTACB program focused on developing strategies to build community capacity. This program is discontinued effective immediately. Although the County remains committed to the development and implementation of a community capacity building strategies

and will continue such activities as part of its operations, there are insufficient PEI-TTACB funds to develop the strategies and implement the new programs.

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 2013-14 Budget

El Dorado County's share of the Statewide PEI Program Component Allocation is provided to CalMHSA directly from the State. CalMHSA budgets may be found online at: http://calmhsa.org/documents/finance/.

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.[68] 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.[69] 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 Welfare and Institutions Code Section 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.

[68] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3200.080, Community Services and Supports.
[69] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3615, Community Services and Supports Service Categories.

(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.

(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.[70]

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 2013-14.

Total anticipated annual revenues for CSS are:

MHSA	$4,660,288
Public Safety Realignment 2011 (AB109)	$110,000
Interest	$30,000
Total	$4,800,288

Total anticipated offsetting expenditures for CSS are:

Medi-Cal, Insurance, Private Payor	$1,116,510

The future level of MHSA funding is unknown, therefore this Plan will anticipated the same revenues annually for the term of this Plan, and will adjust revenues in future Plan Updates as needed.

As of the beginning of FY 2013-14, the remaining CSS fund balance from previous fiscal years is $4,430,880. The fund balance will be utilized to cover amounts in excess of the CSS revenues, contribute to the Prudent Reserve and, in the future, fund the WET and CFTN components.

Full Service Partnership Funding

MHSA requires counties to direct the majority of the CSS funds to the FSP service category (excluding CSS-Housing funds).[71] Planned FSP expenditures (not including FSP services within the Transitional Age Youth (TAY) Services program or the future project of Assisted Outpatient Treatment) are:

FY 2013-14 50.4%
FY 2014-15 52.1%
FY 2015-16 52.1%

Total FSP expenditures (as opposed to GSD or OE expenditures) in the TAY Services program will be determined based upon client need. However, it is estimated that approximately 40% of

[70] 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.
[71] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3620, Full Service Partnership Service Category, subsection (c)

the expenditures in the TAY Services program may be FSP expenditures, but FSP expenditures within the TAY Services program will not be limited to only 40%.

For more detail regarding MHSA allocations and expenditures, please see Attachment C.

CSS Programs

Program/Project	FSP	GSD	OE	FY 13/14 Expenditures[72]	FY 14/15 Expenditures[72]	FY 15/16 Expenditures[72]	FY 13/14 % of Expenditures
Program 1: Youth and Family Strengthening Program							
Project 1a: Youth and Family Full Service Partnership	✓			$600,000	$600,000	$600,000	9.8%
Project 1b: Family Strengthening Academy		✓		$400,000	$400,000	$400,000	6.5%
NEW Project 1c: Foster Care Enhanced Services	✓			$500,000	$500,000	$500,000	8.1%
Program 2: Wellness and Recovery Services							
Project 2a: Wellness Centers		✓	✓	$1,100,000	$900,000	$900,000	17.9%
Project 2b: Adult Full Service Partnership	✓			$2,000,000	$2,000,000	$2,000,000	32.5%
NEW Project 2c: Older Adults Program (Partner program to PEI Older Adults Program)		✓	✓	$250,000	$250,000	$250,000	4.1%
Program 3: Transitional Age Youth (TAY) Services							
NEW Project 3a: TAY Engagement, Wellness and Recovery Services	✓	✓	✓	$350,000	$350,000	$350,000	5.7%
Program 4: Community System of Care							
Project 4a: Outreach and Engagement Services			✓	$250,000	$250,000	$250,000	4.1%
NEW Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)		✓	✓	$500,000	$500,000	$500,000	8.1%
Project 4c: Resource Management Services		✓	✓	$200,000	$200,000	$200,000	3.3%
Total CSS Expenditures				**$6,150,000**	**$5,950,000**	**$5,950,000**	
Reallocation to WET				$0	$224,974	$265,000	
Reallocation to CFTN				$0	$0	$75,799	
Contribution to the Prudent Reserve				$601,716	$0	$0	

[72] Expenditures reflect a planned use of the fund balance.

Future Potential Project:

NEW Project 2d: Assisted Outpatient Treatment	✓			$250,000	$225,000	$175,000
Total Future Potential CSS Expenditures				$7,001,716	$6,399,974	$6,465,799

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 Welfare and Institutions Code Section 18251(d)), utilizing a specific wraparound model, or services provided under the former SB163 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 Full Service Partnership (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 Welfare and Institutions Code section 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 Protective Services (CPS) case, but involvement with CPS 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 California Code of Regulations, Title 9, Section 3200.130, a Full Service Partnership (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 Welfare and Institutions Code Section 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 CPS, but involvement with CPS 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 Dialectical Behavior Therapy (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: Sierra Child and Family Services, West Slope
Procurement Method:	The current contract with Sierra Child and Family Services will continue, and an open procurement process will be utilized for new contacts. Interested vendors will provide Health and Human Services Agency 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 Health and Human Services Agency, Mental Health Division, 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

Community Services and Supports (CSS)

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

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 500 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. Since January 2013, approximately 25 children received services through the MHSA Youth and Family Wraparound project. With the implementation of the new Electronic Health Record system, reporting capabilities in FY 2013-14 will greatly improve. It would be anticipated that the average number of children enrolled in this project would be 40 annually and that the average cost per child would be $15,000. However, some children may have a higher level of need, and the actual cost per child will not be limited to $15,000.
Budget:	Approximately $600,000 annually 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.
Target Population(s):	Children (under age 18) who are Mental Health Division 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):	Placerville (soon to be relocated to Diamond Springs) and South Lake Tahoe Mental Health Clinics. 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, Aggression Replacement Treatment, Trauma-Focused Cognitive Behavioral Therapy, Dialectical Behavior Therapy and Difficult Beginnings. A qualifying Child/Adolescent Levels of Care Utilization System (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 Protective Services (CPS), but involvement with CPS 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 Health and Human Services Agency 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 process. Interested vendors will provide Health and Human Services Agency 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 process wherein interested vendors will provide Health and Human Services Agency 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:	• 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 100 to 200 children and their families could be enrolled in the Family Strengthening Academy annually. It would be anticipated that the average number of children and their families enrolled in this project would be 150 annually and that the average cost per child would be $2,666. However, some children may have a higher level of need, and the actual cost per child will not be limited to $2,666. In FY 2012-13, children were not enrolled into this project due to a lack of understanding of the parameters of the program. Starting in FY 2013-14, more children will be enrolled into this program given the clarification provided to staff regarding the program's parameters.
Budget:	Approximately $400,000 annually. 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: 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.
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 (SMHS) 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, 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. State Settlement and 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**[73] 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. 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

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

	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**[74, 75] 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: 1. Day Treatment Rehabilitative; 2. Day Treatment Intensive;

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

	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 Facility (PHF) (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.
Services Provided By:	☒ Contracted Vendor ☒ Volunteers ☒ County Staff
Procurement Method:	These services will be provided by County Staff and Contracted Vendors. Contracted Vendors will be selected through an open procurement process. Interested vendors will provide Health and Human Services Agency 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

Community Services and Supports (CSS)

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

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 and is unknown at this time. It would be anticipated that the average number of children enrolled in this project would be 40 annually and that the average cost per child would be $12,500. However, some children may have a higher level of need, and the actual cost per child will not be limited to $12,500. As a new program, there were no results to report from FY 2012-13.
Budget:	Approximately $500,000 annually. Contracted vendors will compensated 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: 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 West Slope (Placerville, with relocation to Diamond Springs in the fall)
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 Community Services and Supports (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, the National Alliance on Mental Illness (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. 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 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.[76]

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%
One-on-One Discussions with Mental Health Staff	47%
Computer Skill Building	41%
Crafts	41%
Gardening	41%

