El Dorado County Mental Health Services Act Three-Year Program and Expenditure Plan

Fiscal Years 2017-18 through 2019-20

HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH DIVISION

WELLNESS | RECOVERY | RESILIENCY

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MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: El Dorado

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Patricia Charles-Heathers, Ph.D., MPA	Name: Joe Harn, Auditor-Controller
Telephone Number: 530-621-6270	Telephone Number: 530-621-5487
E-mail: patricia.charles-heathers@edcgov.us	E-mail: joe.harn@edcgov.us
Local Mental Health Mailing Address: El Dorado County Health and Human Services Agency, Behavioral Health Division, 768 Pleasant Valley Road, 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.

Patricia Charles-Heathers, Ph.D., MPA — Local Mental Health Director (PRINT)

Patricia Charles-Heathers — Signature — 6/22/17 — Date

I hereby certify that for the fiscal year ended June 30, 2017, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 3/23/17 for the fiscal year ended June 30, 2016. I further certify that for the fiscal year ended June 30, 2017, 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 — 7-17-17 — Date

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

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: El Dorado

☒ Three-Year Program and Expenditure Plan
☐ Annual Update

Local Mental Health Director	Program Lead
Name:Patricia Charles-Heathers, Ph.D., MPA	Name: Ren Scammon
Telephone Number: 530-621-6270	Telephone Number: 530-621-6321
E-mail: patricia.charles-heathers@edcgov.us	E-mail: ren.scammon@edcgov.us
Local Mental Health Mailing Address: El Dorado County Health and Human Services Agency, Behavioral Health Division 768 Pleasant Valley Road Diamond Springs, CA 95619	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on June 20, 2017.

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.

Patricia Charles-Heathers, Ph.D., MPA
Local Mental Health Director (PRINT)

Patricia Charles-Heathers 6-22-17
Signature Date

Message from the Director

Thank you for taking time to read this report about Behavioral Health services in the County of El Dorado (EDC). This report will provide a summary of the projects and activities that have been made possible through the Mental Health Services Act (MHSA).

The goal of the MHSA is to transform the community behavioral health system in California. The EDC Health and Human Services Agency (HHSA) has been actively working towards that goal since the passage of MHSA in 2004. While there is still much to do, awareness has been raised about the stigma of mental illness and reducing this stigma, along with expansion of the scope of services available to serve individuals with chronic and severe mental illness.

Critical to the success of our MHSA services has been the participation and dedication of our staff, stakeholders, community partners and providers. Through collaborative efforts, we have developed a range of programs and services including those that support our clients and their families as well as education programs and resources that benefit our El Dorado County communities. We are committed to providing quality care and services for our residents and we remain attentive to assure that we exercise sound fiscal management so that MHSA dollars are spent in the most effective manner.

Since the implementation of the Mental Health Services Act (MHSA) in 2005, there have been several changes that impact this service. Some of the changes include how funding is provided to Counties and new component requirements that were discussed in past MHSA Plans. Participation from our partners is therefore critical as we develop our MHSA plans for the coming year. I am confident in the continued success of our MHSA projects and look forward to the collaborative effort that will result in programs and services that most effectively serve our El Dorado County residents.

Best Regards,

Patricia Charles-Heathers, Ph.D., M.P.A.
Director of the County of El Dorado
Health and Human Services Agency

MHSA Background and Purpose of Three-Year Program and Expenditure Plan

Artwork by Wellness Center Client

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 (5) components that address specific goals for priority populations and key community mental health needs. Prevention and Early Intervention (PEI) focuses on education, supports, early interventions and a reduction in disparities for underserved groups seeking access to mental health services. Community Services and Supports (CSS) focuses on the development of recovery-oriented services for children, youth, adults and older adults with serious mental illness. Included in CSS is permanent and supportive housing. The remaining components, Innovation (INN), Workforce Education and Training (WET) and Capital Facilities and Technological Needs (CFTN) serve to introduce new and creative ways of addressing community mental health needs, support the development of well trained, qualified and diverse workforce, and strengthen the foundation of the mental health system.

Under MHSA, counties must develop programs and services based on the following general standards:

- Community collaboration
- Cultural competence
- Client driven
- Family driven
- Wellness, recovery and resiliency focused
- Integrated service experiences for clients and their families

Purpose of Three-Year Program and Expenditure Plan

The purpose of the Three-Year Program and Expenditure Plan is to provide El Dorado County stakeholders with an overview of the direction of Behavioral Health services in El Dorado County for the next three years, and to report on existing MHSA projects and services.

MHSA Legislative Changes and Plan Requirements

The most recent instructions issued by the Mental Health Services Oversight and Accountability Commission (MHSOAC) were for the Fiscal Year (FY) 2015-16 MHSA Plan

Update. MHSA Plans are written for three-year durations; however, plans are to be updated annually to allow for significant changes from the prior year's plan. This new MHSA Three-Year Plan covers FY 2017-18 through FY 2019-20. The MHSOAC adopted new regulations for the PEI and Innovation components effective October 2015 and the new requirements have been incorporated into this Three-Year Plan.

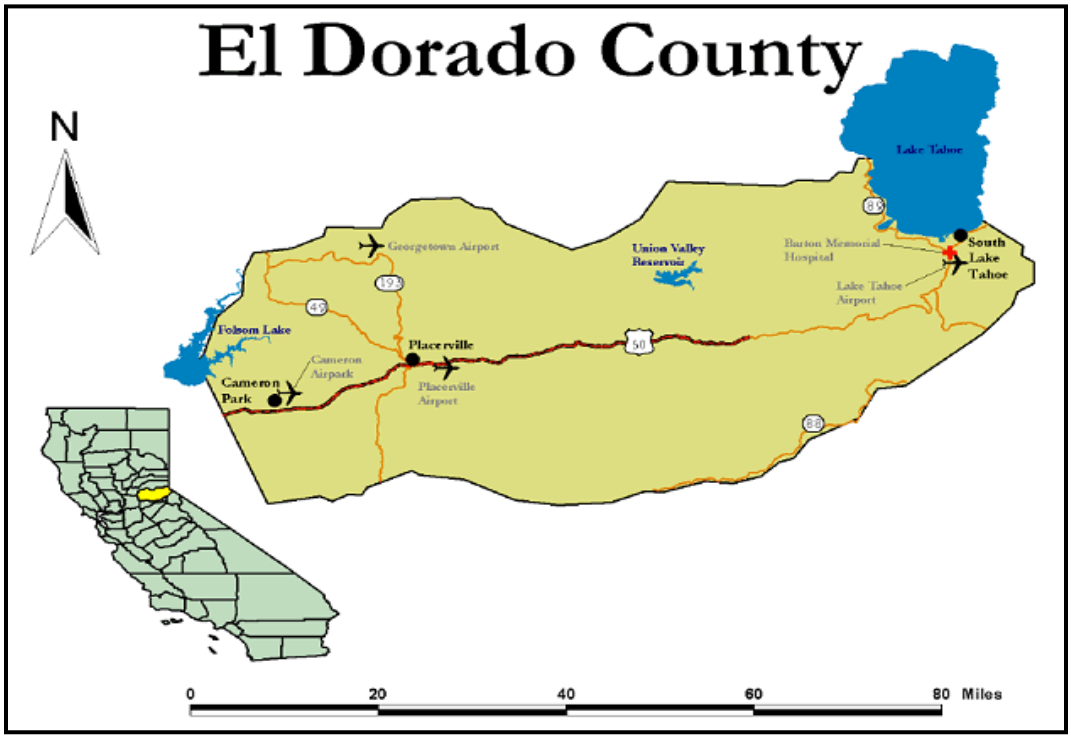
El Dorado County Snapshot / Demographics

Snapshot

El Dorado County, located in east-central California, encompasses 1,805 square miles of rolling hills and mountainous terrain. The County's western boundary contains part of Folsom Lake and the eastern boundary extends to the California-Nevada State line. The County is topographically divided into two zones. The northeast corner of the County is in the Lake Tahoe basin, while the remainder of the County is in the "western slope," the area west of Echo Summit.

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.

The population of El Dorado County is 185,577. Approximately eighty percent of the county's population resides in unincorporated areas of the county. The rural nature of many unincorporated areas of the county results in challenges to obtaining health service (e.g., transportation, outreach to residents, and public awareness relative to available services).



As used within the MHSA Plan Update, the following regional definitions apply:

West County	Cameron Park, El Dorado Hills, Rescue, Shingle Springs
Placerville Area	Diamond Springs, El Dorado, Placerville, Pleasant Valley
North County	Coloma, Cool, Garden Valley, Georgetown, Greenwood, Kelsey, Lotus, Pilot Hill
Mid County	Camino, Cedar Grove, Echo Lake, Kyburz, Pacific House, Pollock Pines, Twin Bridges
South County	Fair Play, Grizzly Flats, Mt. Aukum, Somerset
Tahoe Basin	Meyers, South Lake Tahoe, Tahoma

County Demographics

The following charts provide a summary of El Dorado County's population information in these categories as obtained from WellDorado.org: [1]

- Age Groups
- Race / Ethnicity
- Gender
- Residence by Region
- Languages Spoken at Home (population ages 5+)

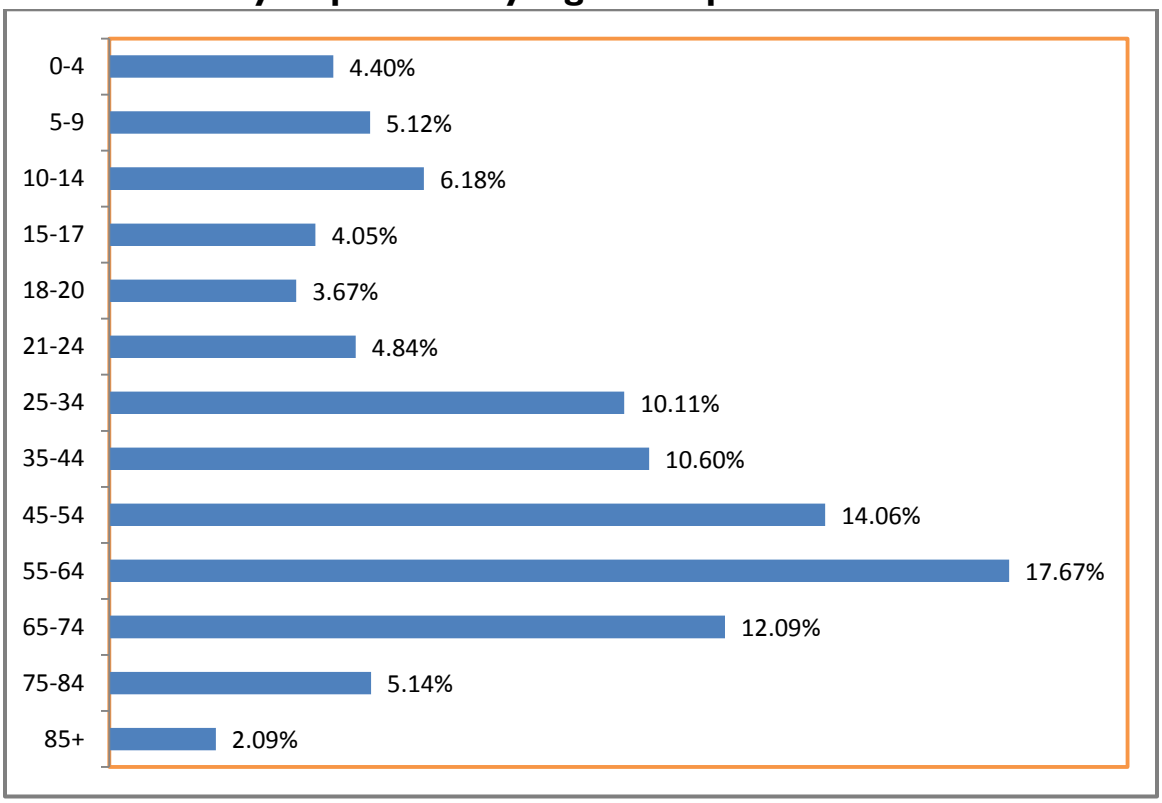
"The WELL DORADO website is intended to help community members and policy makers learn about the health of El Dorado County communities, support collaboration among partners, promote best practices, identify local resources, and drive decisions based on data. Our goal is to strengthen and build healthier communities through the provision of state-of the art web-based assessment and improvement tools."

"The WELL DORADO website is funded by the Public Health Division of the Health and Human Services Agency."

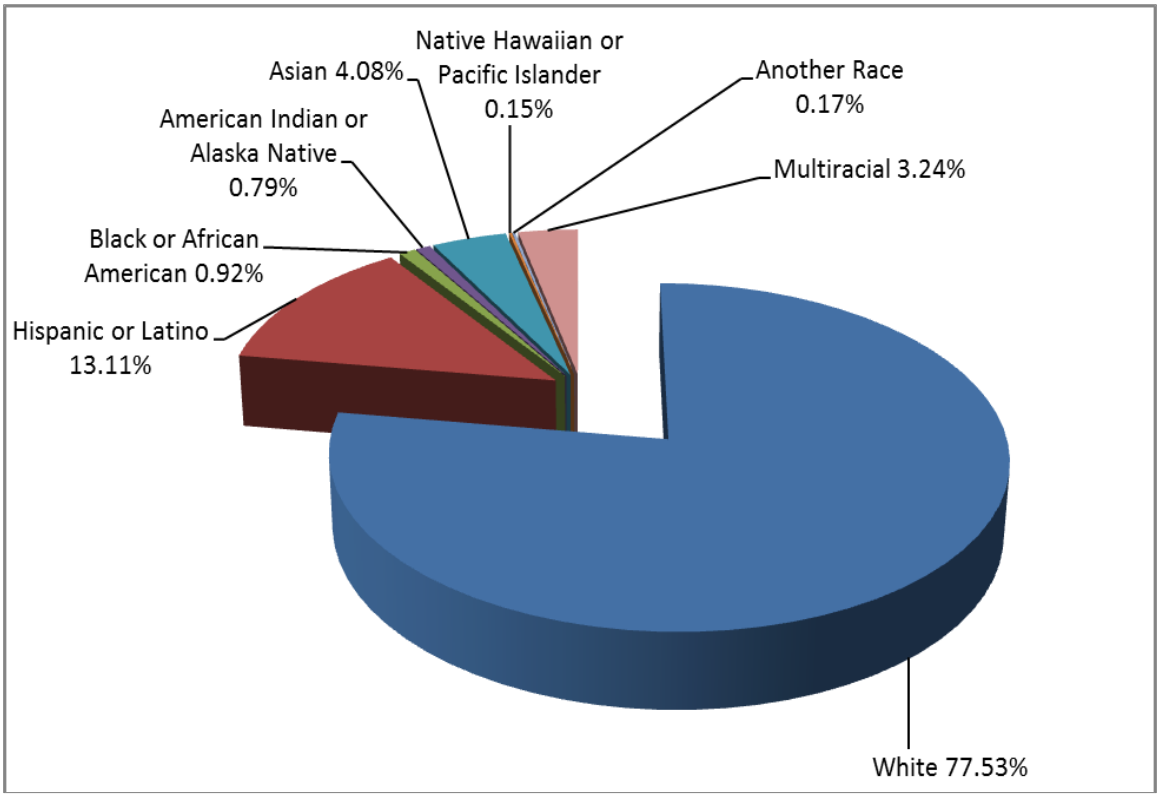
- www.welldorado.org

[1] Healthy Communities Institute. Community Dashboard. February 23, 2017. Retrieved from www.welldorado.org.

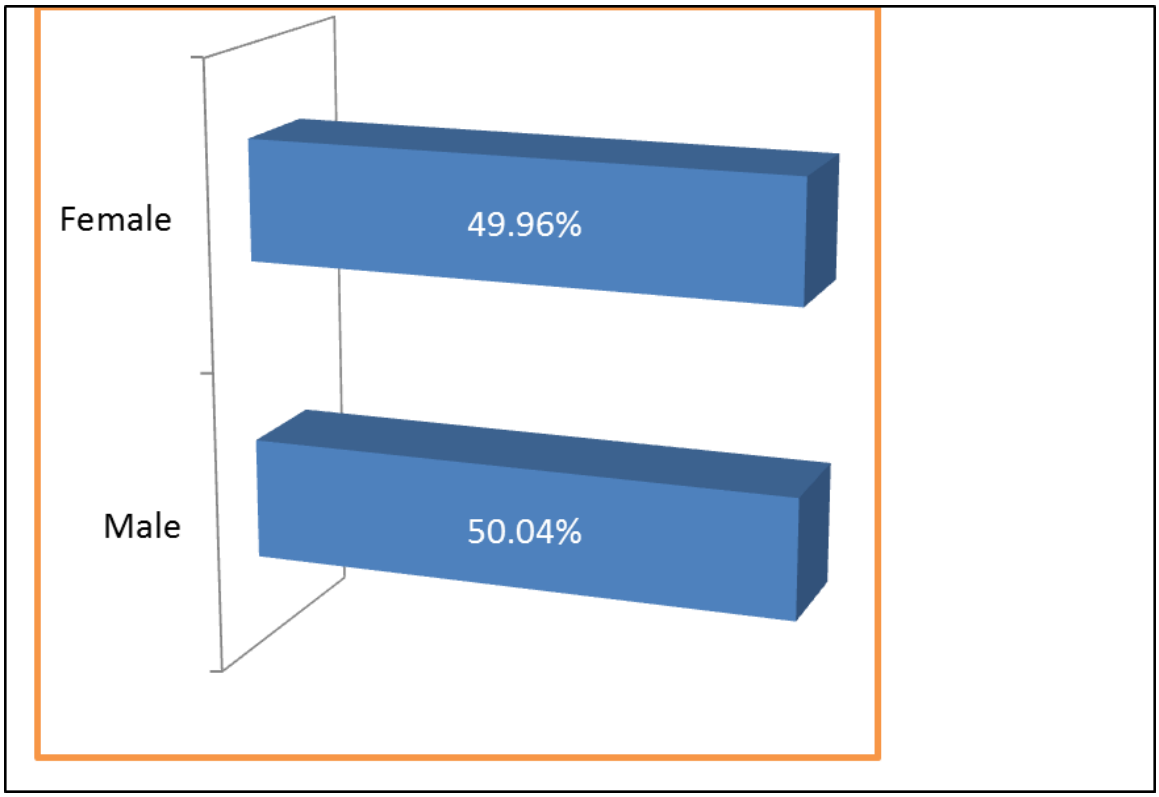
El Dorado County Population by Age Group



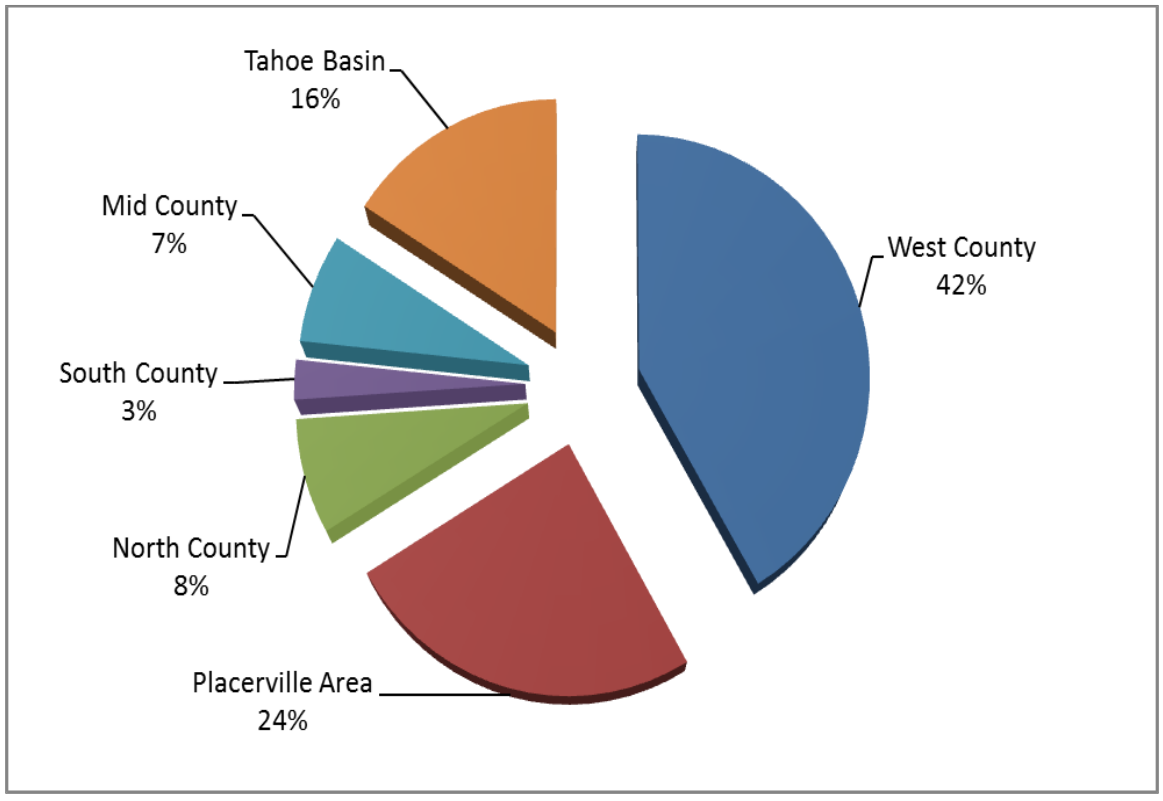
El Dorado County Population by Race and Ethnicity



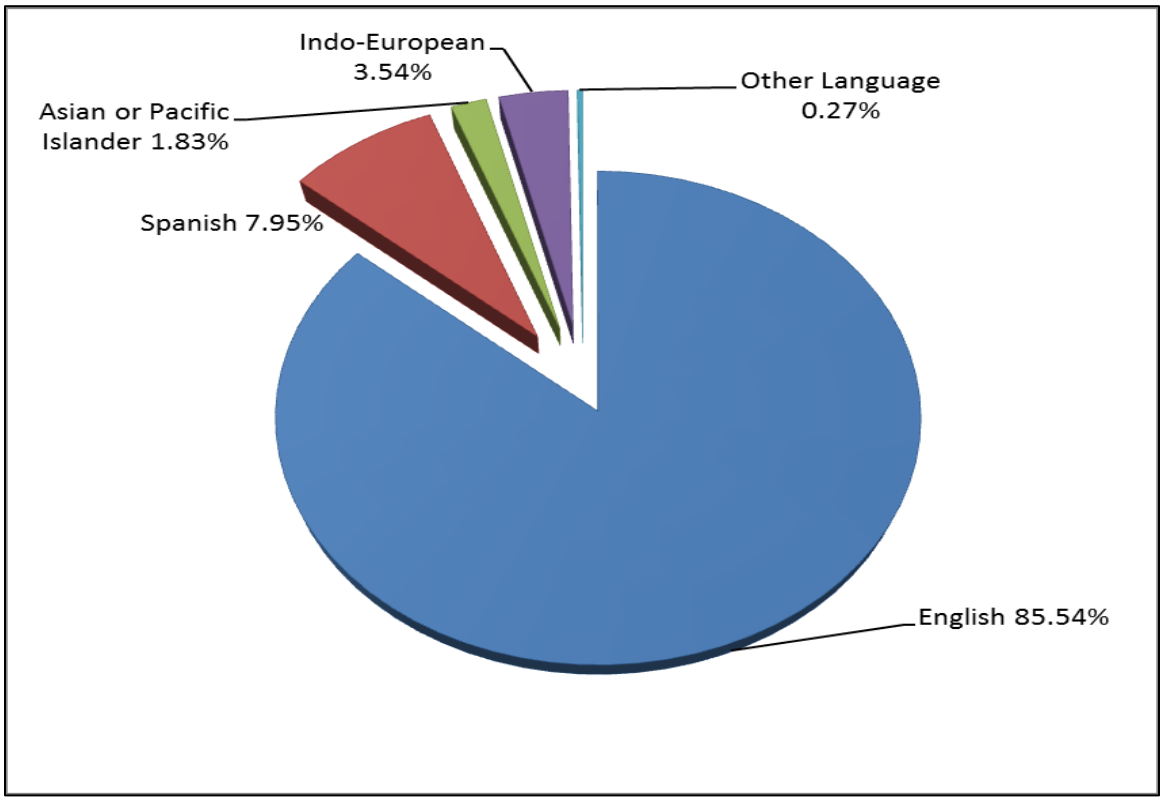
El Dorado County Population by Gender



El Dorado County Residence by Region



El Dorado County Language Spoken at Home (For population ages 5+)



Community Program Planning Process


Artwork by Wellness Center Client

The general public and stakeholders were invited to participate in or host MHSA planning opportunities and provide initial comment to contribute to the development of the County's MHSA Three-Year Program and Expenditure Plan Fiscal Years 2017-18 through 2019-20.

The Community Program Planning Process consisted of three targeted approaches:

- **Community Meetings**: Community meetings were held in October and November 2016. Meetings were hosted by the South Lake Tahoe Mental Health Collaborative, the Drug Free Divide, the Commission on Aging, the West Slope Behavioral Health Division Wellness Center, NAMI El Dorado, and the Adverse Childhood Experiences Study (ACE Study) Collaborative.
- **Survey**: A copy of the survey can be found in the Community Program Planning Process section at the end of this document; and
- **Key Informant Interviews**: Interviews were conducted in January and February 2017.

Additionally, information received throughout the year from stakeholders, including the Mental Health Commission, was considered in the development of this Three-Year Program and Expenditure Plan.

The MHSA project team maintains a MHSA email distribution list for communicating with stakeholders and other interested parties. The distribution list includes over 600+ individuals, including:

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

A press release was issued on September 22, 2016 regarding the MHSA public meetings, distributed to local media contacts and newspapers, posted on the County's web page, and sent out via email to the MHSA distribution list. Flyers were posted and distributed at various

locations. Additionally, the public was invited to provide input via SurveyMonkey®. The survey link was posted to the County's website and sent out via email to the MHSA distribution list. Hard copy surveys were also distributed and collected from a variety of agencies and contract providers. There were 91 attendees at the community program planning meetings. Additionally, the MHSA team conducted several key informant interviews and a special veteran's focus group meeting. The MHSA team received 154 completed surveys (139 English and 15 Spanish).

All input received was considered in the development of this Three-Year Program and Expenditure Plan.

Input Received

Issues of primary concern include:

- Need for more services in the local communities and increased outreach efforts, including mobile outreach
- Comprehensive services to meet the needs of older adults and veterans
- Services for individuals with co-occurring mental illness and substance use disorders, including more local mental health and alcohol and drug providers, and the reduction on the impact to other community services as a result of individuals with co-occurring behaviors
- Peer led community Wellness Center
- Chronic homelessness and lack of affordable housing
- Increased services for individuals experiencing a first episode of psychosis
- Access to mental health services, including children involved with Probation
- Lack of information available explaining what services are available and how to access
- Inadequate funding for all services needed, particularly in light of all the new mandates for children's services
- Need for evidence-based outcome measures

Priority populations were identified as:

- Persons experiencing homelessness
- Children (including ages 0-5, school-aged and foster youth)
- Transitional Age Youth (including first episode psychosis)
- Older Adults
- Veterans
- Adults with serious mental illness (including co-occurring substance abuse)
- Persons with disabilities
- Jail releases and clients on probation
- Person experiencing mental health crisis
- LGBTQ individuals
- Hispanic or Latino individuals

These primary issues and priority populations are addressed in this MHSA Three-Year Plan to the extent possible given the funding levels of MHSA.

More information about the Community Program Planning Process has been included at the end of this document. Any substantive comment that is received about the draft Plan Update during the 30-day comment period and public hearing process will be summarized and included in the final Three-Year Plan.

Notification of the MHSA Three-Year Program and Expenditure Plan

HHSA provided notification of the MHSA Three-Year Program and Expenditure Plan publication as follows:

- **MHSA Three-Year Program and Expenditure Plan Fiscal Years 2017-18 through 2019-20 30-Day Comment Period:** The Draft MHSA Three-Year Plan was posted on the County's website on April 17, 2017 for a 30-day review period. Emails were sent on April 17, 2017 to the MHSA distribution list, the Mental Health Commission members, the Chief Administrative Office (CAO), the Board of Supervisors' offices, and HHSA staff advising recipients that the Draft MHSA Three-Year Plan was posted and available for public comment for 30 days. A press release was distributed on April 17, 2017, to the Tahoe Daily Tribune, Mountain Democrat, Georgetown Gazette, Sacramento Bee, Life Newspaper (Village Life) and El Dorado Hills Telegraph. The public comment period closed on May 17, 2017 at 5:00 p.m.

- **MHSA Three-Year Program and Expenditure Plan Fiscal Years 2017-18 through 2019-20 Public Hearing:** It is anticipated that the Mental Health Commission will hold a public hearing on the Draft MHSA Three-Year Plan on May 24, 2017. The date and time of the meeting was noticed on the Mental Health Commission's calendar and the MHSA web page, and was sent out to individuals on the MHSA email distribution list.

- **El Dorado County Board of Supervisors:** This Plan was presented to the El Dorado County Board of Supervisors for adoption on June 20, 2017. Notification of the date and time was posted on the MHSA web page and was included on the Board of Supervisors agenda.

- **California Mental Health Services Oversight and Accountability Commission (MHSOAC):** Within 30 days of the Board of Supervisors' approval of the MHSA Three-Year Program and Expenditure Plan Fiscal Years 2017-18 through 2019-20, a copy of the Plan will be provided to the MHSOAC as required by the MHSA.

Contracted Providers

MHSA programs list the current provider(s). In the event a new provider is to be selected, providers will be selected in compliance with the Board of Supervisors Policy C-17, Procurement Policy, or the County may elect to implement the program directly. The Current Provider listed for each program/project is subject to change during the implementation of this Three-Year Plan.

MHSA Three-Year Plan Programs

This MHSA Three-Year Plan is ambitious and where necessary, there will be planned implementation of program components over three years. Some services will start or continue at the beginning of the Three-Year Plan and others will start in year two or year three. There may be a need to alter the direction of services based on funding or community demand, and this Plan allows for such flexibility. There will be annual updates to this Three-Year Plan to allow for major changes, if necessary. The programs for each of the five MHSA Components for the next three years are detailed below.

Artwork by Wellness Center Client

Prevention and Early Intervention

The MHSA Prevention and Early Intervention (PEI) component consists of projects intended to prevent serious mental illness / emotional disturbance by promoting mental health, reducing mental health risk factors and by intervening to address mental health problems in the early stages of the illness. PEI projects emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness: 1) suicide; 2) incarceration; 3) school failure or dropout; 4) unemployment; 5) prolonged suffering; 6) homelessness; and 7) removal of children from their homes.

As a result of the new PEI Regulations (adopted October 2015 by the MHSOAC), this Three-Year Plan restructures projects into categories to align with the reporting requirements in the new regulations. Projects must now fall into one of the following categories:

1. Prevention
2. Early Intervention
3. Stigma and Discrimination Reduction
4. Outreach for Increasing Recognition of Early Signs of Mental Illness
5. Access and Linkage to Treatment
6. Suicide Prevention
7. Improving Timely Access to Services for Underserved Populations.

The first six categories of programs are required to be included in the PEI component. The seventh category is optional. However, Timely Access to Services for Underserved Populations aligns with the County's CSS "Outreach and Engagement" project that includes specific funding for improving access to mental health services for individuals who are homeless through the Projects for Assistance in Transition from Homelessness (PATH) grant, and it is therefore not an included category under PEI.

Additionally, specific strategies must be included within the services provided in each category:

- Provide access and linkage to treatment;
- Be designed, implemented, and promoted in ways that improve timely access to mental health services for individuals and/or families from underserved populations.
- Be designed, implemented, and promoted using strategies that are non-stigmatizing and non-discriminatory

While it is the preference of the El Dorado County Health and Human Services Agency, Behavioral Health Division (BHD) that PEI services be evidence-based, PEI programs may be based on one or more of the following standards:

- Evidence-based practice;
- Promising practice; and/or
- Community and/or practice-based evidence.

PEI services must be provided in a manner consistent with the MHSA general standards referenced above. These requirements are further defined in each contract that is developed or amended for PEI services. For example, services provided by individuals who are bilingual and bicultural, as appropriate, through organizations that practice and provide collaboration with other community partners, with services focusing on client and family desires. PEI programs are designed to focus on services that help clients achieve wellness, recovery and resilience by building protective factors and networks of natural and community supports.

Stakeholder involvement in program planning is discussed under "Community Program Planning Process," above. Stakeholders will further be involved in PEI through the BHD's Quality Improvement Committee, which is involved in program implementation, monitoring, quality improvement, evaluation, and budget allocations.

Based on feedback received from the Community Program Planning Process, many smaller individual projects have been combined or consolidated into the above categories, and program/project numbers have been eliminated. A crosswalk has been included at the end of this section identifying the new program organization.

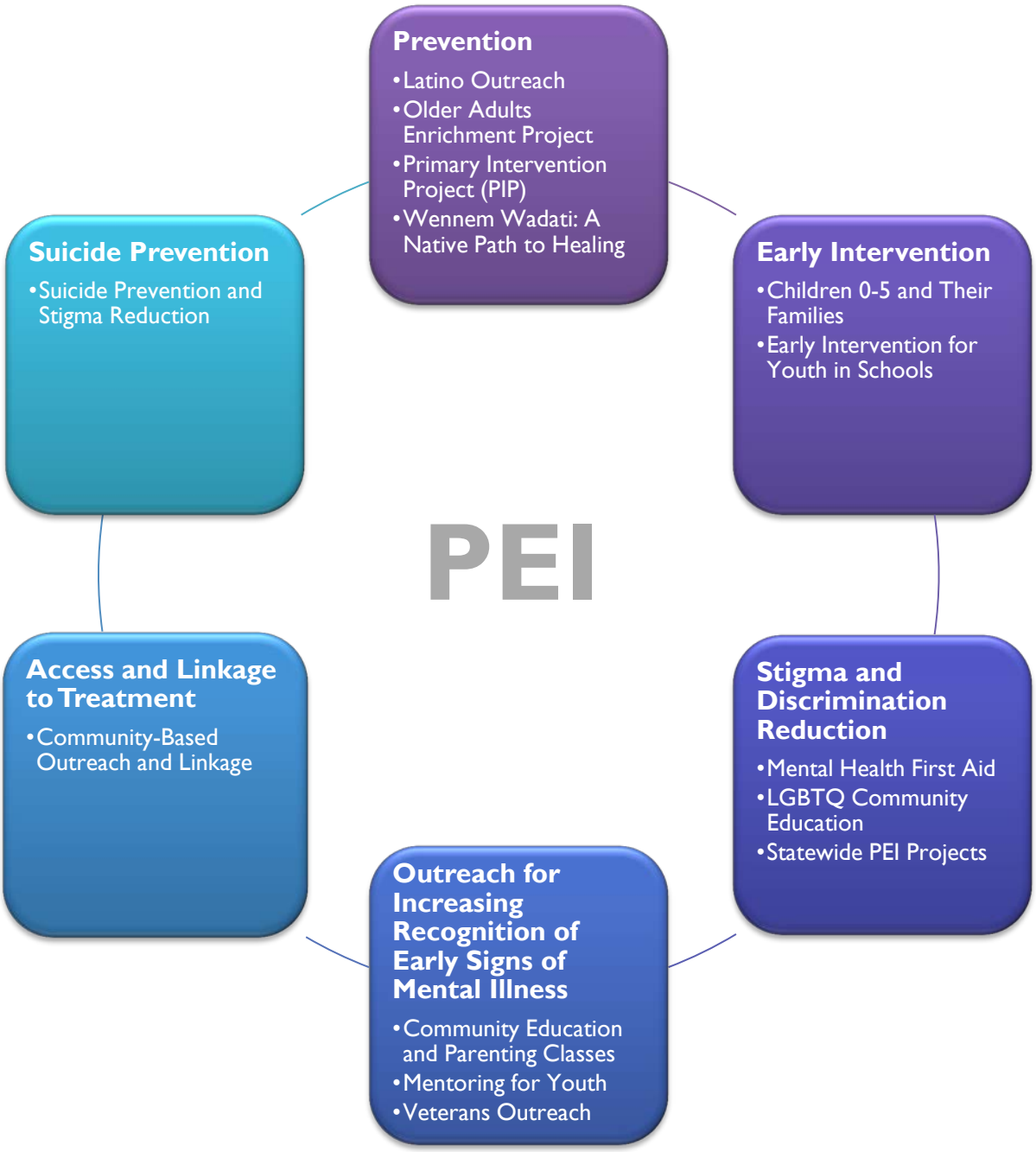
The new PEI Regulations include specific reporting requirements and outcome measures for each type of PEI program. Those requirements are identified within the section for each category. Additionally, the PEI regulations require a broad array of demographic information that will not be listed in each section. The demographic data includes age group, race, ethnicity, primary language, sexual orientation, disability, veteran status and gender.

Additional PEI requirements include:

(a) Counties are required to serve all ages in one or more programs within the PEI Component.

(b) At least 51% of PEI funds shall be used to serve individuals who are 25 years old or younger.
(c) Programs that serve parents, caregivers, or family members with the goal of addressing MHSA outcomes for children or youth at risk of or with early onset of a mental illness can be counted as meeting the requirements in (a) and (b) above.

PEI programs are now structured in the following manner:



Prevention Program

"Prevention Program" means a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of this Program is to bring about mental health including reduction of the applicable negative outcomes as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is greater than average and, as applicable, their parents, caregivers, and other family members. Services may include relapse prevention for individuals in recovery from a serious mental illness and universal prevention.

"Risk factors for mental illness" means conditions or experiences that are associated with a greater than average risk of developing a potentially serious mental illness. Risk factors include, but are not limited to, biological including family history and neurological, behavioral, social/economic, and environmental.