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

	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. 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 Wellness Center moves that will occur in FY 2013-14 (both West Slope and South Lake Tahoe), these MHSA funds will be utilized to facilitate a smooth transition from the Wellness Centers' current locations to their new locations 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 Centers, and storage. To the extent possible, items from the current Wellness Centers will be utilized in the new Wellness Centers.
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 600 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 90 individuals. At 7,200 client visits annually, the average cost per visit would be $153 in FY 2013-14. In FY 2014-15 and FY 2015-16, assuming constant attendance levels, the average cost per visit would be $125. The visits may include sessions with clinicians or other Mental Health staff. In FY 2012-13, there were nearly 7,300 client visits at the Placerville and South Lake Tahoe Wellness Centers. Activities included: • Recovery-oriented groups, including Dual Recovery Anonymous, Symptoms without Stigma, Alcoholics Anonymous, Independent Skill Building (e.g., cooking, hygiene, budgeting, computer skills, recycling, navigating public transportation, communication/ assertiveness, managing intrusive thoughts); • Physical health, social and well-being groups (promoting healthy lifestyles through exercise, positive personal interactions and pursuit of individual interests). • Field trips, such as to food banks, community meals, thrift shops and neighboring communities for shopping. • Social and recreational activities (e.g., NAMI picnic, group meals, coffee, memorial, holiday activities). 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.
Budget:	Approximately $1,100,000 in FY 2013-14. Approximately $900,000 in FY 2014-15 and FY 2015-16. The higher expenses in FY 2013-14 are a result of the relocation of both the West Slope Wellness Center and clinic (from Placerville to Diamond Springs) and the South Lake Tahoe Wellness Center and clinic. Due to the timing of each move, some of the expenses related to the clinic and Wellness Center moves may rollover into Year 2 (for example, the date of the South Lake Tahoe move is unknown and the costs associated with both moves may take some time to be fully processed). 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: Adult Full Service Partnerships **Project 2b**

Project Type:	☒ Full Service Partnerships ☐ General System Development ☐ Outreach Engagement
Objective:	The Full Service Partnership (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):[77]	(a) Individuals selected for participation in the Full Service Partnership Service Category must meet the eligibility criteria in Welfare and Institutions Code (WIC) Section WIC Section 5600.3(a) for children and youth, WIC Section 5600.3(b) for adults and older adults or WIC Section 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:

[77] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3620.05, Criteria for Full Service Partnerships Service Category.

	(1) They are unserved and one of the following: (A) Experiencing a reduction in personal and/or community 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."[78]
Service Location(s):	Countywide.
Project Description:	A Full Service Partnership (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."[79] 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."[80] 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

[78] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3200.310, Unserved.
[79] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3200.130, Full Service Partnership.
[80] California Department of Mental Health, Prepared by the California Institute for Mental Health. *Full Service Partnership Tool Kit, Adult.* 2011, page 11.

	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 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."[81] 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."[82] **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."[83] "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]."[84] FSP services and supports are available to clients living in MHSA-eligible permanent supportive housing.

[81] *Ibid*., page 12.
[82] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3200.160, Fully Served.
[83] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3200.150, Full Spectrum of Community Services.
[84] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3620. Full Service Partnership Service Category, subsection (a).

	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."[85] **Mental Health Services and Supports** The full spectrum of community services includes, but is not limited to, the following: "(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[86] development. (ix) Crisis intervention/stabilization services. (x) Family education services."[87] 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.

[85] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3620, Full Service Partnership Service Category, subsection (b).
[86] Individual Services and Supports Plan (ISSP).
[87] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3620. Full Service Partnership Service Category, subsection (a).

	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."[88] **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: "(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."[89] 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.[90] 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.[91] Other non-Medi-Cal client support expenditures including, but not limited to, "costs of salaries and benefits for employment specialists,

[88] California Department of Mental Health, Prepared by the California Institute for Mental Health. *Full Service Partnership Tool Kit, Adult.* 2011, page 60.
[89] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3620. Full Service Partnership Service Category, subsection (a).
[90] California Department of Mental Health, Prepared by the California Institute for Mental Health. *Full Service Partnership Tool Kit, Adult.* 2011, page 108.
[91] *Ibid.*, pages 103 and 108.

	housing specialists or peer support staff who do not bill for their services."[92] 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 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."[93] 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.[94] 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.

[92] *Ibid.*, page 108.
[93] *Ibid.*, page 52.
[94] *Ibid.*, page 50.

	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.[95] • Increasing clients' social networks and increasing opportunities to meet new people through social, nonprofessionally oriented interactions with other individuals who may act as community supports for the clients.[96] • Establishing safe, affordable, and permanent housing for each client, and identifying emergency housing as may be needed.[97] • Identifying clients who are living in board and care facilities but, with appropriate FSP supports, could make the transition to independent living.[98] • 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.[99] • 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.[100] • 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.[101] • Identifying financial goals and resolving insufficiencies.[102]

[95] *Ibid.*, page 76.
[96] *Ibid.*, page 65.
[97] *Ibid.*, page 102.
[98] *Ibid.*, page 103.
[99] *Ibid.*, page 67.
[100] *Ibid.*, page 39.
[101] *Ibid.*, page 75.
[102] *Ibid.*, page 69.

	• 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.[103] • Addressing a client's drug or alcohol use or other behaviors based on the client's level of readiness for change[104] 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."[105] • 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 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.[106]
Services Provided By:	☒ Contracted Vendor[107] ☒ 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 Health and Human Services Agency 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 a competitive procurement process and multiple vendors may be selected to provide these services. Contracts for specific activities, groups or classes will be done through an open procurement process wherein interested vendors will provide Health and Human Services Agency 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

[103] *Ibid.*, page 81.
[104] *Ibid.*, page 81.
[105] *Ibid.*, page 57.
[106] *Ibid.*, page 105.
[107] These services will be provided by County Staff and volunteers; potential use of Contracted Vendors at a future point in time.

	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 • 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 125 annually and that the average cost per adult would be $16,000. However, some adults may have a higher level of need, and the actual cost per adult will not be limited to $16,000. In FY 2012-13, 101 individuals were served as a FSP client (77 on the West Slope and 24 in South Lake Tahoe).
Budget:	$2,000,000 annually for mental health and non-mental health services and supports, overhead, administrative support, quality assurance review, and other costs attributed to this program. 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: 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 Mental Health Division.
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.[108] In the 2000 census, older adults (age 60+) represented 17% of the population.[109] 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

[108] Retrieved from the 2010 census (http://quickfacts.census.gov/qfd/states/06000.html), March 7 and May 7, 2013.
[109] 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.

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. 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[110]
Procurement Method:	Competitive procurement process.
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)
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 50 annually and that the average cost per adult would be $5,000. However, some adults may have a higher level of need, and the actual cost per adult will not be limited to $5,000. As a new program, there were no results to report from FY 2012-13.
Budget:	Approximately $250,000 annually 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.

[110] 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).

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 the Health and Human Services Agency (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 Welfare and Institutions Code.[111] AOT requires close collaboration between HHSA Mental Health Division, 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.[112]
Budget:	The final budget will be developed with the full project description and may vary from this initial estimate. Year 1: Estimated at $250,000 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. It is estimated that on an annual basis, approximately 12 individuals countywide would met AOT criteria, with an average per person cost of $18,750. The higher costs in Year 1 are due to project start-up costs.