The following information, outcomes and/or indicators are required for each Prevention Program:

1. Unduplicated numbers of individuals served, including demographic data.
    a. If a program served families the County shall report the number of individual family members served.
2. The reduction of prolonged suffering that may result from untreated mental illness by measuring a reduction in risk factors, indicators, and/or increased protective factors that may lead to improved mental, emotional, and relational functioning.
3. Completion of Quarterly and Year End Reports.
4. Implementation challenges, successes, lessons learned, and relevant examples.
5. Any other outcomes and indicators identified.

Latino Outreach

The Latino Outreach project is a prevention program that addresses isolation in the Spanish-speaking or limited English-speaking Latino adult population, peer and family problems in the youth population, and 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. Services are offered countywide through New Morning Youth and Family Services on the West Slope and the Family Resource Center in South Lake Tahoe.

This project utilizes a Promotora services program that provides bilingual/bicultural Spanish-speaking outreach, engagement, screening, integrated service linkage, interpretation services and peer/family support for Latino individuals and families. This strategy is intended to promote mental health and reduce the stigma regarding and barriers to mental health services thereby decreasing the mental health/health disparities experienced by the Latino population. Services offered on each slope of the County may vary from each other depending on the needs identified by the local communities.

Project 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.
- Reduce stigma and discrimination
- Integration of prevention programs already offered in the community is achieved.
- Reduction in suicide, incarcerations, and school failure or dropouts.

Outcome Measures

In addition to the required outcomes and indicators identified for each PEI program type, the following measurements will be evaluated:

- Measurement 1: Customer satisfaction surveys.
- Measurement 2: Client outcome improvement measurements.
- Measurement 3: Increased engagement in traditional mental health services.

Current Provider(s): New Morning Youth and Family Services (West Slope); South Lake Tahoe Family Resource Center (Tahoe Basin)

Older Adults Enrichment Project

The Older Adults Enrichment project has combined the Senior Peer Counseling project with the previous Older Adults Program to provide a more comprehensive program to meet the needs of the senior population in our community. This MHSA Three-Year Plan includes the development of a Friendly Visitor program in year one, as well as an expansion of services to the Tahoe Basin in year two, and training. The Older Adults Enrichment Project may also include the services of a nurse to help address the needs of older adults, as well as assist in access and linkage to health care (including mental health) services.

Senior Peer Counseling is a prevention program which provides free confidential individual counseling to adults age 55 and older. Senior Peer Counseling volunteers evaluate the needs of potential clients, frequently referring them or assisting them in making contact with other community services, including Mental Health evaluation and treatment. Services are available in clients' homes and other community meeting places. Senior Peer Counseling counselors assist clients in regular self-assessment of their feelings of well-being using a standardized measurement tool. The supervisory services of a licensed mental health clinician are essential to the operation of Senior Peer Counseling. The supervisor meets weekly with the volunteers, reviewing the progress of each client, which ensures that standards of practice are met protecting clients, counselors and the community

The ***Friendly Visitor*** program is designed to help older adults prevent or overcome the physical and mental health risks associated with isolation and loneliness through trained volunteers who are willing to provide companionship through weekly visits or phone calls. Volunteers may help identify the client's unmet needs and assist with access and linkage to mental health services or other needed health care or social services resources. This project will help lower the risks associated with social isolation, including but not limited to depression, self-medication, anxiety

and loss of interest in life's daily activities. Similar supervisory services will be provided to the Friendly Visitor program volunteers as provided in Senior Peer Counseling.

Project Goals

- Clients demonstrate an increased number of "Therapeutic Lifestyle Changes" (TLCs) over the course of their counseling.
- Clients identify the primary issue of focus (presenting problem) for counseling.
- Clients achieve improvements in their feelings of well-being as shown on the Outcome Rating Scale (ORS) measurement tool.
- Clients are informed about other relevant mental health and support services.
- New volunteer trainings will be provided based on need for both Senior Peer Counselors and Friendly Visitors.
- Through the use of TLCs, clients improve their mental health and self-sufficiency.
- Clients ameliorate their distress as described in their presenting problem.
- Clients' mental health and satisfaction with life is increased as evidenced by scores on the ORS measurement tool.
- Clients know of, and successfully access, other needed mental health services.

Outcome Measures

In addition to the required outcomes and indicators identified for each PEI program type, the following measurements will be evaluated:

- 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: Exercise, Nutrition / Diet, Nature, Relationships, Recreation / Enjoyable Activities, Relaxation / Stress Management, Religious / Spiritual Involvement, and Contribution / Service
- Measurement 2: ORS which measures the following four psychological categories: 1) Individually (personal well-being); 2) Interpersonally (family, close relationships); 3) Socially (work, school, friendships); and 4) Overall (general sense of well-being)
- Measurement 3: Volunteers will record the clients' self-reported improvement in the presenting problem as selected by the client at the start of counseling.

Current Provider(s): EDCA Lifeskills (Senior Peer Counseling); To be determined (Friendly Visitor)

Primary Intervention Project (PIP)

The Primary Intervention Project (PIP) 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. PIP is currently

offered in the Black Oak Mine Unified School District, the Buckeye Unified School District, the Lake Tahoe Unified School District, and the Rescue Union School District

In the PIP project, supervised and trained child aides provide weekly non-directive play sessions with the selected students. 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. Parents/guardians and teaching staff are encouraged to build alliances to promote student's mental health and social and emotional development. Parental consent is required for student participation.

Project 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
- To decrease school adjustment difficulties at an early age and build protective factors to foster youth resilience and mental health

Outcome Measures

In addition to the required outcomes and indicators identified for each PEI program type, the following measurements will be evaluated:

- 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).

Current Provider(s): Black Oak Mine Unified School District (Divide Area); Tahoe Youth and Family Services (South Lake Tahoe); and West County provider to be determined

Wennem Wadati: A Native Path to Healing

The Wennem Wadati: A Native Path to Healing project is a prevention program designed by The County of El Dorado's Native American Resource Collaborative, which applies a combination of mental health services and traditional cultural teachings unique to the local Native American community. The project 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 project uses various prevention 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. Services are provided at Foothill Indian Education Alliance in Placerville, schools and other community-based sites accessible to the Native American population.

Talking Circles will be conducted at schools and other community-based sites that are accessible to Native American individuals, each facilitated by Cultural Specialists. The project also facilitates monthly traditional gatherings, cultural activities and youth activities designed to

spread cultural knowledge and support family preservation. One multi-day field trip will be scheduled for the Student Leadership group annually. A dedicated crisis line is available 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 Goals

- Increased awareness in the Native American community about the crisis line and available services.
- 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.
- Support culturally relevant mental health providers and their prevention efforts.

Outcome Measures

In addition to the required outcomes and indicators identified for each PEI program type, the following measurements will be evaluated:

- Measurement 1: Casey Life Skills Native American Assessment.

Current Provider(s): Foothill Indian Education Alliance

Early Intervention Program

"Early Intervention Program" means treatment and other services and interventions, including relapse prevention, to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including the applicable negative outcomes that may result from untreated mental illness. Early Intervention Program services are time limited not to exceed the duration identified by the County, and in no situation more than 18 months unless the individual is identified as experiencing first onset of psychotic features, in which case PEI services shall not exceed four years (these individuals would be transferred to other Specialty Mental Health Services). Early Intervention Program services may include services to parents, caregivers, and other family members of the person with early onset of a mental illness, as applicable.

The following information, outcomes and/or indicators are required for each Early Intervention Program:

1. Unduplicated numbers of individuals served, including demographic data.
    a. If a program served families the County shall report the number of individual family members served.
2. The reduction of prolonged suffering that may result from untreated mental illness by measuring reduced symptoms and/or improved recovery, including mental, emotional, and relational functioning.
3. Completion of Quarterly and Year End Reports.

4. Implementation challenges, successes, lessons learned, and relevant examples.
5. Any other outcomes and indicators identified.

Children 0-5 and Their Families

The Children 0-5 and Their Families project is an early intervention program provided by the Infant-Parent Center to children 0-5 and their families. Services are provided in the vendor's Cameron Park office, but services may be provided to all eligible families who wish to be seen in Cameron Park. Additionally, services may be expanded to include South Lake Tahoe depending on the needs of the community which are currently being assessed and evaluated. This project assists in early intervention by addressing needs of young children who may be experiencing symptoms related to adjustment disorder, oppositional defiance disorder, and other childhood emotional disorders.

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. Activities performed 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)

Project 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
- Decreased number of children removed from the home
- Decreased incidence of prolonged suffering of children/families
- Child abuse prevention
- Suicide prevention
- Increased cooperation and referrals between agencies
- Reduced stigma of mental health/counseling interventions among target population
- Improved trust of services as evidenced by an increase in self-referral by target group families
- Decreased cost of 5150 and hospitalizations by providing services in outpatient setting

Outcome Measures

In addition to the required outcomes and indicators identified for each PEI program type, the following measurements will be evaluated:

- Measurement 1: Success will be measured on pre/post testing based on assessment tools, Parent Stress Index, 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: Tracking of self-referred clients
- Measurement 4: Decreased incidents of shaken baby syndrome
- Measurement 5: Reduction of hospital emergency department visits

Current Provider(s): Infant Parent Center

Early Intervention for Youth in Schools

The Early Intervention for Youth in Schools project is an early intervention program provided by Minds Moving Forward. This pilot project provides professional and para-professional staff on school campuses to improve youth mental health and address social and familial variations and stressors, and identify individuals who may be experiencing early onset of a mental illness such as mood disorders or psychosis.

This project provides services to middle and high school students incorporating activities such as outreach, referrals, groups, classes, individual and family therapeutic services and on-going case management. This pilot project will run through June 30, 2019 and will be evaluated for continuation or expansion at the end of the pilot. Based on results of the California Healthy Kids survey, the following schools were identified to participate in the pilot:

1) El Dorado County Office of Education Non-Traditional Schools (Charter Community School and El Dorado Trade School)
2) Camerado Springs Middle School
3) Oak Ridge High School
4) Ponderosa High School

Project Goals

- Increase school-based mental health services.
- Increase knowledge of community resources.
- Raise awareness around early identification of the signs and symptoms of mental illness.
- Reduce stigma and discrimination.
- Improve student wellness and mental health.
- Improve the family relationship.
- Improve school culture as it relates to minimizing activities that may be risk factors for mental illness and encouraging positive mental health.
- Reduce suicidal ideation, attempted suicides and completed suicides.
- Increase academic success, which may not mean higher grade point averages, but could be other successes such as higher rate of completion of homework, increased academic confidence or increased willingness to reach out for academic assistance.
- Increase school attendance rates for participants.
- Decrease referrals for behavior problems or other disciplinary actions for participants.
- Improve results from the California Healthy Kids survey, which would show a reduction in the number of students with feelings of hopelessness or suicidal thoughts.
- Reduce substance use (alcohol, prescription drugs, marijuana, other illicit and life endangering drugs) and/or self-medicating.

Outcome Measures

In addition to the required outcomes and indicators identified for each PEI program type, the following measurements will be evaluated:

- Measurement 1: Continued engagement of students and parents in this project, including rate of attendance/missed appointments.
- Measurement 2: Self-assessments measuring pre-, interim- and post-participation self-perceptions, and pre-, interim- and post-participation assessments completed by the referring party, as allowed by law, to measure the referring parties' perceptions of the students enrolled in this project. May also include parental assessments.
- Measurement 3: Truancy rates/absences of the students enrolled in this project.
- Measurement 4: The number of referrals for behavior problems or other disciplinary actions for the students enrolled in this project.
- Measurement 5: The number of school dropouts within the students enrolled in this project.
- Measurement 6: The number of incarcerations within the students enrolled in this project.
- Measurement 7: The number of attempted or completed suicides by students enrolled in this project.
- Measurement 8: School-wide surveys to determine the level of knowledge about mental illness, available resources and willingness to discuss mental health concerns.
- Measurement 9: The California Healthy Kids Surveys will measure the long-range outcomes at the schools where this project is implemented as it relates to feelings of hopelessness and suicidal thoughts. The outcomes

of this measurement may not be available annually or during the pilot period of the project.

Current Provider(s): Minds Moving Forward

Stigma and Discrimination Reduction Program

"Stigma and Discrimination Reduction Program" means the County's direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families. Stigma and Discrimination Reduction Programs shall include approaches that are culturally congruent with the values of the populations for whom changes in attitudes, knowledge, and behavior are intended.

The following information, outcomes and/or indicators are required for each Stigma and Discrimination Reduction Program:

1. Number of individuals reached, including demographic data.
2. Using a validated method, measure one or more of the following:
    a. Changes in attitudes, knowledge, and/or behavior related to mental illness that are applicable to the specific Program.
    b. Changes in attitudes, knowledge, and/or behavior related to seeking mental health services that are applicable to the specific Program.
3. Completion of Quarterly and Year End Reports.
4. Implementation challenges, successes, lessons learned, and relevant examples.
5. Any other outcomes and indicators identified.

Mental Health First Aid

The Mental Health First Aid project is a stigma and discrimination reduction, 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 three programs available: Mental Health First Aid, which focuses on risk-factors and mental illness in adults; Youth Mental Health First Aid, which focuses on risk-factors and mental illness in youth ages 12 to 25; and a military-focused module for the adult program which focuses on the needs of active duty military personnel, veterans and their families. Classes are offered countywide.
A team of two of Mental Health First Aid instructors provides the 8-hour training session, which includes:

- Identifying the potential risk factors and warning signs for a range of mental health problems, including depression, anxiety/trauma, psychosis, eating disorders, substance use disorders, and self-injury.

- An understanding of the frequency of various mental health disorders in the U.S. and the need for reduced stigma/shame in their communities.
- An action plan including the skills, resources and knowledge to evaluate the situation, select and implement appropriate interventions, and to help an individual in crisis connect with appropriate professional care.
- Information on various resources available to help someone with a mental health problem.
- Upon completion of the training, attendees receive a Mental Health First Aid certification that is valid for three years.

To expand the capacity of this project, the BHD is collaborating with Shingle Springs Health and Wellness Center to expand teaching opportunities and leverage training costs.

Project Goals

- Raise personal awareness about mental health, including increasing personal recognition of mental illness risk-factors.
- 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

In addition to the required outcomes and indicators identified for each PEI program type, the following measurements will be evaluated:

- 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.

Current Provider(s): El Dorado County Health and Human Services Agency, Behavioral Health Division

LGBTQ Community Education

The LGBTQ Community Education project is a stigma and discrimination reduction project that supports differences, builds understanding through community involvement, and provides education to reduce shame and support to end discrimination. This project 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. Informational packets, flyers and educational materials will be purchased and distributed throughout the community, including schools, libraries and community mental health providers. Outreach costs such as mileage reimbursement, postage, packet materials and other multimedia information, and food costs may be purchased through this project. Education, in the form of presentations/discussions, to schools and the general public regarding sexual orientation may be provided.

Project 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

In addition to the required outcomes and indicators identified for each PEI program type, the following measurements will be evaluated:

- Measurement 1: Number of informing material distributed.
- Measurement 2: Number of people reached through presentations.

Current Provider(s): El Dorado County Health and Human Services Agency, Behavioral Health Division

Statewide PEI Projects

The Statewide PEI Project provides a mechanism at the statewide level for counties to collectively address issues of suicide prevention, student mental health, and stigma and discrimination reduction. Due to recent changes at the State, counties are now required to contribute a higher percentage of their PEI allocation to support this project. The annual budget has been increased to comply with this mandate.

The provider of the Statewide PEI Projects (currently CalMHSA) may continue to provide projects such as, but not limited to:

- Educational Materials
- Statewide Suicide Prevention Campaign
- Each Mind Matters Activities
- Walk In Our Shoes
- LivingWorks Education
- Friendship Line for Older Adults
- WellSpace Health (General Population) Hotline
- Student Mental Health Activities

Project Goals

- Reduce the stigma and discrimination associated with mental illness, prevent suicide, and improve student mental health.

Outcome Measures

The Outcome Measures for this project are established and managed by the State. For more information, please see http://calmhsa.org/programs/evaluation/.

Outreach for Increasing Recognition of Early Signs of Mental Illness Program

"Outreach" is a process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.

"Potential responders" include, but are not limited to, families, employers, primary health care providers, visiting nurses, school personnel, community service providers, peer providers, cultural brokers, law enforcement personnel, emergency medical service providers, people who provide services to individuals who are homeless, family law practitioners such as mediators, child protective services, leaders of faith-based organizations, and others in a position to identify early signs of potentially severe and disabling mental illness, provide support, and/or refer individuals who need treatment or other mental health services.

Services may include reaching out to individuals with signs and symptoms of a mental illness, so they can recognize and respond to their own symptoms.

The following information, outcomes and/or indicators are required for each Outreach for Increasing Recognition of Early Signs of Mental Illness Program:

1. Unduplicated numbers of individuals served, including demographic data.
2. The number of potential responders;
3. The setting(s) in which the potential responders were engaged;
    a. Settings providing opportunities to identify early signs of mental illness include, but are not limited to, family resource centers, senior centers, schools, cultural organizations, churches, faith-based organizations, primary health care, recreation centers, libraries, public transit facilities, support groups, law enforcement departments, residences, shelters, and clinics.
4. The type(s) of potential responders engaged in each setting (e.g. nurses, principles, parents).
5. Completion of Quarterly and Year End Reports.
6. Implementation challenges, successes, lessons learned, and relevant examples.
7. Any other outcomes and indicators identified.

Community Education and Parenting Classes

The Community Education and Parenting Classes project is an outreach program provided by a variety of community-based organizations or individuals. Several smaller projects from the last MHSA Three-Year Plan were consolidated into one project in an effort to streamline services provided and allow for greater flexibility. Some existing projects include:

1) ***Parenting Skills*** classes promote emotional and social capability, as well as reduce and treat behavioral and emotional problems in children aged two to twelve.

Parenting classes are a set of comprehensive, multi-faceted, and developmentally-based curricula targeting parents whose children would benefit from the parent involvement in these classes. These programs address the role of multiple interacting risk and protective factors in the development of conduct disorders, serves as a violence prevention strategy, promotes emotional and social competence, and prevents, reduces and treats behavioral and emotional problems in children. Parenting classes include, but are not limited to, Incredible Years, Parenting Wisely, Celebrating Families!, and Triple P-Positive Parenting Program. These classes may be held at therapeutic and non-therapeutic locations, such as community centers, libraries, schools and churches. For classes that span many weeks, attendance at the beginning is generally higher than attendance at the end of the class. Therefore, these classes may be condensed to a shorter time period to encourage continued participation.

Project Goals

- Increase positive and nurturing parents
- Increase child positive behaviors, social competence, and school readiness skills
- Increase parent bonding and involvement with teachers/school
- Decrease harsh, coercive and negative parenting
- Increase family stability
- Increase emotional and social capabilities
- Reduce behavioral and emotional problems in children

Outcome Measures

In addition to the required outcomes and indicators identified for each PEI program type, the following measurements will be evaluated:

- Measurement 1: Pre- and post-class survey (or other evaluation materials required by the evidence-based practice).

Current Provider(s): New Morning Youth and Family Services

2) ***The Nurtured Heart Approach*** classes provide training to parents and caregivers of children and youth with behavioral difficulties at school and/or at home.

This class provides for training in The Nurtured Heart Approach®, a relationship-focused methodology originally developed for working with the most difficult children. It has a proven impact on children, including those who are challenged behaviorally, socially and academically. One of the strengths of the Nurtured Heart Approach is reducing stigma regarding mental illness diagnosis. This project will offer parent education and support which improves the caregiver-child relationship and the child/teens' behavior. If a child's condition requires additional types of intervention, caregiver(s) will be referred to appropriate providers. Activities under this project will include publicity of upcoming trainings, preparation for classes, classes, phone follow-up coaching as needed, and child care during the trainings as needed.

Project Goals

- Improvement in the caregiver-child relationship
- Reduction in problematic behaviors at home, in school, and in the community

- Reduction in dollars spent on mental health services, special education, and criminal justice involvement

Outcome Measures

In addition to the required outcomes and indicators identified for each PEI program type, the following measurements will be evaluated:

- Measurement 1: Pre- and post Conners Comprehensive Behavior Rating Scales (CBRS) assessment
- Measurement 2: Participant surveys

Current Provider(s): Summitview Child and Family Services

3) ***The Foster Care Continuum*** training project will 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. Activities under this project will include the training of foster parents, families involved with Child Welfare Services, support networks, foster family agency staff and Child Welfare Services staff to address behaviors linked to the core issues and functions driving child and adult behavior.

Project Goals

- Improve accountability of behavior.
- Improve foster parent, support networks, family, foster family agencies and County staff expertise.
- Improve quality of care in the home.
- Reduce seven-day notices for change of child placements.
- Reduce the number of placements for children in out-of-home care.
- Develop strong support networks for foster families (i.e., those who provide support to foster families, including but not limited to extended family members, friends, child care providers, respite care providers)

Outcome Measures

In addition to the required outcomes and indicators identified for each PEI program type, the following measurements will be evaluated:

- 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.

Current Provider(s): To be determined in compliance with Board of Supervisors Policy C-17, Procurement Policy.

Mentoring for Youth

The Mentoring for Youth project is an outreach program that pairs mentors with at-risk children and youth age 3 to 18 countywide. Big Brothers Big Sisters recruits, screens and trains adults and older adults to mentor at-risk, unserved and underserved children and youth. Each individual match is case managed by a Big Brothers Big Sister professional staff. A case plan is developed with the parent, teacher, and mentor to target activities that meet the child's individual needs. This project reduces parental stress and increases parent child interaction, as well as parent teacher interaction. The mentor teaches coping mechanisms to deal with day-to-day stressors and any mental health symptoms.

Project Goals

- Determine if child or family has organically or environmentally induced mental illness concerns and develop a case plan for the child.
- Conduct parent workshops.
- Through skill building activities, mentors will develop coping mechanisms with the child.
- 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.

Outcome Measures

In addition to the required outcomes and indicators identified for each PEI program type, the following measurements will be evaluated:

- Measurement 1: Child Intake. Contractor will assess child and family whenever possible, for program effectiveness.
- Measurement 2: Volunteer Enrollment. Contractor will assess potential volunteers for acceptance into program.
- Measurement 3: Child Assessment. Contractor will use completed pre-match and annual behavior evaluations and monthly volunteer match support of all enrolled children.
- Measurement 4: Contractor will administer Big Brothers Big Sisters Pre and End of School Year Start Early Interactive Survey to enrolled children.
- Measurement 5: Contractor will administer Big Brothers Big Sisters Strength of Relationship Survey to volunteer mentors.
- Measurement 6: Contractor shall provide testimonials, as appropriate, from parents, mentors and children.

Current Provider(s): Big Brothers Big Sisters of El Dorado County

Access and Linkage to Treatment Program

"Access and Linkage to Treatment Program" means a set of related activities to connect children, adults and seniors with severe mental illness, as early in the onset of these conditions as practicable, to medically necessary care and treatment, including, but not limited to, care provided by County Behavioral Health programs.

The following information, outcomes and/or indicators are required for each Access and Linkage to Treatment Program:

1. Unduplicated numbers of individuals served, including demographic data.
2. Number of referrals to treatment, and kind of treatment to which person was referred.
3. Number of persons who followed through on the referral and engaged in treatment, defined as the number of individuals who participated at least once in the Program to which the person was referred.
4. Average duration of untreated mental illness for individuals who have not previously received treatment.
5. Average interval between the referral and engagement in treatment, defined as participating at least once in the treatment to which referred.
6. Completion of Quarterly and Year End Reports.
7. Implementation challenges, successes, lessons learned, and relevant examples.
8. Any other outcomes and indicators identified.

Community-Based Outreach and Linkage

The Community-Based Outreach and Linkage project is an access and linkage to behavioral health services program. As mandated by the new PEI Regulations, counties are required to have a specific project that addresses Access and Linkage to Treatment. The Community Program Planning Process also identified this as a high priority. As a result, this new project combines and expands several projects from the previously MHSA Plan into one that is targeted yet comprehensive.

During the Community Program Planning Process, a concern was identified that many people do not know what services are available or where to obtain services. This project will provide a point of contact for general mental health information and community resources, as well as printed information with available mental health services, supports and community resources.

Additionally, the provision of community-based mental health services was an identified community need. This project will partner with the Community-Based Engagement and Support Services Innovation project, other CSS programs, and potentially other community-based services, including but not limited to a community-based Wellness Center.

Staff and/or contractors in this project will work closely with primary care providers, hospitals, Public Health Nurses, community-based organizations, law enforcement, caring friends and family, and individuals in need of services to determine the appropriate referrals for individuals and 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, and housing options. The program will utilize mobile services to the extent possible.

Project Goals

- Raise awareness about mental health issues and community services available.
- Improve community health and wellness through local services.
- Improve access to medically necessary care and treatment.

Outcome Measures

This project will utilize the required outcomes and indicators for Access and Linkage to Treatment Programs.

Veterans Outreach

The Veterans Outreach project is an outreach project aimed at reaching Veterans who may be in need of behavioral health services. This population was identified as an underserved group during the Community Program Planning process.

Services provided under this project may include, but will not be limited to:

- Outreach to Veterans and families by Street Outreach (SO) Worker, particularly those who are homeless or involved in the criminal justice system
- SO Worker will perform intake interviews and assessments for inclusion into the local Homeless Management Information System (HMIS) and to evaluate the immediate needs for referral to the Unmet Needs Team
- Provide linkage to needed resources, including behavioral health, physical health, housing, or other services, and follow-up to ensure linkages were successful
- Provide referrals to Behavioral Health for Veterans who exhibit symptoms, including Post Traumatic Stress Disorder (PTSD)
- Service Connected Disability Benefit Application Assistance
- Document processing including Civilian and Military ID's

The project will also allow for ancillary supports to Veterans and families including, but not limited to assistance with housing costs, transportation, phones, food and emergency shelter.

Project Goals

- Provide outreach and linkage to services for approximately 100 Veterans and families annually
- Develop a single point of entry for homeless Veterans to receive needed services
- Assist Veterans to secure permanent and affordable housing
- Reduce the number of homeless Veterans in our community

Outcome Measures

This project will utilize the required outcomes and indicators for Access and Linkage to Treatment Programs.

Current Provider(s): Outreach to Veterans will be provided by Only Kindness, Inc. who is a local, non-profit agency already well established in the community and well known for providing services to the County's homeless population, including veterans. Only Kindness, Inc. has strong relationships and established referral processes to Volunteers of America (VOA), El Dorado County's Veterans Commission, El Dorado County Jail, Mather Air Force Base, the Military Family Support Group and many others focusing on the general well-being of Veterans. Contracting will be done in compliance with the Board of Supervisors Policy C-17, Procurement Policy

Suicide Prevention Program

"Suicide Prevention Programs" means organized activities that the County undertakes to prevent suicide as a consequence of mental illness. This category of Programs does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness. Suicide Prevention Programs pursuant to this section include, but are not limited to, public and targeted information campaigns, suicide prevention networks, capacity building programs, culturally specific approaches, survivor-informed models, screening programs, suicide prevention hotlines or web-based suicide prevention resources, and training and education.

The following information, outcomes and/or indicators are required for each Suicide Prevention Program:

1. Using a validated method, measure changes in attitudes, knowledge, and/or behavior regarding suicide related to mental illness.
2. California Healthy Kids Survey.
3. Completion of Quarterly and Year End Reports.
4. Implementation challenges, successes, lessons learned, and relevant examples.
5. Any other outcomes and indicators identified.

Suicide Prevention and Stigma Reduction

The Suicide Prevention and Stigma Reduction project provides education and supportive services to residents of El Dorado County regarding suicide prevention. This project has an initial focus on South Lake Tahoe with plans to expand Countywide.

Services provided in the project include suicide prevention awareness campaigns, workshops, trainings, youth events, and wellness fairs. Suicide prevention resources and materials may include pamphlets, brochures, workbooks, and mental health contact sheets in both English and Spanish are available, as well as a website. Community education trainings on suicide prevention and identification of risk factors are provided. This project also establishes linkage with the Statewide Suicide Prevention and SDR programs.

Project Goals

- Increase awareness of mental illness, programs, resources, and strategies.
- Increased linkage to mental health resources.
- Reduce the number of attempted and completed 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.

Outcome Measures

This project will utilize the required outcomes and indicators for Suicide Prevention Programs.

Current Provider(s): Tahoe Youth and Family Services

PEI Administration

County staff will be utilized to perform administrative activities (e.g., contracting, accounting), program analysis, and quality assurance activities related to this Component.

PEI Crosswalk

Below is the crosswalk identifying how PEI projects have been reorganized to comply with the new PEI regulations.

PRIOR THREE-YEAR PLAN	THIS THREE-YEAR PLAN
Program 1: Youth and Children's Services	
Project 1a: Children 0-5 and Their Families	***Early Intervention:*** Children 0-5 and Their Families
Project 1b: Mentoring for 3-5 Year Olds by Adults and Older Adults	***Outreach for Increasing Recognition of Early Signs of Mental Illness:*** Mentoring for Youth
Project 1c: Parenting Skills	***Outreach for Increasing Recognition of Early Signs of Mental Illness:*** Community Education and Parenting Classes
Project 1d: Primary Intervention Project (PIP)	***Prevention:*** Primary Intervention Project (PIP)
Project 1f: Prevention and Early Intervention for Youth in Schools	***Early Intervention:*** Early Intervention for Youth in Schools
Project 1g: Nurtured Heart Approach	***Outreach for Increasing Recognition of Early Signs of Mental Illness:*** Community Education and Parenting Classes
Program 2: Community Education Project	
Project 2a: Mental Health First Aid	***Stigma and Discrimination Reduction:*** Mental Health First Aid
Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education	***Stigma and Discrimination Reduction:*** LGBTQ Community Education
Project 2d: Community Information Access	Discontinued
Project 2e: Suicide Prevention and Stigma Reduction	***Suicide Prevention:*** Suicide Prevention and Stigma Reduction

PRIOR THREE-YEAR PLAN	THIS THREE-YEAR PLAN
Project 2f: Foster Care Continuum Training	***Outreach for Increasing Recognition of Early Signs of Mental Illness:*** Community Education and Parenting Classes
Project 2g: Community Outreach and Resources	***Access and Linkage to Treatment:*** Community-Based Outreach and Linkage
Project 2h: Statewide PEI Projects	***Stigma and Discrimination Reduction:*** Statewide PEI
Program 3: Health Disparities Program	
Project 3a: Wennem Wadati – A Native Path to Healing	***Prevention Projects:*** Wennem Wadati – A Native Path to Healing
Program 3: Health Disparities Program, Project 3b: Latino Outreach	***Prevention:*** Latino Outreach
Program 4: Wellness Outreach Program for Vulnerable Adults	
Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness	***Access and Linkage to Treatment:*** Community-Based Outreach and Linkage
Program 4: Wellness Outreach Program for Vulnerable Adults, Project 4b: Senior Peer Counseling	***Prevention:*** Older Adults Enrichment
Program 4: Wellness Outreach Program for Vulnerable Adults, Project 4a: Older Adult Program	***Prevention:*** Older Adults Enrichment
Program 5: Community-Based Services	
Project 5a: Community-Based Mental Health Services	***Access and Linkage to Treatment:*** Community-Based Outreach and Linkage
Program 5: Community-Based Services, Project 5b: Community Health Outreach Worker	***Access and Linkage to Treatment:*** Community-Based Outreach and Linkage
Not applicable	***Access and Linkage to Treatment:*** Veterans Outreach

Below is the reverse crosswalk, from the new Three-Year Plan to the Prior Three-Year Plan:

THIS THREE-YEAR PLAN	PRIOR THREE-YEAR PLAN
Prevention Programs	
Latino Outreach	***Program 3: Health Disparities Program*** Program 3: Health Disparities Program, Project 3b: Latino Outreach
Older Adults Enrichment	***Program 4: Wellness Outreach Program for Vulnerable Adults*** Project 4b: Senior Peer Counseling
Primary Intervention Project (PIP)	***Program 1: Youth and Children's Services*** Project 1d: Primary Intervention Project (PIP)
Wennem Wadati – A Native Path to Healing	***Program 3: Health Disparities Program*** Project 3a: Wennem Wadati – A Native Path to Healing
Early Intervention	
Children 0-5 and Their Families	***Program 1: Youth and Children's Services*** Project 1a: Children 0-5 and Their Families
Early Intervention for Youth in Schools	***Program 1: Youth and Children's Services*** Project 1f: Prevention and Early Intervention for Youth in Schools
Stigma and Discrimination Reduction	
Mental Health First Aid	***Program 2: Community Education Project*** Project 2a: Mental Health First Aid
LGBTQ Community Education	***Program 2: Community Education Project*** Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education
Statewide PEI	***Program 2: Community Education Project*** Project 2h: Statewide PEI Projects

THIS THREE-YEAR PLAN	PRIOR THREE-YEAR PLAN
Outreach for Increasing Recognition of Early Signs of Mental Illness	
Community Education and Parenting Classes	***Program 1: Youth and Children's Services*** Project 1c: Parenting Skills Project 1g: Nurtured Heart Approach ***Program 2: Community Education Project*** Project 2f: Foster Care Continuum Training
Mentoring for Youth	***Program 1: Youth and Children's Services*** Project 1b: Mentoring for 3-5 Year Olds by Adults and Older Adults
Access and Linkage to Treatment	
Community-Based Outreach and Linkage	***Program 2: Community Education Project*** Project 2g: Community Outreach and Resources ***Program 4: Wellness Outreach Program for Vulnerable Adults*** Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness ***Program 5: Community-Based Services*** Project 5a: Community-Based Mental Health Services Project 5b: Community Health Outreach Worker
Veterans Outreach	Not applicable (new project in FY 2017-18)
Suicide Prevention	
Suicide Prevention and Stigma Reduction	***Program 2: Community Education Project*** Project 2e: Suicide Prevention and Stigma Reduction
Discontinued	***Program 2: Community Education Project*** Project 2d: Community Information Access

Community Services and Supports (CSS)

Community Services and Supports (CSS) projects provide direct services to adults and children who have a severe mental illness or serious emotional disturbance who meet the criteria for receiving specialty mental health services as set forth in Welfare and Institutions Code (WIC) Section 5600.3. Services provided under CSS fall into at least one of the following three funding categories:

Artwork by Wellness Center Client

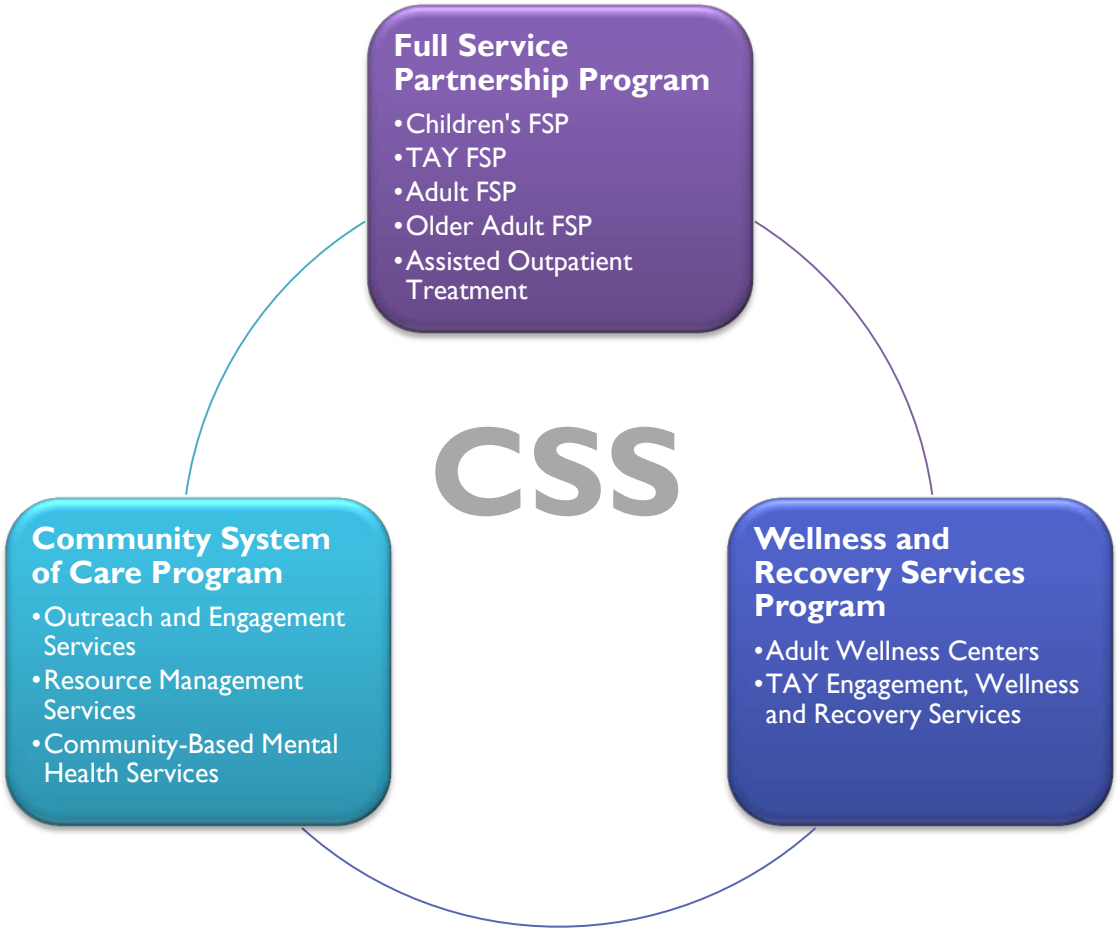
Full Service Partnership (FSP) – funds to provide "whatever it takes" for initial populations. These partnerships shall be culturally competent and shall include individualized client/family-driven mental health services and supports plans which emphasize recovery and resilience, and which offer integrated service experiences for clients and families. 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. The majority of CSS funding must be spent on FSP services.

General System Development (GSD) – funds 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.