[111] Welfare and Institutions Code Sections 5345-5349.5. http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=05001-06000&file=5345-5349.5.
[112] 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.
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 (FSP), Adult FSP), 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 Transitional Age Youth (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 Protective Services (CPS) is developing a strong TAY program for youth involved in child welfare services, and this project will coordinate with CPS 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 Protective Services (CPS) 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 activities, food (prepared and non-prepared), and transportation, as well as other approved activities, can be funded by MHSA for stabilization purposes. 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 FSP project or the Adult FSP project, dependent upon the individual's age. Therefore, the mental health and non-mental health services and project

	costs identified in Children and Youth FSP project and the Adult FSP 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 ☒ Volunteers ☒ County Staff
Procurement Method:	These services will be provided by County Staff and contracted vendors, through a collaborative approach. An open procurement process will be utilized for new contacts. Interested vendors will provide Health and Human Services Agency 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

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 will be served by this project per year. Initially, the number of youth is anticipated to be small, perhaps lower than 50 per year. It would be anticipated that the average number of youth enrolled in this project would be 70 annually and that the average cost per youth would be $5,000. However, some youth may have a higher level of need, such as those who are receiving FSP services, and the actual cost per youth will not be limited to $5,000. As a new program, there were no results to report from FY 2012-13.
Budget:	Approximately $350,000 annually. Services performed by contracted vendors will be paid 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: 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, 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 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 Mental Health Division clinics and Wellness Centers. 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. **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: • 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 Health and Human Services Agency 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 Community-Based Mental Health Services (CSS) 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 Community-Based Mental Health Services (CSS) project provides clinical services for Mental Health Division 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[113] ☐ Volunteers ☒ County Staff
Procurement Method:	None required. 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.
Number Served/ Quantity of Service:	This component anticipates serving 200 unique clients per year in initial engagement activities and potentially all clients of Mental Health in continued engagement in services.
Budget:	Approximately $200,000 annually.

[113] 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: 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[114] ☐ 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: LOCUS/CALOCUS Measurement 5: Outcome measurement tools (e.g., Child and Adolescent Needs and Strengths (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. In calendar year 2012, the Mental Health Division saw 2,510 individuals, who received any type of mental health service, from a one-time crisis intervention to the full array of mental health services. Of those, 1,804 received a planned, outpatient mental health service (either through traditional or MHSA funding). It is anticipated that a portion of those clients would prefer to receive mental health services in their local communities. It would be anticipated that the average number of client enrolled in this project would be 100 annually and that the average cost per individual would be $5,000. However, some individuals may have a higher level of need, and the actual cost per individual will not be limited to $5,000. As a new program, there were no results to report from FY 2012-13.

[114] 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: Community-Based Mental Health Services Project 4b

Budget:	Approximately $500,000 annually. The combination CSS-PEI Community-Based Mental Health Services program will fund the equivalent of a 5.0 FTE staff (Mental Health Clinicians, Workers, Aides), along with supervisory and support staff and overhead for community-based services. If staffing levels and funding allows, additional resources (e.g., additional Mental Health Clinicians/Mental Health Workers, Psychiatrists) will be allocated to community-based services. These funds will be leveraged with Assembly Bill (AB) 109 (Public Safety Realignment of 2011) funds when services for CSS-eligible individuals are provided through the Community Corrections Center. If contracted through local providers, expenses will be 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: 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 Mental Health Division Wellness and Recovery Programs. With preparations for and the arrival of the Affordable Care Act, these services will also include close coordination between Mental Health Division staff and primary care physicians, including consultations between Mental Health Division 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.
Budget:	Approximately $200,000 annually. Includes a commitment to the ACCEL program for up to $7,500 annually to support the ACCEL positions of Program Manager and Program Director.

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 2013-14: $0 FY 2014-15: $224,974 FY 2015-16: $265,000

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

Objective:	To provide funding for ongoing CFTN projects.
Outcome Measures:	Please see the Capital Facilities and Technology (CFTN) component project descriptions for the anticipated project outcomes.
Budget:	FY 2013-14: $0 FY 2014-15: $0 FY 2015-16: $75,799

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 2013-14: $601,716 FY 2014-15: $0 FY 2015-16: $0

Discontinued CSS Programs/Projects

There are no CSS programs/projects to be discontinued under the FY 2013-14 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.[115]

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

[115] California Code of Regulations, 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 Mental Health Division (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 Services project's ICM team (see the "Adult Full Service Partnership" project for more information about the ICM team) 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.

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 will be reserved for the resident manager, and 47 units will target low−income households earning 50% of the El Dorado County area median income and below. Six units will be dedicated to the El Dorado County MHSA housing program and will target households that are eligible for services under the MHSA FSP program. The MHSA services program will 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 will be processed by lottery as completion of construction approaches. 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 adults aged 18 to 59 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 is anticipated to take one year to complete.

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.[116] "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.[117] 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.[118]

- **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.[119]

- **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

[116] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3200.320, Workforce Education and Training.
[117] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3200.253, Public Mental Health System.
[118] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3841, Training and Technical Assistance Funding Category.
[119] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3842, Mental Health Career Pathway Programs Funding Category.

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 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.[120]

- **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.[121]

- **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.[122]

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:

[120] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3843, Residency and Internship Programs Funding Category.
[121] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3844, Financial Incentive Programs Funding Category.
[122] California Code of Regulations, Title 9, Division 1, Chapter 14, Section 3845, Workforce Staffing Support Funding Category.

(A) Recruitment;

(B) Supported employment services;

(C) Creating and implementing promotional opportunities; or

(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. [123]

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

Mental Health Workforce

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

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 2013-14. The last workforce needs assessment, published in 2008, identified similar the same 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 webpage.[124] 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 2013-14, the remaining WET fund balance from previous fiscal years is $360,026. There is no risk of WET fund reversion in FY 2013-14.

After FY 2013-14, it is estimated there will be no remaining fund balance. Therefore, per Welfare and Institutions Code Section 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:

Fiscal Year	Amount
FY 2013-14	$0
FY 2014-15	$224,974
FY 2015-16	$265,000

For more detail regarding MHSA allocations and expenditures, please see Attachment C.

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

WET Programs

Program/Project	Training and Technical Assistance	Residency and Internship Programs	Workforce Staffing Support	Mental Health Career Pathways Programs	Financial Incentive Programs	FY 13/14 Expenditures[125]	FY 14/15 Expenditures[126]	FY 15/16 Expenditures[127]
Program 1: Workforce Education and Training (WET) Coordinator	✓		✓			$50,000	$50,000	$50,000
Program 2: Workforce Development	✓		✓			$100,000	$95,000	$90,000
Program 3: Psychiatric Rehabilitation Training	✓					$5,000	$5,000	$5,000
NEW Program 4: Early Indicators of Mental Health Issues			✓			$50,000	$45,000	$40,000
NEW Program 5: Suicide Education and Training			✓			$50,000	$50,000	$40,000
NEW Program 6: Consumer Leadership Academy			✓	✓		$30,000	$35,000	$40,000
NEW Program 7: Crisis Intervention Team Training			✓			$20,000	$0	$0
Total Proposed WET Budget						**$305,000**	**$280,000**	**$265,000**

[125] Expenditures reflect a planned use of the fund balance.
[126] Expenditures reflect a planned use of the fund balance and reallocation of funds from CSS to WET.
[127] Expenditures reflect reallocation of funds from CSS to WET.

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.[128]	
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 Health and Human Services Agency staff.	

[128] California Code of Regulations, 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 2013-14. WET programs will continue to expand in future years.
Budget	Up to $50,000 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 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.
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	Up to $75,000 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).

Program Name: Psychiatric Rehabilitation Training 3

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. Implementation of this training project has not yet occurred, but is anticipated to start in FY 2013-14. 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 Health and Human Services Agency staff, volunteers and interested consumers.	
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.	

Program Name: Psychiatric Rehabilitation Training 3

Number of Services / Quantity of Service	Training to be provided two to four times per year. No training under this project was conducted in FY 2012-13.
Budget	Up to $5,000 annually.