Outreach and Engagement (OE) – funds for outreach and engagement of those populations that are currently receiving little or no service. In an effort to reach underserved populations, outreach and engagement efforts may involve collaboration with community-based organizations, faith-based agencies, tribal organizations and health clinics, schools, law enforcement agencies, veterans groups, organizations that help individuals who are homeless or incarcerated, and other groups or individuals that work with underserved populations.

CSS Program Group Restructure

Based on feedback received from the Community Program Planning Process, some projects may have been combined or consolidated and project numbers have been eliminated. Programs are now arranged in alignment with the funding categories. A crosswalk has been included at the end of this section identifying the new project organization.



Outcomes and Indicators
The State has not yet identified standardized outcomes and indicators for CSS programs. When the State provides those standards, they shall be incorporated into this MHSA Plan as if they were originally included because those standards will be a mandated reporting requirement.

Standard indicators and outcomes utilized by the BHD and its contracted providers are:

- Measurement 1: Levels of Care Utilization System (LOCUS) for adults; Child and Adolescent Levels of Care Utilization System (CALOCUS) for children and youth
- Measurement 2: Outcome measurement tools (e.g., Child and Adolescent Needs and Strengths (CANS); Adult Needs and Strengths Assessment (ANSA))

Full Service Partnership (FSP) Program

The FSP Program serves children, transitional age youth (TAY), adults and older adults, and each project will follow the criteria as set forth in WIC §5600.3. All FSP projects will utilize the following basic guidelines as appropriate to each age group.

According to the California Code of Regulations (CCR), Title 9, Section 3200.130, a FSP is "the collaborative relationship between the County and the client, and when appropriate, the client's family, through which the County plans for and provides the full spectrum of community services so that the client can achieve the identified goals". FSPs emphasize services that are client and family-driven, accessible, individualized, tailored to a client's "readiness for change". FSPs require a "whatever it takes" approach to provision of services, meaning finding the methods and means to engage a client, determine his or her needs for recovery, and create collaborative services and support to meet those needs. 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. Additionally, it is critical to provide both mental health and non-mental health services and supports. In addition to mental health services and supports, MHSA funds will be used to access non-mental health resources identified within the treatment plan that are needed by the client to successfully fulfill their individualized treatment plan including, but not limited to:

- Medication support
- Moving expenses
- Child-care costs
- Educational expenses
- Transportation assistance
- Emergency expenses for food or shelter
- Food
- Clothing
- Housing assistance
- Cost of health care treatment
- Cost of treatment of co-occurring conditions, such as substance abuse
- Respite care
- Other expenses that the FSP team considers appropriate and are previously approved in the individualized treatment plan

Children's Full Service Partnership

The Children's Full Service Partnership project combines services from the two projects in the former MHSA Three-Year Plan's CSS Youth and Family Strengthening Program (Project 1a: Youth and Family Full Service Partnership and Project 1c: Foster Care Enhanced Services) into one comprehensive FSP project that serves all eligible children. Children in foster care who are eligible for services as a result of the *Katie A. v. Bonta* State Settlement will continue to be served under this project. Due to recent and ongoing changes in legislation related to AB 403, services in this project will be aligned with the current and forthcoming requirements in the Continuum of Care Reform (CCR).

The Children's FSP project is aimed at helping El Dorado County children and youth avoid more restrictive and expensive placements, including group home placement, hospitalization and incarceration. A FSP project provides an individualized approach to meeting needs for mental health and support services to children/youth and their families who are at risk of foster care placement, or who are already in foster care, to prevent placement in a higher level of

care facility. The County has identified wraparound principles and services as the Children's FSP project. Wraparound principles include family and individual voice, team-based decision making, and use of natural supports, collaboration, community-based service, cultural competence, individualized plans, strength-based interventions, persistence and outcome-based strategies.

Additionally, funding in the amount of $20,000 is for CASA as a sole source contract to help ensure that all children receiving services through this project have an assigned CASA, providing the provision of such funding is not determined in conflict with the roles of an agency providing the children with services and CASA.

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

Current Provider(s): New Morning Youth and Family Services, West Slope; Sierra Child and Family Services, West Slope and South Lake Tahoe; Stanford Youth Solutions, West Slope; Summitview Child and Family Services, West Slope; Tahoe Youth and Family Services, South Lake Tahoe; CASA El Dorado

Transitional Age Youth (TAY) Full Service Partnership

The Transitional Age Youth (TAY) Full Service Partnership provides services to meet the unique needs of TAY and encourage continued participation in mental health services. In the prior MHSA Plan, the TAY wellness and FSP components were together in one project. In this Three-Year MHSA Plan, there are two standalone projects for TAY, one for FSP services and one for TAY Outreach, Engagement and Wellness services.

Individuals participating in this project who are eligible for TAY Full Service Partnership services would be eligible for the type and extent of activities and supportive services identified in the Children and Youth Full Service Partnership project or the Adult Full Service Partnership

project, dependent upon the individual's age. This project is 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.

Through Mental Health Block Grant (MHBG) funding specifically for First Episode of Psychosis (FEP) services, this MHSA project includes services to address the needs of TAY experiencing their first episode of psychosis. MHBG funding may be utilized in collaboration with this project to provide further services to TAY in community-based locations, such as schools, in compliance within the requirements of the MHBG and MHSA. The age of individuals who qualify for the FEP and MHBG programs will align with the target population identified in the FEP and MHBG program statements. Evaluation of the FEP and MHBG programs will be performed in a manner consistent with the program statements.

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/juvenile hall
- Measurement 2: Achieving goals identified in the client plan
- Measurement 3: Education attendance and performance
- Measurement 4: Number of days of homelessness / housing stability
- Measurement 5: Education attendance and performance
- Measurement 6: Employment status
- Measurement 7: Continued engagement in mental health
- Measurement 8: Linkage with primary health

Current Provider(s): El Dorado County Health and Human Services Agency, Behavioral Health Division

Adult Full Service Partnership

The Adult Full Service Partnership 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. 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.

Intensive Case Management (ICM)
In El Dorado County, adults who are enrolled in the FSP project 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 on the ICM team. 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.

Crisis intervention services (psychiatric emergency services) are a key component of an ICM team. The ICM crisis staff provides crisis intervention services 24 hours per day, 7 days per week, to respond to crisis needs, if and when they arise.

Included within the Adult FSP project is the contracted operation of an Adult Residential Facility, which allows individuals who have been placed in a locked facility out of county to return to El Dorado County for continued treatment. These clients require a high level of staff support and the client-to-clinician ratio is low.

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 in the client plan.
- Measurement 3: Continued engagement in services.

Current Provider(s): El Dorado County Health and Human Services Agency, Behavioral Health Division; Summitview Child and Family Services (for operation of an Adult Residential Facility)

Older Adult Full Service Partnership

The Older Adult Full Service Partnership project follows the same program as the Adult Full Service Partnership, with the focus on individuals who are age 60 and older and the unique needs of older adults. This project may include the services of a nurse to help address the needs of older adults, as well as assist in access and linkage to health care (including mental health) services.

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 in the client plan
- Measurement 3: Continued engagement in services

Current Provider(s): El Dorado County Health and Human Services Agency, Behavioral Health Division

Assisted Outpatient Treatment

The Assisted Outpatient Treatment (AOT) project provides for limited term, court-ordered outpatient mental health treatment for those individuals meeting the criteria set forth by the law. This law allows El Dorado County two new tools to assist people with mental illness who meet the specified criteria. The first tool is the ability to mandate someone to AOT through the use of court-ordered treatment if they have refused to participate in voluntary treatment. The second tool is the use of a court order to authorize the transport of a person in the AOT project for them to be psychiatrically assessed. This can occur if the individual is deteriorating and unsafe in the community even if they do not meet criteria of being a danger to self or others per WIC § 5150. AOT services are similar to the FSP projects already established in El Dorado County. The FSP and AOT project include an array of intensive services necessary for recovery for each individual person. Additionally, AOT requires close collaboration between the BHD, Law Enforcement and the Justice System.

Project Goals

- Reduction in institutionalization
- People are maintained in the community
- Services are individualized
- 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: Reduction in institutionalization and incarceration
- Measurement 3: Continued engagement in services, as needed, after discharge from AOT

Current Provider(s): El Dorado County Health and Human Services Agency, Behavioral Health Division

Wellness and Recovery Services Program

The Wellness and Recovery Services Program is designed to provide Behavioral Health services that may be needed on a shorter-term basis, which will support individuals to access natural and/or community-based supports for managing their mental illness upon graduation. The Vision of the El Dorado County Health and Human Services Agency is "Transforming Lives and Improving Futures," and consistent with that Vision, the BHD provides individuals who meet criteria for Specialty Mental Health Services with client- and family-driven services and supports to allow them to achieve their own vision of Wellness, Recovery and Resilience.

Adult Wellness Centers

The Adult Wellness Centers project provides a welcoming location for individuals with severe mental illness to receive mental health services. 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.

Activities within the Wellness Centers include individual meetings between BHD 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.

The Wellness Centers provide the setting from which to build local capacity to meet the diverse needs of the seriously mentally ill and their families. Collaboration with other disciplines, community-based organizations, Public Health, NAMI, consumers, and volunteers allows enhanced services to be provided to participants, including their family members and peer support.

This MHSA Three-Year Plan includes an expansion of services to include more opportunities for peers. The Consumer Leadership Academy, formerly a WET project, has been incorporated into the Adult Wellness Centers project to provide educational opportunities to inform and empower consumers to become more involved in meaningful participation in the Wellness Centers and the community. The Academy includes peer-training, peer supportive skills training, job skills training, and training related to consumer leadership in the community. A meaningful role in the community may serve to be one of the most effective preventative measures to relapse to illness. Establishment of a stipend program to address costs incurred for participants will be pursued. Staff support for a range of these events will be provided.

Costs included under the Adult Wellness Centers project include, but are not limited to staff, consumer stipends, 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, County vehicles), toiletries, and laundry. Replacement and repair of Wellness Center items (e.g., equipment, furniture) are also included.

During the Community Program Planning Process there was strong support for a more community-focused and community-based Wellness Center. The BHD will continue to explore this option and will implement a community-based Wellness Center in the event an appropriate opportunity arises to do so.

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: Attainment of individualized goals (graduation)

Current Provider(s): El Dorado County Health and Human Services Agency, Behavioral Health Division

TAY Engagement, Wellness and Recovery Services

The TAY Engagement, Wellness and Recovery Services project provides services to meet the unique needs of transitional age youth and encourage continued participation in Behavioral Health services. Youth will be empowered to take responsibility for themselves and for their future, including continued participation in Behavioral Health services, but they will be supported in their development journey through this project.

This project will collaborate with other agencies that may be involved with the youth, such as Child Welfare Services or Probation, to develop an appropriate treatment plan for the youth. Wellness and recovery strategies may include:

- Case Management
- Peer Support
- Substance abuse and psychiatric treatment
- Supportive housing
- Crisis response services

- Transportation assistance
- Recreation and social activities
- Linkage to vocational services

This age group also needs assistance with developing 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
- Child care and children needs
- Educational and career development
- Obtaining medical, dental, vision and mental health care
- Access to community resources
- Self-care
- Home care (e.g., laundry, cleaning)
- Drug and alcohol abuse awareness and prevention
- Safe sex and reproductive health information

Through Mental Health Block Grant (MHBG) funding specifically for First Episode of Psychosis (FEP) services, this MHSA project includes services to address the needs of TAY experiencing their first episode of psychosis. MHBG funding may be utilized in collaboration with this project to provide further services to TAY in community-based locations, such as schools, in compliance within the requirements of the MHBG and MHSA. The age of individuals who qualify for the FEP and MHBG programs will align with the target population identified in the FEP and MHBG program statements. Evaluation of the FEP and MHBG programs will be performed in a manner consistent with the program statements.

Project Goals

- Decreased days of homelessness, institutionalization, hospitalization, and incarceration
- Increased linkage to available 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: Linkage with primary health care
- Measurement 6: Attainment of individualized goals (graduation)

Current Provider(s): El Dorado County Health and Human Services Agency, Behavioral Health Division

Community System of Care Program

The Community System of Care Program is designed to provide outreach to and engage services to individuals who meet medical necessity for Specialty Mental Health Services and to support the Behavioral Health system of care.

Outreach and Engagement Services

The Outreach and Engagement Services project engages individuals with a serious mental illness in Specialty Mental Health Services and assists in continued engagement in services by addressing barriers to service. Mental health professionals, in concert with peer counselors when possible, will provide outreach and engagement services for individuals with serious mental illness who are homeless, in the jails, receiving primary care services, and who require outreach to their homes in order to reach the at-risk population. Outreach and engagement services for current Behavioral Health clients will also be included to help them continue engagement in services. Individuals who contact Behavioral 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.

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.

Additionally, HHSA receives approximately $35,000 federal funding annually for Projects for Assistance in Transition from Homelessness (PATH). The PATH program has been contracted to a community-based organization, Only Kindness, Inc. for outreach, case management, benefit applications, training, linkage to services and housing assistance countywide. These funds are designed to help individuals/families who are homeless or soon to be homeless and who have a mental health issue, receive necessary services, apply for public assistance/benefits, and assistance in obtaining housing or remaining in housing.

Transportation assistance may be provided to individuals and families under this project, including but not limited to bus script/passes and gas cards.

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: Number of and resulting determination for requests for services
- Measurement 2: Length of time from request for service to determination of eligibility for Specialty Mental Health Services
- Measurement 3: Timely processing of requests for services

Current Provider(s): El Dorado County Health and Human Services Agency, Behavioral Health Division; Only Kindness, Inc. for the PATH program

Resource Management Services

The Resource Management Services project develops key community relationships, provides program evaluation and quality improvement oversight for the MHSA projects, and improves 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. Project evaluation and quality improvement oversight includes researching, developing, administering, scoring, analyzing and reporting activities related to project evaluation, utilization, outcome measures, quality improvement, and data management.

This project is designed to develop key relationships, thereby building access to resources for the consumers and families served (health care, housing, vocational, educational, benefits, and substance abuse treatment), while also providing project evaluation and quality improvement oversight for the MHSA projects.

Project evaluation and quality improvement oversight includes researching, developing, administering, scoring, analyzing and reporting activities related to project 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 Wellness and Recovery Services Program. These services will also include close coordination between BHD staff and primary care physicians, including consultations between BHD psychiatrists and providers of primary health care services.

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.

Project Goals

- Improve the number and quality of resources available to clients and their families.
- Improve access and service delivery.
- Improve project 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 and community
- Measurement 2: Client satisfaction surveys
- Measurement 3: Establishment and implementation of standard evaluation process for MHSA programs

Current Provider(s): El Dorado County Health and Human Services Agency, Behavioral Health Division

Community-Based Mental Health Services

The Community-Based Mental Health Services project provides assessments and Specialty Mental Health Services in local communities and/or to identified target populations, such as individuals eligible for AB 109 services. Clinical staff will visit local communities to provide mental health services to clients and to the extent possible will utilize mobile services, including but not limited to staffing and equipment necessary for mobile Psychiatric Emergency Services. Staff will provide assessments and, for individuals meeting the criteria for Specialty Mental Health Services, deliver mental health services in outlying communities. Groups/classes may also be provided in local communities, provided there is adequate demand for the minimum number of attendees.

Community-based services may also include the establishment of a community-based Wellness Center, with the possibility of being peer run and/or in collaboration with other community-based providers and/or housing opportunities.

Project Goals

- Improve community health through local services
- Increased access to and engagement with Behavioral Health services
- Increased connection to the community
- Increased stability as evidenced by securing basic life needs (e.g., housing, income, food)

Outcome Measures

- Measurement 1: Number of individuals engaged in Specialty Mental Health Services in outlying areas of the county
- Measurement 2: For mobile Psychiatric Emergency Services, to the extent available, number of crisis assessments performed and the outcome of those assessments (e.g., hospitalization, safety plan, referral to community-based services)

Current Provider(s): El Dorado County Health and Human Services Agency, Behavioral Health Division

CSS Crosswalk

Below is the crosswalk identifying how CSS projects have been reorganized in response to community input and MHSA reporting requirements.

PRIOR THREE-YEAR PLAN	THIS THREE-YEAR PLAN
Program 1: Youth and Family Strengthening Program	
Project 1a: Youth and Family Full Service Partnership	***Full Service Partnership Projects:*** Children's Full Service Partnership
Project 1c: Foster Care Enhanced Services	***Full Service Partnership Projects:*** Children's Full Service Partnership
Program 2: Wellness and Recovery Services	
Project 2a: Wellness Centers	***Wellness and Recovery Services Projects:*** Adult Wellness Centers
Project 2b: Adult Full Service Partnership	***Full Service Partnership Projects:*** Adult Full Service Partnership
Project 2c: Older Adults Program	Discontinued effective FY 2015-16
Project 2d: Assisted Outpatient Treatment	***Full Service Partnership Projects:*** Assisted Outpatient Treatment
Not applicable	***Full Service Partnership Projects:*** Older Adult Full Service Partnership
Program 3: Transitional Age Youth (TAY) Services	
Project 3a: TAY Engagement, Wellness and Recovery Services	***Wellness and Recovery Services Projects:*** TAY Engagement, Wellness and Recovery Services

PRIOR THREE-YEAR PLAN	THIS THREE-YEAR PLAN
Not applicable	***Full Service Partnership Projects:*** Transitional Age Youth Full Service Partnership
Program 4: Community System of Care	
Project 4a: Outreach and Engagement Services	***Community System of Care Projects:*** Outreach and Engagement Services
Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)	***Community System of Care Projects:*** Community-Based Mental Health Services
Program 4: Community System of Care, Project 4c: Resource Management Services	***Community System of Care Projects:*** Resource Management Services

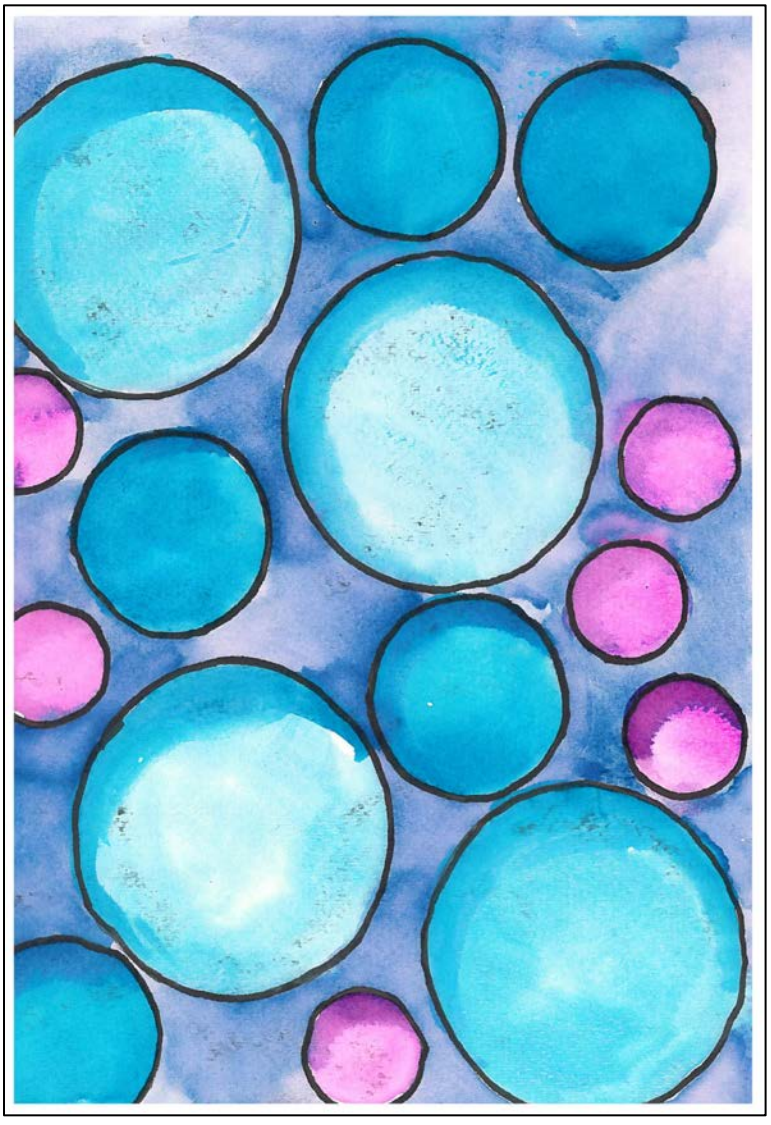
Below is the reverse crosswalk, from the new Three-Year Plan to the Prior Three-Year Plan:

THIS THREE-YEAR PLAN	PRIOR THREE-YEAR PLAN
Full Service Partnership Projects	
Children's Full Service Partnership	***Program 1: Youth and Family Strengthening Program:*** Project 1a: Youth and Family Full Service Partnership Project 1c: Foster Care Enhanced Services
Transitional Age Youth Full Service Partnership	***Program 3: Transitional Age Youth (TAY) Services*** Project 3a: TAY Engagement, Wellness and Recovery Services
Adult Full Service Partnership	***Program 2: Wellness and Recovery Services:*** Project 2b: Adult Full Service Partnership
Older Adult Full Service Partnership	Not applicable
Assisted Outpatient Treatment	***Program 2: Wellness and Recovery Services:*** Project 2d: Assisted Outpatient Treatment

THIS THREE-YEAR PLAN	PRIOR THREE-YEAR PLAN
Wellness and Recovery Services Projects	
Adult Wellness Centers	***Program 2: Wellness and Recovery Services:*** Project 2a: Wellness Centers
TAY Engagement, Wellness and Recovery Services	***Program 3: Transitional Age Youth (TAY) Services*** Project 3a: TAY Engagement, Wellness and Recovery Services
Community System of Care Projects	
Outreach and Engagement Services	***Program 4: Community System of Care*** Project 4a: Outreach and Engagement Services
Community-Based Mental Health Services	***Program 4: Community System of Care*** Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)
Resource Management Services	***Program 4: Community System of Care*** Program 4: Community System of Care, Project 4c: Resource Management Services

Housing Projects

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 Project 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 project offers consumers housing and supportive services that will enable them to live more independently in our communities.



Artwork by Wellness Center Client

West Slope – Trailside Terrace, Shingle Springs
MHSA Housing funds were utilized to provide for five units in Shingle Springs targeting households that are eligible for services under the Full Service Partnership project. All units are occupied and the BHD maintains a waiting list.

East Slope – The Aspens at South Lake, South Lake Tahoe
MHSA Housing funds were utilized to provide for six units in South Lake Tahoe targeting households that are eligible for services under the Full Service Partnership project. All units are occupied and the BHD maintains a waiting list.

Local Housing Assistance
These CSS-Housing funds must be utilized to provide housing assistance to those with a serious mental illness who are homeless or soon-to-be-homeless, and include costs such as rental assistance, security deposits, utility deposits, other move-in costs, and/or moving costs.

The BHD will continue to explore options for affordable housing in El Dorado County.

Innovation (INN)

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 plans must be approved by the MHSOAC prior to the expenditure of funds in this component. The MHSOAC approved new regulations for INN effective October 1, 2015 with the following general requirements:

Innovation projects must address one of the following as its primary purpose:

1. Increase access to mental health services to underserved groups
2. Increase the quality of mental health services, including measurable outcomes
3. Promote interagency and community collaboration related to mental health services or supports or outcomes
4. Increase access to mental health services

El Dorado County had two Innovation projects approved on August 25, 2016 and both projects began shortly thereafter.

Restoration of Competency in an Outpatient Setting

The Restoration of Competency in an Outpatient Setting project increases access to mental health services as its primary purpose. The goal of this three year project is to provide necessary services in a community setting. The Misdemeanant will receive a full Mental Health assessment to determine his/her mental health and Alcohol and Drug Program service needs, family and community supports, medication compliance, and family/friend supportive housing. If appropriate housing has been identified and medication compliance has been determined, and it has been determined that it is safe for the Misdemeanant to be in an outpatient setting, the Misdemeanant will be approved for participation in the Restoration of Competency in an Outpatient Setting project.

Misdemeanants will have an opportunity to receive Restoration of Competency services and Specialty Mental Health Services from County Behavioral Health. These services include, but are not limited to, the assignment of a Mental Health Clinician and a Mental Health Worker trained in Restoration of Competency, psychiatric services as indicated, and Wellness Center staff to provide Wellness Activities in a social setting. Wellness Activities may include, but are not limited to, managing emotions, exercise group, conversation skills, healthy pleasures for sober living, smoking cessation, self-care, life skills, and mindfulness skills. Participating individuals will have the opportunity to attend the Behavioral Health Division's Wellness Center activities that are available Monday through Friday from 1pm to 4pm and include natural supports, such as family and friends, in the treatment process. If an individual loses housing and is no longer medication compliant, or otherwise unsafe to maintain in an outpatient setting, they may be appropriately hospitalized (i.e., through the 5150 process) or returned to jail for the Restoration of Competency services provided in the jail setting, or to wait for an available inpatient Restoration of Competency bed.

The Service Need

The current practice for Restoration of Competency is to have individuals wait in jail until an inpatient bed is available. El Dorado County Health and Human Services Agency, Behavioral Health Division is responsible for Restoration of Competency for individuals charged with a misdemeanor. The County is currently using a facility that is located far from the County and results in Misdemeanants who are found to be incompetent to stand trial losing connection to natural supports in the community. El Dorado County is experiencing:

- An increase in the number of individuals who are found incompetent to stand trial due primarily to a culture shift in our judicial system.
- Higher acuity clients in our community.
- An increase in resistance to treatment since implementation of AB 109 and Prop 47.
- While individuals are waiting for a bed, they remain in jail but are forced into isolation 23 hours a day because they are not labeled "incarcerated" and are therefore not able to be with the general population.
- Lack of beds at facilities that perform Restoration of Competency, leading to individuals having to wait several months (in isolation for 23 hours a day) for a bed to become available.
- High placement costs for individuals who need Restoration of Competency services.
- Current information indicates a quicker rate of restoration from an inpatient setting than is anticipated from outpatient restoration, but the data does not take into account the wait time in jails prior to admission to an inpatient program.

The primary challenge to be addressed is whether a Restoration of Competency in an Outpatient Setting project would be successful in a rural community, thereby reducing the number of days a Misdemeanant would have to remain in jail in isolation awaiting inpatient Restoration of Competency services, maintain the Misdemeanant's connection with his or her community, and reduce the cost of Restoration of Competency services.

It is anticipated that this process will also encourage participants who may be found guilty of a misdemeanor after the provision of Restoration of Competency services to continue engaging in mental health services while in jail and once released, continue with mental health services which could potentially reduce recidivism.

The goal of this project is to provide Restoration of Competency in an Outpatient Setting to individuals, living in their community, seeing their Mental Health Professionals, reducing days of incarceration waiting for a bed, and having the support of their family and community, as well as to reduce recidivism.

Community-Based Engagement and Support Services

The Community-Based Engagement and Support Services project promotes interagency collaboration related to mental health services, supports, or outcomes as its primary purpose. The goal of this four year project is to increase physical and mental health care access for

families, pregnant women, and children ages birth through 18 years resulting in reduced high risk pregnancy, family violence, substance abuse, and mental health issues including perinatal mood and anxiety disorders.

According to the Maternal, Child and Adolescent (MCAH) Health Needs Assessment and Action Plan, El Dorado County is experiencing:

- High rate of mood disorder hospitalizations in 15 to 24 year-olds due to lack of early identification of mental health issues, provider screening, and resource identification.
- High rate of mood disorder hospitalizations in pregnant women due to lack of early identification of mental health issues, provider screening, and resource identification.
- High rate of substance use hospitalizations in 15 to 24 year-olds due to mental health issues, social isolation, inadequate problem solving skills, poor self-esteem, limited knowledge on the effects of substance use, and where or how to obtain assistance for their behavioral health issues.
- High rate of substance abuse hospitalizations in pregnant women due to mental health issues, social isolation, inadequate problem solving skills, poor self-esteem, and limited knowledge on the effects of substance use during pregnancy.
- Low rate of early prenatal care entry in females delivering a live birth due to substance abuse and mental health issues.
- High rate of domestic violence calls in the county due to lack of education, early identification of problem behaviors, and resource identification.

Due to the above identified health disparities in El Dorado County, community partners agreed that primary prevention and early intervention strategies are needed to get ahead of the behavioral health issues in order to build a healthier County.

Researchers have further found that how parents and children respond to stressors is more important than the stressors themselves in determining outcomes. If parents and children are resilient, they are more likely to achieve healthy and favorable outcomes. "Resilience is the process of managing stress and functioning well even when faced with challenges, adversity and trauma." *Center for the Study of Social Policy*

Our project will help to build resilience in families and communities by utilizing a trauma informed approach to: socially connect parents in each community with a special focus on those who live in isolated communities, provide information and support as to how to achieve optimal health and build healthy relationships, conduct parenting classes which include information on child development, provide education on and linkage to community resources, empower parents to raise happy and healthy children, and provide information on how to manage stress appropriately.

Our project is modeled after the Oregon Early Learning Model in the strong collaboration that it utilizes to provide a wide array of services, from multiple agencies. Built into the concept of the Hub is community – people get together to work, learn, and grow through supportive relationships. Foundational to community must be a belief and understanding that people can help and serve one another in both formal and informal ways. They can help strengthen and connect a community providing opportunities for people to work together and support each other in new ways.

Community Hubs will leverage the best practices in early childhood, health and community building to inform systems change and increase access to health care, social services and behavioral health services for pregnant women and families, including children birth through 18 years of age. This systems change will offer a local point of access for services and outreach to isolated families in surrounding communities. Hubs will be established at libraries located in the five supervisorial districts within El Dorado County.

Community Hubs differ from single services in that they foster more effective, accessible, and coordinated services and actively work to take down silos. While many service systems have been designed to meet a specific need using narrowly defined service criteria, a Hub offers an opportunity to understand and support individual and family strengths and needs comprehensively. The Hubs will offer health prevention activities including support groups, educational classes and engagement opportunities for the purposes of building resiliency within the community.

Community Health Advocates (CHAs) will be assigned to each Hub, charged with engaging isolated pregnant women, families and children birth through eighteen, assisting them in health navigation that may include insurance, medical homes and accessing services. Using a trauma-informed approach, Public Health Nurses (PHNs) will provide case management, health screening, mental health screening, alcohol and drug screening, and assist clients in accessing services to meet individualized needs, including referrals to contracted mental health partners. Community Hubs bring collaborative partners together in leveraging resources supporting the healthy development of children and families in our county.

Workforce Education and Training (WET)

"Workforce Education and Training" includes education and training projects and activities for prospective and current public mental health system employees, contractors and volunteers. 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.

Workforce Education and Training (WET) Coordinator

The Workforce Education and Training (WET) Coordinator project, required by the MHSA, coordinates WET projects and activities, serves as the liaison to the State, provides leadership for the implementation of the locally identified WET funding priorities, develops goals of the workforce development project, and identifies career enhancement opportunities.

Workforce Development

The Workforce Development project includes education and training programs and activities for prospective and current mental health system employees, contractors, law enforcement and first responders and volunteers. Clinical and cultural competency trainings may be provided in person or via a web-based training system.

The Crisis Intervention Team Training project, which was a separate project in the prior Three-Year Plan, has been realigned into the Workforce Development project if the community determines that this training is needed. It would provide crisis intervention training workshops for law enforcement and other first responders to provide increased knowledge of available community resources, tools and skills to manage and de-escalate crisis situations.

As part of this project, prepared food (including, but not limited to snacks, lunch, beverages) may be purchased through MHSA funds and provided for attendees of WET trainings, in addition to approved registration fees, travel and trainer costs.

Outcome Measures

- Measurement 1: Number of training opportunities for the public mental health system workforce, including staff, contractors, volunteers and consumers

Capital Facilities and Technology (CFTN)

"Capital Facilities and Technology" are items necessary to support the development of an integrated infrastructure and improve the quality and coordination of care. Capital Facilities and Technological Needs funds should produce long-term impacts with lasting benefits that move the mental health system toward 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.

Electronic Health Record System Implementation

The Electronic Health Record System Implementation project enables Behavioral Health staff to safely and securely access a client's medical record. The use of electronic mental health records enhances communication between treating health care professionals, thus promoting coordination of mental and physical health care needs.

Funding from this project may also be utilized to provide integration with other mental health service providers and primary health care providers, either through license expansion for the BHD's current electronic health record system, or through the use of add-on software. Add-on software allows for increased communications between entities to facilitate referrals, authorizations, invoicing and client progress notes, amongst other benefits such as providing a better continuum of care for shared clients.

Additionally, this funding may be utilized for outcome measure/performance management software and/or other software and hardware in support of Behavioral Health.

Current Provider(s): Netsmart (Avatar Clinical Work Station); others to be determined in compliance with the Board of Supervisors Policy C-17, Procurement Policy

Telehealth

The Telehealth project provides for the expansion of 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. The County's large geographic area makes it difficult to provide face-to-face services in some remote areas of our County. Telehealth allows psychiatrists and other Behavioral Health professionals to provide Specialty Mental Health Services using video conferencing technology, allowing clients and providers to see and hear one another through a secure network.

Based on feedback received from the Community Program Planning Process, there may be a need to purchase telehealth equipment for outlying location(s) in the County.

Community Wellness Center

The Community Program Planning Process identified needs related to more services in the local communities, a peer led Wellness Center, with more services for individuals who are homeless, and better access to Behavioral Health services. A potential option to address these needs is the development of a community-based Wellness Center that would provide additional services and supports to address these needs.

Initial funding for such a location would be accomplished by transferring up to $500,000 from CSS to CFTN. WIC § 5892(b) allows counties to use a portion of their CSS funds for WET, CFTN, and/or 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, and the $500,000 is within the allowable range of a transfer. Additional transfer of funds within the limits of WIC § 5892(b) may be necessary in Year 2 or Year 3 of this Three-Year Plan to accomplish this project.

The County will explore options for a Community Wellness Center, additional funding opportunities (e.g., grants, collaborative approaches), program structure, and other necessary planning processes. This program would be completed in compliance with County required policies and procedures.

The proposed transfer of $500,000 from Community Services and Supports (CSS) to Capital Facilities and Technology (CFTN) is to support a community based, peer run, Wellness Center with a separate on-site housing component for the County's identified chronic homeless population who have chronic/severe mental illness.

For this project to move forward, property/space would need to be identified as appropriate, improvements made to accommodate the program, determine management and operations structure (County or contractor), identify and train Peer Support Specialists from our graduated Peer Leadership Academy, develop classes and groups, identify community partners willing to participate, and review funds for sustainability of the program, including MHSA, grants or other funding possibilities.

<u>Community Based Wellness Center</u>:

- Wellness Focus: example: life skills, employment development
- Structured Environment: scheduled classes, groups, and presentations via a monthly calendar
- Voluntary Activities: sign in sheets for those tracking their attendance
- Orientation/Interview: screening tools as indicated and wanted by the individual for the purpose of connecting them to appropriate services
- County resident requirements
- Peer Support Specialists (paid, stipend or hourly wage)
- County or Contracted Management: for oversight of the program
- Advisory Council

On-site Community Partnership:

- Health and Human Services Agency partners/eligibility
- Path Grant Program (connect services to the homeless population)
- Veteran's Outreach
- Crisis Intervention Team
- NAMI
- HUD/County Housing Program

Housing Components:

- Individuals with chronic homelessness and chronic/severe mental illness:
- Partnerships with a housing program
- Kitchen/life skills training
- Laundry facility/life skills training
- Verified county resident
- Collaboration with Behavioral Health Division Intensive Case Management Team

Expenditure Plan and FY 2017-18 Budget

MHSA Funding
The revenue and expenditure data contained in this Plan is based upon the FY 2017-18 HHSA budget. In the event the actual revenues are higher than anticipated, the additional funding may be utilized to support the projects identified in this Three-Year Plan or rolled into the fund balance to be utilized on projects identified in the FY 2017-18 Plan. In the event the actual revenues are lower than anticipated, the County will access fund balances remaining from previous years at a higher than anticipated rate and/or reduce funding levels.

Based on current projections, there are sufficient revenues and fund balance for all planned expenditures for the next three fiscal years. Further adjustments to the budget may be necessary due to changing revenues or projected County expenditures.

Annual Revenues
MHSA funds are based on a one percent (1%) tax on personal income in excess of $1,000,000 and the amount received by the County varies each month and each year based upon the tax revenues received by the State.

Fund Balances
In addition to the FY 2017-18 revenues, the El Dorado County MHSA projects maintain fund balances accrued from previous fiscal years that may be accessed during the term of this Three-Year Plan. There are planned usages of fund balance.

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 is $1,898,284.

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 ten years from the year of allocation will revert to the State.