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. El Dorado County Office of Education (EDCOE) will identify and/or develop online training modules and resources that will be made available to all educators and community partners working with children and youth (e.g., Boys and Girls Club, Big Brothers Big Sisters)	
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	El Dorado County Office of Education (EDCOE) will identify a menu of SAMHSA approved evidenced-based programs that may be selected for implementation by each school district. This will allow each school district to select the programs that most specifically meet the need of their students, beyond existing programs. To the extent allowed by licensing, these programs will also be available to educators and community partners working with children and youth. The selected programs will primarily focus on anti-bullying, reducing substance abuse, and positive behaviors. To identify potential SAMHSA-approved programs, EDCOE will 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 and evaluate effectiveness.	
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Support	
Procurement Method	Sole Source – El Dorado County Office of Education (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 the public mental health system for individuals and families in need of services at earlier opportunities. • Implement 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 the Mental Health Division.
Number of Services / Quantity of Service	This training program will be available to all school districts within El Dorado County. As a new program, there were no results to report from FY 2012-13.
Budget	Up to $50,000 annually on a reimbursement basis. PEI funds would be utilized for purchase of program materials, staff training, implementation cost, and ongoing program support. EDCOE will commit ongoing in-kind contributions of administrative oversight, staff time, technology, and resources to support this PEI plan.

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 ☐ Contractors ☐ Volunteers	☐ Consumers and Family Members ☐ Law Enforcement ☒ Teachers/Education
Service Location(s)	Countywide	
Project Duration	Ongoing	
Activities Performed	El Dorado County Office of Education (EDCOE) will identify and/or develop online training modules and resources that will be made available to all educators. 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 (SAMHSA Model Programs). 2) Develop and implement online training modules. 3) Train at least ten suicide prevention train-of-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 mandatory staff 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.	
Services Provided By	☒ Contracted Vendor ☒ Volunteers ☒ County Staff Support	

Program Name: Suicide Education and Training 5

Procurement Method	Sole Source – El Dorado County Office of Education (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. As a new program, there were no results to report from FY 2012-13.
Budget	Up to $50,000 annually on a reimbursement basis.

Program Name: Consumer Leadership Academy 6
(Previously under PEI)

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. Consumers 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) or the MHSA WET Regional. 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.	
Services Provided By	☐ Contracted Vendor ☒ Volunteers ☒ County Staff	
Procurement Method	None. Services provided by Health and Human Services Agency staff.	

Program Name: Consumer Leadership Academy 6

(Previously under PEI)

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 6 participants per academy. There was one Consumer Leadership Academy held in FY 2012-13.
Budget	Up to $30,000 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.

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	One-time training	
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."[129] 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	
Procurement Method	Sole source to the individual/organization utilized by the El Dorado County Sheriff's Office for CIT training.	

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

Program Name: Crisis Intervention Team Training 7

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 training will be funded through MHSA WET funds. As a new program, there were no results to report from FY 2012-13.
Budget	Up to $20,000 in FY 2013-14 on a reimbursement basis. In the event the CIT training cannot be conducted in FY 2013-14, these funds will roll into FY 2014-15.

Discontinued WET Programs/Projects

There are no WET programs/projects to be discontinued under the FY 2013-14 MHSA Plan.

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 Project Proposals 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 webpage.[130]

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 2013-14, the remaining CFTN fund balance from previous fiscal years is $706,901.

During the term of this Plan, it is anticipated there will be an adequate CFTN fund balance to continue to operate the CFTN programs in FY 2013-14 and FY 2014-15. In FY 2015-16, it is anticipated that approximately $75,799 in CSS funds will need to be reallocated to CFTN in accordance with Welfare and Institutions Code Section 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 more detail regarding MHSA allocations and expenditures, please see Attachment C.

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

CFTN Programs

Program/Project	FY 13/14 Expenditures[131]	FY 14/15 Expenditures[131]	FY 15/16 Expenditures[132]	FY 13/14 % of Expenditures
Program 1: Electronic Health Record System Implementation				
Project 1a: Avatar Clinical Workstation	$225,000	$175,000	$150,000	58.3%
Project 1b: Electronic Outcome Measurement Tools	$5,000	$5,000	$5,000	1.3%
Program 2: Telehealth (formerly Telemedicine)	$130,000	$25,000	$25,000	33.7%
Program 3: Electronic Care Pathways	$25,900	$5,900	$5,900	6.7%
Total CFTN Expenditures	**$385,900**	**$210,900**	**$185,900**	

[131] Expenditures reflect a planned use of the fund balance.
[132] Expenditures reflect a planned use of the fund balance and reallocation of funds from CSS to CFTN.

Project Name: Avatar Clinical Workstation 1a

Objective	Successful implementation of an Electronic Health Record (EHR) system for the Mental Health Division's two outpatient clinics, as well as the Psychiatric Health Facility (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 Mental Health Division 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 Mental Health Division, 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 Mental Health Division. – *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	Expenditures of $13,332 in FY 2011-12. Expenditures of $689,730 in FY 2012-13. $225,000 for FY 2013-14, $175,000 for FY 2014-15 and $150,000 in FY 2015-16. Costs include 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 Psychiatric Health Facility (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 Level of Care Utilization System (LOCUS) for adults, and the Child and Adolescent level of Care Utilization System (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 Child & Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (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,

Program Name: Electronic Outcome Measurement Tools 1b

	mental health, juvenile justice, and early intervention applications."[133] "The Adult Needs and Strengths Assessment (ANSA) is a 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."[134] 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 Mental Health Division.
Procurement Method	The CANS and ANSA are available at no cost through the open domain.
Current Year 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	Expenditures of $5,000 annually. These costs include staff, administrative and overhead costs, as well as licensing fees and programming support, if needed.

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

Program Name: Telehealth (formerly Telemedicine) 2

Program Name Change:	This project was formerly known as "Telemedicine", however the industry has more recently been utilizing the phrase "Telehealth" to describe these services. However, the terms "telemedicine", "telepsychiatry" and "telehealth" are generally used to refer to the process of providing/receiving health information and treatment via video conferencing.
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. El Dorado County is designated as a Mental Health Professional Shortage Area by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) and like many counties, continues to struggle with recruiting psychiatrists. 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

Program Name: Telehealth (formerly Telemedicine) 2

	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 Mental Health Division. Purchase of additional video conferencing equipment will be done in compliance with the Board of Supervisors' Procurement Policy.
Current Year 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 $130,000 in FY 2013-14. In the event the purchase of the video conferencing equipment is not completed in FY 2013-14, these funds will roll into FY 2014-15. Approximately $25,000 in FY 2014-15 and FY 2015-16. Costs include 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 Mental Health Division 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 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. Electronic Care Pathways automates this process throughout the system utilizing the iReach system. The collaborative associated with the electronic care pathways in El Dorado County is ACCEL, 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. Starting in FY 2013-14, ACCEL will develop and implement an Adult Mental Health Care Pathway. Mental Health Division staff attend ACCEL meetings, process referrals, and maintain information in the iReach system.
Services Provided By	☒ Contracted Vendor ☒ County Staff Infocom Systems Services or other IT support engaged through ACCEL.
Procurement Method	Sole source to ACCEL, whose costs are shared by participating agencies.
Current Year Goals	• Reassess possible integration of the Electronic Care Pathway into the EHR system (Avatar). • Develop and Adult Mental Health Care Pathway.
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.

Program Name: Electronic Care Pathways 3

Budget	$25,900 in FY 2013-14 ($20,000 for the development of an Adult Mental Health Care Pathway; $900 for IT support of the iReach system; $5,000 for mental health program evaluation). In the event the Adult Mental Health Care Pathway is not fully developed and/or implemented in FY 2013-14, unspent funds dedicated to that project will roll into FY 2014-15. $5,900 in FY 2014-15 and FY 2015-16 ($900 for IT support of the iReach system; $5,000 for mental health program evaluation).