Transfer of Funds Between Components
WIC § 5892(b) allows counties to use a portion of their CSS funds for WET, CFTN, and the Prudent Reserve. The total amount of CSS funding used for this purpose may not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2017-18 Budgeted Revenues and Expenditures by Component

	CSS	PEI	WET	INN	CFTN	CSS Housing	TOTAL
Prop 63 (MHSA)	$5,500,000	$1,375,000	--	$361,842	--	--	**$7,236,842**
Federal: PATH and MHBG	$343,000	--	--	--	--	--	**$343,000**
Medi-Cal	$2.633.000	--	--	--	--	--	**$2,633,000**
Private Insurance	$3,000	--	--	--	--	--	**$3,000**
Private Payors	$5,000	--	--	--	--	--	**$5,000**
Misc. Revenue	$120,000	--	--	--	--	--	**$120,000**
AB 109 / AOT (Community Corrections Partnership)	$186,000	--	--	--	--	--	**$186,000**
Transfer from CSS	($500,000)	--	--	--	$500,000	--	**--**
Fund Balance	$6,400,000	$2,260,000	$108,392	$1,509,872	$299,407	$1,572	**$10,579,243**
Total Revenues Budgeted	**$14,690,000**	**$3,635,000**	**$108,392**	**$1,871,714**	**$799,407**	**$1,572**	**$21,106,085**
FY 2017-18 MHSA Plan Expenditures	**$11,060,000**	**$2,131,900**	**$108,392**	**$891,951**	**$799,407**	**$1,572**	**$14,993,222**
Estimated Fund Balance 7/1/18	$3,630,000	$1,503,100	$0	**$979,763**	$0	$0	$6,112,863

Three-Year Plan Estimated Budget

ESTIMATES	CSS	PEI	WET	INN	CFTN	CSS Housing	TOTAL
Year 1							
Fund Balance 7/1/17	$6,400,000	$2,260,000	$108,392	$1,509,872	$299,407	$1,572	$10,579,243
FY 2017-18 Revenues	$8,290,000	$1,375,000	--	$361,842	$500,000	--	$10,526,842
FY 2017-18 Expenditures	($11,060,000)	($2,131,900)	($108,392)	($891,951)	($799,407)	($1,572)	($14,993,222)
Year 2							
Fund Balance 7/1/18	$3,630,000	$1,503,100	--	$979,763	--	--	$6,112,863
FY 2018-19 Revenues	$8,790,000	$1,375,000	--	$361,842	--	--	$10,526,842
FY 2018-19 Expenditures	($10,750,000)	($2,131,900)	--	($932,800)	--	--	($13,814,700)
Year 3							
Fund Balance 7/1/19	$1,670,000	$746,200	--	$408,805	--	--	$2,825,005
FY 2019-20 Revenues	$8,990,000	$1,425,000	--	$375,000	--	--	$10,790,000
FY 2019-20 Expenditures	($10,500,000)	($2,131,900)	--	($743,297)	--	--	($13,375,197)
New Three-Year Plan for FY 2020-21 through FY 2022-2023 Starting 7/1/2020							
Fund Balance 7/1/2020	$160,000	$39,300	--	$40,508	--	--	$239,808

El Dorado County is a fiscally conservative county. This means that 100% of the expenditures are budgeted, even though the BHD historically comes in under budget in expenditures. For example, the staffing vacancy rate is approximately 7-8%, and therefore staffing and benefits are regularly under budget estimates. Another item that is out of the control of the BHD is the number of requests for services each year and the number of individuals hospitalized in an out-of-county psychiatric hospital. Annually, there may be fluctuation in the numbers of clients served, which results in the budgeted expenditures not matching the actual expenditures.

Although the estimated fund balances as of July 1, 2020 appear low, the MHSA programs in El Dorado County have traditionally been underspent for such reasons as those identified above, which has resulted in a higher than anticipated fund balance at the start of this Three-Year Plan. Below is the revenue and expenditure history for the last Three-Year Plan. For example:

FUND BALANCES	CSS	PEI	WET	INN	CFTN	CSS Housing	TOTAL
Year 1 (FY 14/15) Ending Fund Balance							
Per FY 14/15 Plan	$2,695,818	$678,919	$0	$1,626,033	$96,297	n/a	$5,097,067
Actuals	**$6,551,597**	**$1,833,143**	**$110,936**	**$1,660,524**	**$405,607**	**n/a**	**$10,561,806**
Year 2 (FY 15/16) Ending Fund Balance							
Per FY 14/15 Plan	$198,259	$242,991	$0	$1,926,293	$0	n/a	$2,367,543
Per FY 15/16 Plan	$3,180,085	$1,056,900	$0	$1,363,380	$140,333	included in CSS	$5,740,698
Actuals	**$6,531,782**	**$2,037,495**	**$157,753**	**$1,948,275**	**$355,935**	included in CSS	**$11,031,239**
Year 3 (FY 16/17) Ending Fund Balance							
Per FY 14/15 Plan	($2,335,597)	$102,763	$0	$2,226,553	$0	n/a	($6,281)
Per FY 15/16 Plan	$1,623,075	$618,658	$0	not identified pending INN Plan	$62,833	included in CSS	$2,304,566
Per FY 16/17 Plan	$3,050,809	$1,811,587	$0	$757,267	$14,836	included in CSS	$5,634,499
Projected	**$6,400,000**	**$2,260,000**	**$108,392**	**$1,509,872**	**$299,407**	**$1,572**	**$10,579,243**

MHSA Component Funding

PEI

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 2017-18. All funding for PEI programs is from MHSA, leveraged through collaboration.

Program	FY 17-18 MHSA Plan Budget	FY 18-19 MHSA Plan Budget	FY 19-20 MHSA Plan Budget
Prevention Program			
Latino Outreach Project	$231,150	$231,150	$231,150
Older Adults Enrichment Project	$150,000	$150,000	$150,000
Primary Intervention Project (PIP)	$275,000	$275,000	$275,000
Wennem Wadati: A Native Path to Healing Project	$125,750	$125,750	$125,750
Early Intervention Program			
Children 0-5 and Their Families Project	$250,000	$250,000	$250,000
Early Intervention for Youth in Schools Project	$150,000	$150,000	$150,000
Stigma and Discrimination Reduction Program			
Mental Health First Aid Project	$120,000	$120,000	$120,000
LGBTQ Community Education Project	$5,000	$5,000	$5,000
Statewide PEI Projects	$55,000	$55,000	$55,000
Outreach for Increasing Recognition of Early Signs of Mental Illness Program			
Community Education and Parenting Classes Project	$150,000	$150,000	$150,000
Mentoring for Youth Project	$75,000	$75,000	$75,000
Access and Linkage to Treatment Program			
Community-Based Outreach and Linkage Project	$300,000	$300,000	$300,000
Veterans Outreach	$150,000	$150,000	$150,000
Suicide Prevention Program			
Suicide Prevention and Stigma Reduction Project	$30,000	$30,000	$30,000
Administrative Costs			
Administrative Costs - MHSA Team	$65,000	$65,000	$65,000
Total Budget PEI Projects	**$2,131,900**	**$2,131,900**	**$2,131,900**

PEI Expenditure Crosswalk

THIS THREE-YEAR PLAN	FY 17-18 Budget	Change from Previous Year	PRIOR THREE-YEAR PLAN	FY 16-17 Budget
Prevention Programs				
Latino Outreach	$231,150	⇔	***Program 3: Health Disparities Program*** Program 3: Health Disparities Program, Project 3b: Latino Outreach	$231,150
Older Adults Enrichment	$150,000	⇑ (expanded project)	***Program 4: Wellness Outreach Program for Vulnerable Adults*** Project 4b: Senior Peer Counseling	$145,000
Primary Intervention Project (PIP)	$275,000	⇔	***Program 1: Youth and Children's Services*** Project 1d: Primary Intervention Project (PIP)	$275,000
Wennem Wadati – A Native Path to Healing	$125,750	⇔	***Program 3: Health Disparities Program*** Project 3a: Wennem Wadati – A Native Path to Healing	$125,750
Early Intervention				
Children 0-5 and Their Families	$250,000	⇑ (expanded project)	***Program 1: Youth and Children's Services*** Project 1a: Children 0-5 and Their Families	$175,000
Early Intervention for Youth in Schools	$150,000	⇔	***Program 1: Youth and Children's Services*** Project 1f: Prevention and Early Intervention for Youth in Schools	$150,000
Stigma and Discrimination Reduction				
Mental Health First Aid	$120,000	⇑	***Program 2: Community Education Project*** Project 2a: Mental Health First Aid	$117,000
LGBTQ Community Education	$5,000	⇔	***Program 2: Community Education Project*** Project 2c: Parents, Families, Friends of Lesbians and Gays (PFLAG) Community Education	$5,000

THIS THREE-YEAR PLAN	FY 17-18 Budget	Change from Previous Year	PRIOR THREE-YEAR PLAN	FY 16-17 Budget
Statewide PEI	$55,000		***Program 2: Community Education Project*** Project 2h: Statewide PEI Projects	$9,500
Outreach for Increasing Recognition of Early Signs of Mental Illness				
Community Education and Parenting Classes	$150,000		***Program 1: Youth and Children's Services*** Project 1c: Parenting Skills Project 1g: Nurtured Heart Approach ***Program 2: Community Education Project*** Project 2f: Foster Care Continuum Training	$119,500
Mentoring for Youth	$75,000		***Program 1: Youth and Children's Services*** Project 1b: Mentoring for 3-5 Year Olds by Adults and Older Adults	$75,000
Access and Linkage to Treatment				
Community-Based Outreach and Linkage	$300,000	 (expanded project)	***Program 2: Community Education Project*** Project 2g: Community Outreach and Resources ***Program 4: Wellness Outreach Program for Vulnerable Adults*** Project 4a: Wellness Outreach Ambassadors and Linkage to Wellness ***Program 5: Community-Based Services*** Project 5a: Community-Based Mental Health Services Project 5b: Community Health Outreach Worker	$115,000
Veterans Outreach	$150,000	**NEW**	Not applicable (new project in FY 2017-18)	--

THIS THREE-YEAR PLAN	FY 17-18 Budget	Change from Previous Year	PRIOR THREE-YEAR PLAN	FY 16-17 Budget
Suicide Prevention				
Suicide Prevention and Stigma Reduction	$30,000	⇔	***Program 2: Community Education Project*** Project 2e: Suicide Prevention and Stigma Reduction	$30,000
Other				
Discontinued	--	⇓	***Program 2: Community Education Project*** Project 2d: Community Information Access	$16,000
Administrative Costs - MHSA Team	$65,000	⇓	Administrative Costs - MHSA Team	$100,000
TOTAL	**$2,131,900**	⇑		**$1,688,900**

CSS

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. It is not anticipated that any CSS funding will revert to the State in FY 2017-18. There is a small decrease in CSS projected for Years 2 and 3 of this Three-Year Plan, however it is not estimated that those reductions will have a significant impact on the services provided, and depending upon MHSA and Medi-Cal revenues, may not need to be implemented. This issue will continue to be monitored and will be addressed in subsequent Plan Updates.

Program	FY 17-18 MHSA Plan Budget	FY 18-19 MHSA Plan Budget	FY 19-20 MHSA Plan Budget
Full Service Partnership Projects			
Children's FSP Project	$1,800,000	$1,700,000	$1,650,000
TAY FSP Project	$250,000	$375,000	$375,000
Adult FSP Project	$4,675,000	$4,700,000	$4,650,000
Older Adult FSP Project	$100,000	$100,000	$100,000
Assisted Outpatient Treatment	$200,000	$175,000	$175,000
Wellness and Recovery Services Projects			
Adult Wellness Centers Project	$2,300,000	$2,200,000	$2,100,000
TAY Engagement, Wellness and Recovery Services Project	$350,000	$200,000	$200,000
Community System of Care Projects			
Outreach and Engagement Services Project	$800,000	$775,000	$775,000
Resource Management Services Project	$115,000	$100,000	$75,000
Community-Based Mental Health Services Project	$260,000	$250,000	$250,000
Administrative Costs			
Administrative Costs - MHSA Team	$210,000	$175,000	$150,000
Total Budget CSS Projects	**$11,060,000**	**10,750,000**	**10,500,000**

CSS Expenditure Crosswalk

THIS THREE-YEAR PLAN	FY 17-18 Budget	Change from Previous Year	PRIOR THREE-YEAR PLAN	FY 16-17 Budget
Full Service Partnership Projects				
Children's Full Service Partnership	$1,800,000		***Program 1: Youth and Family Strengthening Program:*** Project 1a: Youth and Family Full Service Partnership Project 1c: Foster Care Enhanced Services	$1,860,699
Transitional Age Youth Full Service Partnership	$250,000	**NEW**	***Program 3: Transitional Age Youth (TAY) Services*** Project 3a: TAY Engagement, Wellness and Recovery Services	Included under Wellness and Recovery Services below
Adult Full Service Partnership	$4,675,000		***Program 2: Wellness and Recovery Services:*** Project 2b: Adult Full Service Partnership	$4,566,260
Older Adult Full Service Partnership	$100,000	**NEW**	Not applicable	--
Assisted Outpatient Treatment	$200,000		***Program 2: Wellness and Recovery Services:*** Project 2d: Assisted Outpatient Treatment	$200,000
Wellness and Recovery Services Projects				
Adult Wellness Centers	$2,300,000		***Program 2: Wellness and Recovery Services:*** Project 2a: Wellness Centers	$2,045,874

THIS THREE-YEAR PLAN	FY 17-18 Budget	Change from Previous Year	PRIOR THREE-YEAR PLAN	FY 16-17 Budget
TAY Engagement, Wellness and Recovery Services	$350,000	↓	***Program 3: Transitional Age Youth (TAY) Services*** Project 3a: TAY Engagement, Wellness and Recovery Services	$714,707 (included FSP services)
Community System of Care Projects				
Outreach and Engagement Services	$800,000	↓	***Program 4: Community System of Care*** Project 4a: Outreach and Engagement Services	$802,578
Community-Based Mental Health Services	$260,000	↑	***Program 4: Community System of Care*** Project 4b: Community-Based Mental Health Services (Partner program to PEI Community-Based Mental Health Services)	$230,761
Resource Management Services	$115,000	↑	***Program 4: Community System of Care*** Program 4: Community System of Care, Project 4c: Resource Management Services	$107,000
Other				
Administrative Costs - MHSA Team	$210,000	↓	Administrative Costs - MHSA Team	$215,107
TOTAL	**$11,060,000**	↑		**$10,742,986**

WET

MHSA no longer provides funding for WET activities. The County has been operating this project through funds previously received and remaining as a fund balance. WET funds that are not expended are subject to reversion after FY 2017-18. The entire remaining WET fund balance has been budgeted in FY 2017-18. The two WET projects will continue to be funded in future years by transferring CSS funds to this component as may be needed. At this time, those transfers are not included here, but will be addressed in subsequent Plan Updates. Given new mandates and changes in State policies, it is recommended that some CSS funding be utilized in subsequent year to fund ongoing WET programs if funding is available.

Program	FY 17-18 MHSA Plan Budget	FY 18-19 MHSA Plan Budget	FY 19-20 MHSA Plan Budget
WET Coordinator Project	$30,000	--	--
Workforce Development Project	$77,392	--	--
Administrative Costs - MHSA Team	$1,000	--	--
Total Budget WET Projects	**$108,392**	**--**	**--**

CFTN

MHSA no longer provides funding for CFTN activities. The County has been operating this project through funds previously received and remaining as a fund balance. CFTN funds that are not expended are subject to reversion after FY 2017-18. The entire remaining CFTN fund balance has been budgeted in FY 2017-18. It is anticipated that there will be a transfer from CSS to CFTN to address community needs as identified in the discussion above. However, that funding will not be transferred from CSS until it is needed in CFTN.

Program	FY 17-18 MHSA Plan Budget	FY 18-19 MHSA Plan Budget	FY 19-20 MHSA Plan Budget
Electronic Health Record System Implementation – Avatar Clinical Workstation Project	$248,407	--	--
Telehealth Project	$50,000	--	--
Community Wellness Center	$500,000	--	--
Administrative Costs - MHSA Team	$1,000	--	--
Total Budget CFTN Projects	**$799,407**	**$N/A**	**$N/A**

Innovation

Of the total MHSA funding received by the County for CSS and PEI, five percent (5%) of the funding is allocated to Innovation.

Program	FY 17-18 MHSA Plan Budget	FY 18-19 MHSA Plan Budget	FY 19-20 MHSA Plan Budget
Restoration of Competency in an Outpatient Setting Project	$216,576	$223,808	$0
Community-Based Engagement and Support Services Project	$672,375	$705,992	$741,297
Administrative Costs - MHSA Team	$3,000	$3,000	$2,000
Total Budget INN Projects	**$891,951**	**$932,800**	**$743,297**

MHSA Three-Year Plan Instructions

Since there were no new instructions issued to the counties by the MHSOAC for the FY 2017-18 Plan, the FY 2016-17 Mental Health Services Act Annual Update instructions have been included.

Fiscal Year 2016/17 Mental Health Services Act Annual Update

Instructions

General: Round all amounts to the nearest whole dollar.

Heading: Enter the County name and the date the worksheet is completed.

Component Worksheets:

General: Each individual component worksheet has a section for fiscal year (FY) 2016/17.
Column A represents the total estimated program expenditures for each program and represents the sum of the funding sources for the program. Counties should do their best to estimate the funding from the sources identified so as to reflect the estimated expenditures of the entire program.

Definitions:

Medi-Cal Federal Financial Participation (FFP) represents the estimated Medi-Cal FFP to be received by the program based on Medi-Cal Certified Public Expenditures (CPE) incurred by the County.
1991 Realignment represents the estimated 1991 Realignment to be used to fund the program.
Behavioral Health Subaccount represents the estimated funding from the Behavioral Health Subaccount used to fund the program. This would generally represent some of the matching funds for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) programs.
Estimated Other Funding represents the any other funds used to fund the program, which could include, but is not limited to, County General Fund, grants, patient fees, insurance, Medicare.

Community Services and Supports Worksheet:

The County should identify Community Services and Support (CSS) programs as either those with Full Service Partnership (FSP) expenditures and those without FSP expenditures (i.e., any program with a FSP expenditure would be reported under the FSP program section). Enter the program names on a line in the appropriate section. The line number does not need to correlate with the program number.
Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.
Enter the estimated funding for CSS Administration in columns B through F. Total estimated CSS Administration is automatically calculated as the sum of columns B through F.
Enter the estimated funding for CSS MHSA Assigned Housing Funding in columns B through F. Total estimated CSS MHSA Assigned Housing Funding is automatically calculated as the sum of columns B through F.
Total CSS estimated expenditures and funding is automatically calculated.
FSP Programs as a percent of total is automatically calculated as the sum of total estimated FSP program expenditures divided by the sum of CSS funding. Counties are required to direct a majority of CSS funding to FSP pursuant to California Code of Regulations Section 3620.

Prevention and Early Intervention Worksheet:

The County should identify Prevention and Early Intervention (PEI) programs as either those focused on prevention or those focused on early intervention. Enter the PEI program names on a line in the appropriate section. The line number does not need to correlate with the program number.
Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.

Enter the estimated funding for PEI Administration in columns B through F. Total estimated PEI Administration is automatically calculated as the sum of columns B through F.
Enter the estimated funding for PEI Assigned Funds in columns B through F. PEI Assigned Funds represent funds voluntarily assigned by the County to California Mental Health Services Authority (CalMHSA) or any other organization in which counties are acting jointly. Total estimated PEI Assigned Funds is automatically calculated as the sum of columns B through F.
Total PEI estimated expenditures and funding is automatically calculated.

Innovations Worksheet:

The County should enter the Innovation (INN) program names on a line in the appropriate section. The line number does not need to correlate with the program number.
Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.
Enter the estimated funding for INN Administration in columns B through F. Total estimated INN Administration is automatically calculated as the sum of columns B through F.
Total INN estimated expenditures and funding is automatically calculated.

Workforce, Education and Training Worksheet:

The County should enter the Workforce, Education, and Training (WET) program names on a line in the appropriate section. The line number does not need to correlate with the program number.
Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.
Enter the estimated funding for WET Administration in columns B through F. Total estimated WET Administration is automatically calculated as the sum of columns B through F.
Total WET estimated expenditures and funding is automatically calculated.