Between June 1, 2008 and July 31, 2013, 248 children have been referred to the Mental Health Division 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 2013-14 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.[135]

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.[136]

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.[137]

Innovation plans must be approved by the MHSOAC prior to the expenditure of funds in this component.[138] To avoid a delay in the implementation of this Plan, the Innovation Plan will be

[135] Welfare and Institutions Code Section 5830(b).
[136] Welfare and Institutions Code Section 5830(d).
[137] Welfare and Institutions Code Section 5830(c).

developed separately, 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.[139] The proposed regulations have several steps to complete prior to adoption and implementation.[140] The above requirements for INN are not anticipated to change significantly under the new regulations.

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/).

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 2013-14 for INN is $1,065,944. The Innovation budget will be discussed in greater detail in the Innovation Plan that will be developed and published separately from this document.

For more detail regarding MHSA allocations and expenditures, please see Attachment C.

Innovation Projects

Through the community planning process, the public submitted ideas for Innovation projects, including, but not limited to:

- 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.
- Therapeutic Preschool: Would the establishment of a therapeutic preschool that provides mental health interventions for preschool behaviors outside of typical development including behavior management techniques, play therapy, certified therapy dog, mindfulness and nutrition therapy provide a safety net for children who might

[138] Welfare and Institutions Code Section 5830(c).
[139] 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.
[140] For more information about the regular rulemaking (regulation) process, see http://www.oal.ca.gov/Regular_Rulemaking_Process.htm.

otherwise be expelled from preschool, allow for successful transition back to a regular preschool setting and improve school success rates for children entering kindergarten? (Increased quality of services and/or access to services in a preschool setting)

- Independent Living Skills: Would the establishment of a program for independent skills training near clients living in Board and Care facilities in Galt and Sacramento assist clients with increased access to services and allow for the transition to more independent housing within their home county?
- Stigma Project: Would the establishment of high school classes through peer trainers focusing on stigma through student designed presentations including the creation of YouTube videos, film and edit a documentary, storyboards for videos, news releases, brochures and posters etc. reduce the stigma attached to receiving mental health services? (Increased access to services and/or promote interagency and community collaboration)
- Bullying Prevention Project: Would the intentional linking of students to skill building "friendship" groups addressing skills such as kindness, meeting facilitation, speaking in front of others, positive relationship building, safety, how to include others, facilitating fun, connection to school, and patience by a group leader reduce bullying on school campuses? (Promote interagency and community collaboration)

These potential Innovation projects are under exploration to determine which will qualify as Innovation projects. 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 2013-14 MHSA Plan. The previous INN program was discontinued in FY 2012-13.

Glossary

AB	Assembly Bill
AB109	Public Safety Realignment 2011
ANSA	Adult Needs and Strengths Assessment
AOD	Alcohol and Other Drugs
AOT	Assisted Outpatient Treatment
ART	Aggression Replacement Therapy
BBBS	Big Brothers Big Sisters
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
CPP	Community Planning Process
CPRT	Child Parent Resource Team
CPS	Child Protective Services
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
DMH	California Department of Mental Health
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
EMS	Emergency Medical Services
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
HRSA	Health Resources and Services Administration
ICC	Intensive Care Coordination
ICM	Intensive Case Management
IHBS	Intensive Home-Based Services
INN	Innovation
ISSP	Individual Services and Supports Plan
IT	Information Technologies
IY	Incredible Years
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
NARC	Native American Resource Collaborative
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
SACOG	Sacramento Area Council of Governments
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
SMHS	Specialty Mental Health Services

SPC	Senior Peer Counseling
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 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, Interim Director	Name: Joe Harn, Auditor-Controller
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 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, Interim Director
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, Auditor-Controller
County Auditor Controller / City Financial Officer (PRINT) Signature Date

[1] Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)

MHSA COUNTY COMPLIANCE CERTIFICATION

County: El Dorado County

Local Mental Health Director	Program Lead
Name: Don Ashton, Interim Director	Name: Ren Scammon
Telephone Number: (530) 642-7300	Telephone Number: (530) 621-6340
E-mail: don.ashton@edcgov.us	E-mail: ren.scammon@edcgov.us
County Mental Health Mailing Address: El Dorado County Health and Human Services 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 mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

This annual update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft annual update was circulated to representatives of stakeholder 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 December 10, 2013.

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, Interim Director _____ _____

Local Mental Health Director/Designee (PRINT) Signature Date

County: El Dorado County

Date: _____

Attachment A
FY 2013-14 MHSA Annual Update Instructions

Mental Health Services
Oversight & Accountability Commission

Title

FY 2013-2014 MHSA Annual Update 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.

These are instructions for the Annual Updates beginning in Fiscal Year (FY) 2013-2014. These instructions are based on WIC and the California Code of Regulations (CCR) in effect at the time of this drafting.

Purpose

The purposes of these instructions are to:

- Assist counties and their stakeholders in developing the FY 2013-2014 Annual Update 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 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 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.

Who Should be Involved in the Stakeholder Process

WIC § 5848 states that each Annual Update 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

Who Should be Involved in the Stakeholder Process (cont.)

- Veterans
- Representatives from veterans organizations
- Providers of alcohol and drug services
- Health care organizations
- Other important interests.

CCR Title 9 Section 3300 further includes:

- Representatives of unserved and/or underserved populations and family members of unserved/underserved populations
- Stakeholders that represent 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 Title 9 Section 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 Title 9 Section 3320 states that counties shall adopt the following standards in planning, implementing, and evaluating programs:

- Community collaboration, as defined in CCR Title 9 Section 3200.060
- Cultural Competence, as defined in CCR Title 9 Section 3200.100
- Client Driven, as defined in CCR Title 9 Section 3200.120
- Wellness, recovery, and resilience focused
- Integrated service experiences for clients and their families, as defined in CCR Title 9 Section 3200.190

Public Review

WIC § 5848 states that an Annual Update 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.

Public Review (cont.)

Additionally, the mental health board shall conduct a public hearing on the draft Annual Update at the close of the 30-day comment period.

Each Annual Update shall include any substantive written recommendations for revision.

What to Include in the Annual Update About the Stakeholder Process

Per **CCR Title 9 Section 3315**, this section of the Annual Update 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
- 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
- A summary and analysis of any substantive recommendations

What to Include in the Annual Update About Programs

WIC § 5847 states the Annual Update shall include updates from the Plan for the following programs:

- Prevention and Early Intervention (PEI)
- 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 and the cost per person must be included.
- Services to adults and seniors, that shall include services to address the needs of transition age youth ages 16 to 25. The number of adults and seniors served and the cost per person must be included.
- Innovation (INN)
- Technological needs and capital facilities
- Identification of shortages in personnel and the additional assistance needs from education and training programs

In addition to the required elements above, counties should include the following information as part of the Annual Update:

- A description of county demographics, such as size of the county, threshold languages, unique characteristics, etc.
- The number of children, adults, and seniors to be served
- The cost per person
- Examples of notable community impact
- Any challenges or barriers with each of the programs and strategies to mitigate those challenges or barriers
- Note new, significantly changed, and discontinued programs

What to Include in the Annual Update About INN	**WIC § 5830** states that counties shall expend funds for their INN programs upon approval by the MHSOAC. Annual updates should include sufficient information described in WIC § 5847 about a new or changed INN program so that the MHSOAC may determine if the program meets statutory requirements and can be approved.
What to Include in the Annual Update About Performance Outcomes	**WIC § 5847** 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 Community Services and Supports (CSS) services, PEI programs, or INN programs. Please specify the time period these performance outcomes cover.
What to Include in the Annual Update 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 Annual Update. Please use the MHSA County Compliance Certification form included with these Instructions.
What to Include in the Annual Update 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 Annual Update. Please use the MHSA County Fiscal Certification form, which the MHSOAC anticipates releasing in January 2013.
What to Include in the Annual Update About Board of Supervisor Adoption	**WIC § 5847** states that the county mental health program shall prepare and submit Annual Updates adopted by the county Board of Supervisors. Please include evidence that the Board of Supervisors adopted the Annual Update and the date of that adoption.
What to Include in the Annual Update About An Expenditure Plan	**WIC § 5847** states that each county shall prepare an expenditure plan for the Annual Update based on available unspent funds and estimated revenue allocations provided by the state. Please complete the FY 13/14 MHSA Funding Summary included with these Instructions.

What to Include in the Annual Update About An Expenditure Plan (cont.)

In addition, please include the budgeted amount to be spent on:

- Full Service Partnerships, as defined in CCR, Title 9, Section 3620
- General System Development, as defined in CCR, Title 9, Section 3630
- Outreach Engagement, as defined in CCR, Title 9, Section 3640
- PEI by program
- INN by project

When the Annual Update Should be Submitted to the MHSOAC

Please submit your FY 2013-2014 MHSA Annual Update to the MHSOAC within 30 days of adoption by the Board of Supervisors.

Attachment B
MHSA Surveys

Mental Health Services Act (MHSA)
Older Adults Survey 2013

Surveys were made available to the Commission on Aging at its May meeting and at the Placerville and El Dorado Hills Senior Centers the last two weeks of May.

Surveys were provided to home-delivered meal recipients throughout the County at the end of June/beginning of July.

A total of 162 surveys were returned to the MHSA Program Team.

El Dorado County
Health and Human Services Agency
Mental Health Division
Mental Health Services Act (MHSA) Programs
August 16, 2013

MHSA
EL DORADO

1. **What impediments do you feel older adults experience when in need of mental health services? Please select up to 5 impediments:**

   Number of Respondents for this question: 160

Impediment	# of Responses	% of Responses
Not wanting to bother others	106	66.25%
Lack of private transportation	81	50.63%
Cost of services	79	49.38%
Not knowing where to start	77	48.13%
Physical health limitation	70	43.75%
Stigma associated with mental health/illness	59	36.88%
Lack of or insufficient public transportation	51	31.88%
Cost of transportation	50	31.25%
Travel distance to services from home	40	25.00%
Concern friends or family may find out	26	16.25%
Lack of trust in service provider	25	15.63%
Inconvenient appointment times	22	13.75%
Cultural differences	5	3.13%
Language differences	2	1.25%
Other: • Mental health issues in the elderly get dismissed as "old age" • Lack of service in the area for seniors • Not sure if still the case, I was told to go early in a.m. and stand in line-feet, legs are disabled so I never went[1] • Realizing they need help • Denial • Denial; Lack of insight • Not knowing that MCI is not just getting old. Being tasked with actions they can't perform.		

[1] This is no longer the process. Individuals are provided with specific appointment times when they seek services.

These responses can be grouped together in more general categories as follows:

Summary Category	Total # of Responses[2]	Specifically	# of Responses	% of Responses
Transportation	172	Lack of private transportation	81	50.63%
		Lack of or insufficient public transportation	51	31.88%
		Travel distance to services from home	40	25.00%
Cost	129	Cost of services	79	49.38%
		Cost of transportation	50	31.25%
Impact to Others	106	Not wanting to bother others	106	66.25%
Stigma	85	Stigma associated with mental health/illness	59	36.88%
		Concern friends or family may find out	26	16.25%
Lack of Information	77	Not knowing where to start	77	48.13%
Physical Health Limitation	70	Physical health limitation	70	43.75%
Provider Issue	47	Lack of trust in service provider	25	15.63%
		Inconvenient appointment times	22	13.75%
Cultural/Language Differences	7	Cultural differences	5	3.13%
		Language differences	2	1.25%

[2] Respondents may have identified multiple responses that fall under a single Summary Category (i.e., selected both "Lack of private transportation" and "Lack of or insufficient public transportation").

When responses are identified only by the summary categories (where multiple items under the same summary category provided by the same person are only counted once), the responses are as follows:

Summary Category	# of Responses	% of Responses
Transportation	116	72.50%
Impact to Others	106	66.25%
Cost	102	63.75%
Lack of Information	77	48.13%
Stigma	70	43.75%
Physical Health Limitation	70	43.75%
Provider Issue	42	26.25%
Cultural/Language Differences	7	4.38%

2. How do you feel older adults would most like to receive information about the importance of positive mental health? Please select up to 5 options:

Number of Respondents for this question: 158

Response	# of Responses	% of Responses
At a doctor's office	114	72.15%
At a community center / senior center	86	54.43%
Via mail	83	52.53%
In their home	79	50.00%
At a hospital	48	30.38%
Via newspaper	46	29.11%
Via telephone	39	24.68%
At a religious center	29	18.35%
Via the internet	19	12.03%
From the library	19	12.03%
At a county building	13	8.23%
Other: • Broadcast media; thrift stores		

3. **Where do you feel older adults would most like to receive mental health services? Please select up to 3 options:**

Number of Respondents for this question: 158

Response	# of Responses	% of Responses
In their home	112	70.89%
At a doctor's office	108	68.35%
At a community center / senior center	82	51.90%
At a hospital	49	31.01%
At a religious center	20	12.66%
At a county building	18	11.39%
Other: • One-on-one with friend • Depends, I believe in the type of MH issues senior has & physical health also cost and privacy • All of the above - it depends on the individual • Counselor's office		

4. **How do you feel older adults would most like to receive mental health services?**

Number of Respondents for this question: 156

Response	% of Responses	# of Responses
Individual appointment	125	80.13%
With their family	50	32.05%
In group counseling	30	19.23%
In a peer group setting	26	16.67%
Other: • By mail • At a County Building, not at a senior center • Don't know: I do not know anyone who is mentally ill or in need of mental health services. Therefore I cannot answer any of these questions. I personally have not needed these services. • Depends on variable factors • Coffee or donut shop		

Mental Health Services Act (MHSA) Older Adults Survey

What impediments do you feel older adults experience when in need of mental health services? Please <u>select up to 5</u> impediments:

- ☐ Lack of private transportation
- ☐ Lack of or insufficient public transportation
- ☐ Cost of transportation
- ☐ Travel distance to services from home
- ☐ Stigma associated with mental health/illness
- ☐ Not wanting to bother others
- ☐ Concern friends or family may find out
- ☐ Not knowing where to start
- ☐ Physical health limitation
- ☐ Cost of services
- ☐ Cultural differences
- ☐ Language differences
- ☐ Inconvenient appointment times
- ☐ Lack of trust in service provider
- ☐ Other (specify):

How do you feel older adults would most like to receive information about the importance of positive mental health? Please <u>select up to 5</u> options:

- ☐ Via telephone
- ☐ Via mail
- ☐ Via newspaper
- ☐ Via the internet
- ☐ In their home
- ☐ At a doctor's office
- ☐ At a hospital
- ☐ At a religious center
- ☐ At a community center / senior center
- ☐ At a county building
- ☐ From the Library
- ☐ Other (specify):

Where do you feel older adults would most like to receive mental health services? Please <u>select up to 3</u> options:

- ☐ In their home
- ☐ At a doctor's office
- ☐ At a hospital
- ☐ At a religious center
- ☐ At a community center / senior center
- ☐ At a county building
- ☐ Other:

How do you feel older adults would most like to receive mental health services?

- ☐ Individual appointment
- ☐ With their family
- ☐ In a peer group setting
- ☐ In group counseling
- ☐ Other:

Please return this form to the Senior Center, or to Health and Human Services Agency, MHSA Project Team, 670 Placerville Drive, Suite 1B, Placerville, CA 95667

Mental Health Services Act (MHSA) Older Adults Survey

What impediments do you feel older adults experience when in need of mental health services? Please <u>select up to 5</u> impediments:

- ☐ Lack of private transportation
- ☐ Lack of or insufficient public transportation
- ☐ Cost of transportation
- ☐ Travel distance to services from home
- ☐ Stigma associated with mental health/illness
- ☐ Not wanting to bother others
- ☐ Concern friends or family may find out
- ☐ Not knowing where to start
- ☐ Physical health limitation
- ☐ Cost of services
- ☐ Cultural differences
- ☐ Language differences
- ☐ Inconvenient appointment times
- ☐ Lack of trust in service provider
- ☐ Other (specify):

How do you feel older adults would most like to receive information about the importance of positive mental health? Please <u>select up to 5</u> options:

- ☐ Via telephone
- ☐ Via mail
- ☐ Via newspaper
- ☐ Via the internet
- ☐ In their home
- ☐ At a doctor's office
- ☐ At a hospital
- ☐ At a religious center
- ☐ At a community center / senior center
- ☐ At a county building
- ☐ From the Library
- ☐ Other (specify):

Where do you feel older adults would most like to receive mental health services? Please <u>select up to 3</u> options:

- ☐ In their home
- ☐ At a doctor's office
- ☐ At a hospital
- ☐ At a religious center
- ☐ At a community center / senior center
- ☐ At a county building
- ☐ Other:

How do you feel older adults would most like to receive mental health services?

- ☐ Individual appointment
- ☐ With their family
- ☐ In a peer group setting
- ☐ In group counseling
- ☐ Other:

Please return this form to your Home Delivered Meal Driver by the end of this week.

Mental Health Services Act (MHSA)
Wellness Center/Clubhouse Activities Survey 2013

Surveys were made available to Wellness Center participants in Placerville and South Lake Tahoe during the month of June 2013.

A total of 36 surveys were returned to the MHSA Program Team.

1. Please select your location:

Number of Respondents for this question: 35

Location	# of Responses	% of Responses
Placerville	21	60.00%
South Lake Tahoe	14	40.00%

2. On average, how often do you attend the Wellness Center/Clubhouse?

Number of Respondents for this question: 35

Location	Placerville		South Lake Tahoe		Total – Both Slopes	
Attendance Frequency	# of Responses	% of Responses	# of Responses	% of Responses	# of Responses	% of Responses
1 day per week	2	9.52%	0	0.00%	2	5.71%
2 days per week	6	28.57%	0	0.00%	6	17.14%
3 days per week	6	28.56%	2	14.29%	8	22.86%
4 days per week	1	4.77%	9	64.29%	10	28.58%
5 days per week	2	9.52%	1	7.14%	3	8.57%

Location	Placerville		South Lake Tahoe		Total – Both Slopes	
Attendance Frequency	# of Responses	% of Responses	# of Responses	% of Responses	# of Responses	% of Responses
1 to 2 times per month	1	4.77%	0	0.00%	1	2.86%
3 to 5 times per month	0	0.00%	0	0.00%	0	0.00%
6 to 8 times per month	2	9.52%	0	0.00%	2	5.71%
9 or more times per month	0	0.00%	0	0.00%	0	0.00%
A few times per year	0	0.00%	1	7.14%	1	2.86%
Other (please specify):	1	4.77%	1	7.14%	2	5.71%

3. What is your gender?

Number of Respondents for this question: 34

Location	Placerville		South Lake Tahoe		Total – Both Slopes	
Gender	# of Responses	% of Responses	# of Responses	% of Responses	# of Responses	% of Responses
Female	10	50.00%	8	57.14%	18	52.94%
Male	10	50.00%	6	42.86%	16	47.06%

4. Which category below includes your age?

Number of Respondents for this question: 35

Location	Placerville		South Lake Tahoe		Total – Both Slopes	
Age	# of Responses	% of Responses	# of Responses	% of Responses	# of Responses	% of Responses
18 – 25	2	9.52%	0	0.00%	2	5.71%
26 – 40	11	52.39%	4	28.58%	15	42.86%
41 – 59	6	28.57%	5	35.71%	11	31.43%
60 or older	2	9.52%	5	35.71%	7	20.00%

5. In which of the following Wellness Center/Clubhouse activities (existing or new) would you participate?

Number of Respondents for this question: 36

Location	Placerville		South Lake Tahoe		Total – Both Slopes	
Response	# of Responses	% of Responses	# of Responses	% of Responses	# of Responses	% of Responses
Art	15	68.18%	6	42.86%	21	58.33%
Computer Skill Building	8	36.36%	6	42.86%	14	38.89%
Cooking	8	36.36%	5	35.71%	13	36.11%
Crafts	8	36.36%	6	42.86%	14	38.89%
Educational Discussion on Mental Health Topics	9	40.91%	9	64.29%	18	50.00%
Educational Discussion on Non-Mental Health Topics (such as travel, sports, etc.)	4	18.18%	5	35.71%	9	25.00%
Exercise	7	31.82%	5	35.71%	12	33.33%
Field Trips	11	50.00%	13	92.86%	24	66.67%
Foreign Language Skills	5	22.73%	0	0.00%	5	13.89%
Games	12	54.55%	6	42.86%	18	50.00%
Gardening	6	27.27%	8	57.14%	14	38.89%
Independent Living Skills	6	27.27%	7	50.00%	13	36.11%
Job Skill Building	7	31.82%	4	28.57%	11	30.56%
Leadership Class	7	31.82%	6	42.86%	13	36.11%
Music	11	50.00%	5	35.71%	16	44.44%
Nutrition	5	22.73%	4	28.57%	9	25.00%
One-On-One Discussions with Mental Health Staff	8	36.36%	8	57.14%	16	44.44%
Peer Support Groups	9	40.91%	4	28.57%	13	36.11%
Photography	6	27.27%	4	28.57%	10	27.78%

Providing Community Education regarding Mental Health Topics	5	22.73%	5	35.71%	10	27.78%
Relationship Skills	9	40.91%	9	64.29%	18	50.00%
Skill Sharing	5	22.73%	3	21.43%	8	22.22%
T-House Outreach / Community Building	5	22.73%	4	28.57%	9	25.00%
Theatrical Performance	5	22.73%	2	14.29%	7	19.44%
Volunteering	12	54.55%	7	50.00%	19	52.78%
Other (please specify): Suggestions include Karaoke, Science, Yoga, Fabric/Textiles, Movies, and Dance	9	40.91%	2	14.29%	11	30.56%

El Dorado County
Health and Human Services Agency
Mental Health Division
Mental Health Services Act (MHSA)

Wellness Center/Clubhouse Activities Survey

1. **Please select your location:**

   ☐ Placerville ☐ South Lake Tahoe

2. **On average, how often do you attend the Wellness Center/Clubhouse?**

   ☐ 1 day per week
   ☐ 2 days per week
   ☐ 3 days per week
   ☐ 4 days per week
   ☐ 5 days per week
   ☐ 1 to 2 times per month
   ☐ 3 to 5 times per month
   ☐ 6 to 8 times per month
   ☐ 9 or more times per month
   ☐ A few times per year
   ☐ Other (please specify):

3. **What is your gender?**

   ☐ Female ☐ Male

4. **Which category below includes your age?**

   ☐ 18 – 25 ☐ 26 – 40 ☐ 41 – 59 ☐ 60 or older

5. **In which of the following Wellness Center/Clubhouse activities (existing or new) would you participate?**

   ☐ Art
   ☐ Computer Skill Building
   ☐ Cooking
   ☐ Crafts
   ☐ Educational Discussion on Mental Health Topics
   ☐ Educational Discussions on Non-Mental Health Topics (such as travel, sports, etc.)
   ☐ Exercise
   ☐ Field Trips
   ☐ Foreign Language Skills
   ☐ Games
   ☐ Gardening
   ☐ Independent Living Skills
   ☐ Job Skill Building
   ☐ Leadership Class
   ☐ Music
   ☐ Nutrition
   ☐ One-on-One Discussions with Mental Health Staff
   ☐ Peer Support Groups
   ☐ Photography
   ☐ Providing Community Education regarding Mental Health Topics
   ☐ Relationship Skills
   ☐ Skill Sharing
   ☐ T-House Outreach / Community Building
   ☐ Theatrical Performance
   ☐ Volunteering
   ☐ Other (please specify):

Attachment C
MHSA Allocations and Expenditures

FY 2012/13
MHSA FUNDING SUMMARY

County: **El Dorado County** **Date:** **09/30/2013**

	MHSA Funding						
	PEI	**CSS**	**INN**	**WET**	**CFTN**	**Local Prudent Reserve**	**Total FY 2012/13 Funding**
FY 2012/13 Revenues							
New MHSA Funding	$1,056,313	$4,347,694	$277,977	$0	$0	$0	$5,681,984
Funding from Other Sources and Offsetting Expenditures (e.g., Medi-Cal reimbursement, interest)	$0	$663,234	$0	$2,142	$0	$0	$665,376
FY 2012/13 Net Revenues	$1,056,313	$5,010,928	$277,977	$2,142	$0	$0	$6,347,360
FY 2012/13 Expenditures:	$667,329	$2,215,253	$9,274	$30,227	$689,730	$0	$3,611,813
FY 2012/13 Contribution to Fund Balance / (Use of Fund Balance)	$388,984	$2,795,675	$268,703	($28,085)	($689,730)	$0	$2,735,547

FY 2013/14
MHSA FUNDING SUMMARY

County: El Dorado County **Date:** 10/31/2013

	MHSA Funding							
	PEI	**PEI-TTACB**	**CSS**	**INN**	**WET**	**CFTN**	**Local Prudent Reserve**	**Total FY 2013/14 Funding**
A. Estimated FY 2013/14 Funding								
Estimated Unspent Funds from Prior Fiscal Years (Fund Balance)	$1,203,584	$21,700	$4,430,880	$1,065,944	$360,026	$706,901	$1,898,284	$8,462,035
Estimated New MHSA FY 2013/14 Funding	$1,066,068	$0	$4,660,288	$299,430	$0	$0	$0	$4,959,718
Funding from Other Sources (Public Safety Realignment 2011 (AB109), interest)	$0	$0	$140,000	$0	$0	$0	$0	$140,000
Estimated Available Funding for FY 2013/14:	**$2,269,652**	**$21,700**	**$9,231,168**	**$1,365,374**	**$360,026**	**$706,901**	**$1,898,284**	**$13,561,753**
B. Estimated FY 2013/14 Expenditures:								
PEI - Program 1: Youth and Children's Services Program								
Project 1a: Children 0-5 and Their Families	$125,000							$0
Project 1b: Mentoring for 3-5 Year Olds	$75,000							$0
Project 1c: Incredible Years	$50,000							$0
Project 1d: Primary Intervention Project (PIP)	$106,350							$0
Project 1e: SAMHSA Model Programs	$192,500							$0
PEI - Program 2: Community Education Project								
Project 2a: Mental Health First Aid	$35,000							$0
Project 2b: National Alliance on Mental Illness Training	$10,000							$0
Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education	$5,000							$0
Project 2d: Community Information Access	$10,000							$0
Project 2e: Suicide Prevention and Stigma Reduction	$30,000							$0
Project 2f: Foster Care Continuum Training	$50,000							$0
Project 2g: Community Outreach and Resources	$20,000							$0
PEI - Program 3: Health Disparities Program								
Project 3a: Wennem Wadati - A Native Path to Healing	$125,725							$0
Project 3b: Latino Outreach	$231,128							$0
PEI - Program 4: Wellness Outreach Program for Vulnerable Adults								
Project 4a: Wellness Outreach Ambassadors and Linkage to Clubhouse Membership	$50,000							$0
Project 4b: Senior Peer Counseling	$35,000							$0
Project 4c: Older Adults Program	$75,000							$0

FY 2013/14
MHSA FUNDING SUMMARY

County: El Dorado County **Date:** 10/31/2013

	MHSA Funding							
	PEI	PEI-TTACB	CSS	INN	WET	CFTN	Local Prudent Reserve	Total FY 2013/14 Funding
PEI - Program 5: Community-Based Services								
Project 5a: Community-Based Mental Health Services	$75,000							$0
Project 5b: Community Health Outreach Worker	$35,000							$0
PEI - Administrative Costs [a]	$216,308							$0
PEI - TTACB		$21,700						$0
CSS - Program 1: Youth and Family Strengthening Program								
Project 1a: Youth and Family Full Service Partnership			$600,000					$600,000
Project 1b: Family Strengthening Academy			$400,000					$400,000
Project 1c: Foster Care Enhanced Services			$500,000					$500,000
CSS - Program 2: Wellness and Recovery Services								
Project 2a: Wellness Center			$1,100,000					$1,100,000
Project 2b: Adult Full Service Partnership			$2,000,000					$2,000,000
Project 2c: Older Adults Program (Partner program to PEI Older Adults Program)			$250,000					$250,000
Future Potential Project 2d: Assisted Outpatient Treatment (Laura's Law)			$250,000					$250,000
CSS - Program 3: Transition Age Youth (TAY) Services								
Project 3a: TAY Engagement, Wellness and Recovery Services			$350,000					$350,000
CSS - Program 4: Resource Management Services								
Project 4a: Outreach and Engagement Services			$250,000					$250,000
Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)			$500,000					$500,000
Project 4c: Resource Management Services			$200,000					$200,000
Innovation				TBD				$0
WET - Program 1: Workforce Education and Training (WET) Coordinator					$50,000			$50,000
WET - Program 2: Workforce Development					$100,000			$100,000
WET - Program 3: Psychiatric Rehabilitation Training					$5,000			$5,000
WET - Program 4: Early Indicators of Mental Health Issues					$50,000			$50,000
WET - Program 5: Suicide Prevention Training					$50,000			$50,000
WET - Program 6: Consumer Leadership Academy					$30,000			$30,000
WET - Program 7: Crisis Intervention Team Training					$20,000			$20,000

FY 2013/14
MHSA FUNDING SUMMARY

County: El Dorado County **Date:** 10/31/2013

	MHSA Funding							
	PEI	PEI-TTACB	CSS	INN	WET	CFTN	Local Prudent Reserve	Total FY 2013/14 Funding
CFTN - Program 1: Electronic Health Record System Implementation								
Program 1a: Avatar Clinical Workstation						$225,000		$225,000
Program 1b: Electronic Outcome Measurement Tools						$5,000		$5,000
CFTN - Program 2: Telehealth (formerly Telemedicine)						$130,000		$130,000
CFTN - Program 3: Electronic Care Pathways						$25,900		$25,900
Off-setting Expenditures (Medi-Cal, Insurance, Private Payor)			($1,116,510)					($1,116,510)
FY 2013/14 Year End Estimated Fund Balance	$2,269,652	$21,700	$2,831,168	$1,365,374	$55,026	$321,001	$1,898,284	$6,470,853

D. Estimated Local Prudent Reserve Balance	
1. Local Prudent Reserve Balance on June 30, 2013	$1,898,284
2. Contributions to the Local Prudent Reserve in FY13/14 [a]	$601,716
3. Distributions from Local Prudent Reserve in FY13/14	$0
4. Estimated Local Prudent Reserve Balance on June 30, 2014	$2,500,000

[a/] Per 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/MentalHealth-InfoNotices.aspx. Since PEI is predominantly contract provider funded, the administrative costs are listed separately. The other MHSA components have the administrative costs built into the overall project costs.

Additonal Notes:

MHSA Administration is budgeted to receive an additional $20,893 in Medi-Cal reimbursements for FY 2013-14.

Per 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.