Capital Facilities/Technological Needs Worksheet:

The County should identify Capital Facilities/Technological Needs (CFTN) projects as either capital facilities projects or technological needs projects. Enter the CFTN program names on a line in the appropriate section. The line number does not need to correlate with the program number.
Enter the estimated funding for each program in columns B through F. Total estimated program expenditures are automatically calculated as the sum of columns B through F.
Enter the estimated funding for CFTN Administration in columns B through F. Total estimated CFTN Administration is automatically calculated as the sum of columns B through F.
Total CFTN estimated expenditures and funding is automatically calculated.

Funding Summary Worksheet:

General: The County should report estimated available funding and expenditures for FY 2015/16 by each component. The estimated unspent funds are automatically calculated. The County should use available forecasts of estimated Mental Health Services Act (MHSA) funding to try and determine new available MHSA funding for FY 2015/16.

Sections A, C and E

Line 1 Enter the estimated available funding from the prior fiscal years for FY 2016/17 in Section A.

Line 2 Enter the estimated new funding for FY 2016/17 for each component. The County should reduce the amount of estimated distributions by any estimated prior year reverted funding assuming the reverted funds will be offset against new distributions.

Line 3 Enter the amount of funds requested to be transferred from CSS to CFTN, WET and/or the Local Prudent Reserve. Funds requested to be transferred to CFTN, WET and/or the Local Prudent Reserve will be subtracted from the Estimated Available CSS Funding and the amount is automatically calculated in Column A (CSS). Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

Line 4 Enter the requested amount to be accessed from the Prudent Reserve for either CSS or PEI. The total is automatically summed in Column F (Prudent Reserve).

Line 5 This amount is automatically calculated and represents the estimated available funding for each component.

Sections B, D and F

This amount is automatically transferred from the CSS, PEI, INN, WET, and CFTN worksheet.

Section G

This amount is automatically calculated and represents the difference between the estimated available funding and the estimated expenditures at the end of FY 2017/18.

Section H

Enter the estimated Local Prudent Reserve balance on June 30, 2016. The rest of the cells are automatically calculated.

FY 2017/18 Mental Health Services Act Annual Update

County: El Dorado Date: 4/8/17

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	6,400,000	2,260,000	1,509,872	108,392	299,407	
2. Estimated New FY 2017/18 Funding	8,790,000	1,375,000	361,842			
3. Transfer in FY 2017/18[a/]	(500,000)			0	500,000	0
4. Access Local Prudent Reserve in FY 2017/18	0	0				0
5. Estimated Available Funding for FY 2017/18	14,690,000	3,635,000	1,871,714	108,392	799,407	
B. Estimated FY 2017/18 MHSA Expenditures	11,060,000	2,131,900	891,951	108,392	799,407	
G. Estimated FY 2017/18 Unspent Fund Balance	3,630,000	1,503,100	979,763	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2017	1,898,284
2. Contributions to the Local Prudent Reserve in FY 2017/18	0
3. Distributions from the Local Prudent Reserve in FY 2017/18	0
4. Estimated Local Prudent Reserve Balance on June 30, 2018	1,898,284

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2017/18 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: El Dorado Date: 4/8/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children's FSP Project	1,800,000	1,318,959	477,041			4,000
2. TAY FSP Project	250,000	46,539	66,256			137,205
3. Adult FSP Project	4,675,000	3,436,019	1,238,981			
4. Older Adult FSP Project	100,000	73,498	26,502			
5. Assisted Outpatient Treatment Project	200,000	121,995	53,005			25,000
Non-FSP Programs						
1. Adult Wellness Centers Project	2,300,000	1,686,448	609,552			4,000
2. TAY, Engagement, Wellness and Recovery Services Project	350,000	86,912	92,758			170,330
3. Outreach and Engagement Services Project	800,000	644,928	0			155,072
4. Resource Management Services Project	115,000	115,000	0			
5. Community-Based Mental Health Services Project	260,000	30,094	68,906			161,000
CSS Administration	210,000	210,000				
CSS MHSA Housing Program Assigned Funds	1,572	1,572				
Total CSS Program Estimated Expenditures	11,061,572	7,771,965	2,633,000	0	0	656,607
FSP Programs as Percent of Total	63.5%					

FY 2017/18 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: El Dorado

Date: 4/8/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Latino Outreach Project	231,150	231,150				
2. Older Adults Enrichment Project	150,000	150,000				
3. Primary Intervention Project	275,000	275,000				
4. Wennem Wadati: A Native Path to Healing Project	125,750	125,750				
PEI Programs - Early Intervention						
5. Children 0-5 and Their Families Project	250,000	250,000				
6. Early Intervention for Youth in School Project	150,000	150,000				
PEI Programs - Stigma and Discrimination Reduction						
7. Mental Health First Aid Project	120,000	120,000				
8. LGBTQ Community Education Project	5,000	5,000				
9. Statewide PEI Projects	55,000	55,000				
PEI Programs - Outreach for Increasing Recognition of Early Signs of Mental Illness						
10. Community Education and Parenting Classes Project	150,000	150,000				

11. Mentoring for Youth Project	75,000	75,000				
PEI Programs - Access and Linkage to Treatment						
12. Community-Based Outreach and Linkage Project	300,000	300,000				
13. Veterans Outreach Project	150,000	150,000				
PEI Programs - Suicide Prevention						
14. Suicide Prevention and Stigma Reduction Project	30,000	30,000				
PEI Administration	70,300	70,300				
PEI Assigned Funds	0	0				
Total PEI Program Estimated Expenditures	2,131,900	2,131,900	0	0	0	0

FY 2017/18 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: El Dorado Date: 4/8/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Restoration of Competency in an Outpatient Setting Project	216,576	216,576				
2. Community-Based Engagement and Support System Project	672,375	672,375				
3.						
4.						
5.						
INN Administration	3,000	3,000				
Total INN Program Estimated Expenditures	891,951	891,951	0	0	0	0

FY 2017/18 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: El Dorado Date: 4/8/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce Education and Training (WET) Coordinator Project	30,000	30,000				
2. Workforce Development Project	77,392	77,392				
3.	0					
4.	0					
WET Administration	1,000	1,000				
Total WET Program Estimated Expenditures	108,392	108,392	0	0	0	0

FY 2017/18 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: El Dorado Date: 4/8/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Community Wellness Center	500,000					
2.						
CFTN Programs - Technological Needs Projects						
1. Electronic Health Record System Implementation - Avatar Clinical Workstation Project	248,407	248,407				
2. Telehealth Project	50,000	50,000				
3.						
CFTN Administration	1,000	1,000				
Total CFTN Program Estimated Expenditures	799,407	299,407				0

FY 2014-15
Revenue and
Expenditure Report

Annual Mental Health Services Act Revenue and Expenditure Report
FY 2014-15 Summary

TABLE A

COUNTY: El Dorado **DATE:** 1/13/2016

PEI Statewide Funds assigned to CalMHSA? (Y/N) Y

	Fiscal Year 2014-15	(A) Community Services and Supports	(B) Prevention and Early Intervention	(C) Innovation	(D) Workforce Education and Training	(E) Capital Facilities and Technological Needs	(F) TTACB	(G) WET Regional Partnerships	(H) PEI Statewide Projects Funds	(I) Unencumbered Housing Funds	(J) Prudent Reserve	(K) Total-All Components
1	**Unspent Funds Available From Prior Fiscal Years[1]**											
a	Local Prudent Reserve										$1,898,284	$1,898,284
b	FY 2006-07 Funds				$0							$0
c	FY 2007-08 Funds				$0	$0						$0
d	FY 2008-09 Funds	$0	$0	$0	$0	$0	$0	$0	$0			$0
e	FY 2009-10 Funds	$0	$0	$0	$0	$0	$0	$0	$0			$0
f	FY 2010-11 Funds	$0	$0	$567,681	$140,098	$592,766	$13,710	$0	$0			$1,314,255
g	FY 2011-12 Funds	$0	$0	$178,575	$0	$0	$21,700	$0	$120,278			$320,553
h	FY 2012-13 Funds	$1,557,946	$630,549	$323,260	$0	$0						$2,511,755
i	FY 2013-14 Funds	$3,819,655	$954,914	$251,293	$0	$0						$5,025,862
j	Cumulative Interest	$30,078	$11,206	$8,831	$3,653	$12,347	$317	$0	$3,337			$69,769
k	TOTAL	$5,407,679	$1,596,669	$1,329,640	$143,751	$605,113	$35,727	$0	$123,615	$0	$1,898,284	$11,140,478
2	**MHSA Funds Revenue in FY 2014-15[2]**											
a	Transfer of funds from the Local Prudent Reserve										$0	$0
b	FY 2014-15 MHSA Revenue Received	$5,346,640	$1,336,660	$351,753				$0		$0		$7,035,053
c	FY 2014-15 Interest Earned on MHSA Funds	$18,235	$5,384	$4,483	$485	$2,040	$0	$0	$734	$0	$0	$31,361
d	TOTAL	$5,364,875	$1,342,044	$356,236	$485	$2,040	$0	$0	$734	$0	$0	$7,066,414
3	**Expenditure and Funding Sources for FY 2014-15[3]**											
A	MHSA Funds											
a	FY 2006-07 MHSA Funds				$0							$0
b	FY 2007-08 MHSA Funds				$0	$0						$0
c	FY 2008-09 MHSA Funds				$0	$0		$0				$0
d	FY 2009-10 MHSA Funds				$0	$0		$0				$0
e	FY 2010-11 MHSA Funds				$46,817	$81,299		$0				$128,116
f	FY 2011-12 MHSA Funds	$0	$0	$6,426	$0	$0	$0	$0	$87,967			$94,393
g	FY 2012-13 MHSA Funds	$1,557,946	$630,549	$0	$0	$0						$2,188,495
h	FY 2013-14 MHSA Funds	$3,410,081	$406,074	$0	$0	$0						$3,816,155
i	FY 2014-15 MHSA Funds	$0	$0	$0	$0	$0		$0		$0		$0
	MHSA Net Expenditures Subtotal for FY 2014-15	$4,968,027	$1,036,623	$6,426	$46,817	$81,299	$0	$0	$87,967	$0		$6,227,159
j	Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0		$0
B	Other Funds											
a	1991 Realignment	$0	$0	$0	$0	$0	$0	$0	$0	$0		$0
b	Behavioral Health Subaccount	$0	$0	$0	$0	$0	$0	$0	$0	$0		$0
c	Other	$0	$0	$0	$0	$0	$0	$0	$0	$0		$0
d	TOTAL MHSA and Other Funds	$4,968,027	$1,036,623	$6,426	$46,817	$81,299	$0	$0	$87,967	$0		$6,227,159
e	Total Program Expenditures	$4,968,027	$1,036,623	$6,426	$46,817	$81,299	$0	$0	$87,967	$0		$6,227,159

NOTE TO COUNTY: Total Program Expenditures, 3(d), MUST match Total Expenditure Funding Sources, 3(e). If ERROR, recheck and correct.

4	**Transfers to Prudent Reserve, WET, CFTN[4]**											
	a	FY 2012-13	$0			$0	$0					$0	$0
	b	FY 2013-14	$0			$0	$0					$0	$0
	c	FY 2014-15	$0			$0	$0					$0	$0
5	**Adjustments[5]**												
	a	Local Prudent Reserve										$0	$0
	b	FY 2006-07 Funds				$0							$0
	c	FY 2007-08 Funds				$0	$0						$0
	d	FY 2008-09 Funds				$0	$0		$0				$0
	e	FY 2009-10 Funds				$0	$0		$0				$0
	f	FY 2010-11 Funds				$0	$0		$0				$0
	g	FY 2011-12 Funds	$0	$0	$0	$0	$0		$0				$0
	h	FY 2012-13 Funds	$0	$0	$0	$0	$0						$0
	i	FY 2013-14 Funds	$0	$0	$0	$0	$0						$0
	j	FY 2014-15 Funds	$0	$0	$0	$0	$0		$0		$0		$0
	k	Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0		$0
l	TOTAL		$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
6	**Unspent Funds in the Local MHS Fund[6]**												
	a	Local Prudent Reserve Balance										$1,898,284	$1,898,284
	b	FY 2006-07 Funds				$0							$0
	c	FY 2007-08 Funds				$0	$0						$0
	d	FY 2008-09 Funds	$0	$0	$0	$0	$0	$0	$0	$0			$0
	e	FY 2009-10 Funds	$0	$0	$0	$0	$0	$0	$0	$0			$0
	f	FY 2010-11 Funds	$0	$0	$567,681	$93,281	$511,467	$13,710	$0	$0			$1,186,139
	g	FY 2011-12 Funds	$0	$0	$172,149	$0	$0	$21,700	$0	$32,311			$226,160
	h	FY 2012-13 Funds	$0	$0	$323,260	$0	$0						$323,260
	i	FY 2013-14 Funds	$409,574	$548,840	$251,293	$0	$0						$1,209,707
	j	FY 2014-15 Funds	$5,346,640	$1,336,660	$351,753	$0	$0		$0		$0		$7,035,053
	k	Interest	$48,313	$16,590	$13,314	$4,138	$14,387	$317	$0	$4,071	$0		$101,130
l	TOTAL		$5,804,527	$1,902,090	$1,679,450	$97,419	$525,854	$35,727	$0	$36,382	$0	$1,898,284	$11,979,733

TABLE B[7]

Estimated FFP Revenue Generated In FY 2014-15	Amount
Federal Financial Participation (FFP)	$2,849,221

RER Contact Person	
Name	Michele McAfee
Title	Accountant I
Phone	(530) 295-6910
Email	michele.mcafee@edcgov.us

Enclosure 3

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2014-15
Community Services and Supports (CSS) Summary

County: El Dorado **Date:** 1/13/2016

	Community Services and Supports Component	Total (Gross) Mental Health Expenditures
FSP Programs		
1	CSS WP1 - Youth and Family Strengthening	$552,148
2	CSS WP2 - Adult Wellness & Recovery	$1,434,743
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
21		
22		
23		
24		
25		
	Subtotal FSP Programs	$1,986,891
Non-FSP Programs		
1	CSS Non-FSP	$2,630,605
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
	Subtotal Non-FSP Programs	$2,630,605
Total FSP and Non-FSP Programs		$4,617,496
CSS Evaluation		
CSS Administration		$350,531
CSS MHSA Housing Program Assigned Funds		
Total CSS Expenditures		$4,968,027

Updated: 05/08/2015

Enclosure 3

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2014-15
Prevention and Early Intervention (PEI) Summary

County: El Dorado **Date:** 1/13/2016

Prevention and Early Intervention Component	(A) Total (Gross) Mental Health Expenditures
PEI Programs-Prevention	
1 WP2 - Community Education Project	$41,305
2 WP4 - Wellness Outreach/Vulnerable Adults	$25,350
3	
4	
5	
6	
7	
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10	
11	
12	
13	
14	
15	
Subtotal PEI Programs-Prevention	$66,655
PEI Programs-Early Intervention	
1 WP1 - Youth and Children's Services	$601,062
2 WP3 - Health Disparities Program	$213,301
3 WP5 - Community-Base Services	$113,930
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
14	
15	
Subtotal PEI Programs-Prevention	$928,293
PEI Programs-Other	
1	
2	
3	
Subtotal PEI Programs-Other	$0
Subtotal PEI Programs-Prevention & Early Intervention and Other	$994,948
PEI Evaluation	$0
PEI Administration	$41,675
Total PEI Expenditures	$1,036,623

Updated: 05/08/2015

Enclosure 3

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2014-15
Innovation (INN) Summary

County: El Dorado **Date:** 1/13/2016

Innovation Component	(A) Total (Gross) Mental Health Expenditures
Innovation Programs	
1 Planning	$0
2 Closing the Gap	$0
3	$0
4	$0
5	$0
6	$0
7	$0
8	$0
9	$0
10	$0
11	$0
12	$0
13	$0
14	$0
15	$0
16	$0
17	$0
18	$0
19	$0
20	$0
21	$0
22	$0
23	$0
24	$0
25	$0
Subtotal	$0
Innovation Evaluation	$0
Innovation Administration	$6,426
Total Innovation Expenditures	$6,426

Updated: 05/08/2015

Enclosure 3

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2014-15
Workforce Education and Training (WET) Summary

County: El Dorado **Date:** 1/13/2016

Workforce Education and Training Component	(A) Total (Gross) Mental Health Expenditures
WET Funding Category	
Workforce Staffing Support	
Training and Technical Assistance	$7,552
Mental Health Career Pathways Programs	$36,526
Residency and Internship Programs	$349
Financial Incentive Programs	
Total WET Programs	$44,427
WET Administration	$2,390
Total WET Expenditures	$46,817

Updated: 05/08/2015

Enclosure 3

Annual Mental Health Services Act Revenue and Expenditure Report
Fiscal Year 2014-15
Capital Facilities/Technological Needs (CF/TN) Summary

County: El Dorado **Date:** 1/13/2016

Capital Facility/Technological Needs Projects	(A) Total (Gross) Mental Health Expenditures
Capital Facility Projects	
1 WP1 - Electronic Health record (CWS)	$54,140
2 WP2 - Telehealth	$24,989
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
Total CF Projects	$79,129
Capital Facility Administration	
Total Capital Facility Expenditures	$79,129
Technological Needs Projects	
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	
13	
Total TN Projects	$0
Technological Needs Administration	$2,170
Total Technological Needs Expenditures	$2,170
Total CFTN Expenditures	$81,299

Updated: 05/08/2015

Enclosure 3

Annual Mental Health Services Act Revenue and Expenditure Report
Fiscal Year 2014-15
Other MHSA Funds Summary

County: El Dorado **Date:** 1/13/2016

	(A) Total (Gross) Expenditures
Training, Technical Assistance and Capacity Building	$0
WET Regional Partnerships	$0
PEI Statewide Projects	$87,967

Updated: 07/24/2015

Enclosure 3

Annual Mental Health Services Act Revenue and Expenditure Report
Fiscal Year 2014-15
Unencumbered Housing Funds Summary

County: El Dorado **Date:** 1/13/2016

	(A) Total (Gross) Expenditures
Unencumbered Housing Funds	$0

Updated: 05/08/2015

Enclosure 3

Annual Mental Health Services Act Revenue and Expenditure Report for Fiscal Year 2014-15
Adjustments Summary

County:

Date: 1/13/2016

FY	Amount	Reason For Adjustment
TOTAL	$0	
	$0	

NOTE TO COUNTY: Total Adjustments recorded in the Adjustments Summary worksheet MUST match Total Adjustments recorded on the RER Summary Worksheet. If ERROR, recheck and correct.

Annual Mental Health Services Act Revenue and Expenditure Report
FY 2014-15

END NOTES:

[1] Total unspent funds from prior fiscal years MUST match the Total Unspent Funds in the Local MHS Fund from prior year RER.

[2] DHCS will utilize the allocation report provided by the SCO and counties should utilize the same report when determining the total State MHSA Fund revenue to be reported on the FY 2014-15 RER. The report is available at: http://www.sco.ca.gov/ard_payments_mentalhealthservicefund.html

[3] Expenditure funding sources for each component must equal the total program expenditures as reported on the Component Summary Worksheets.

[4] WIC Section 5892(b) permits a County to use up to 20 percent of the average amount of funds allocated to the county for the previous five years to fund technological needs and capital facilities, human resource needs, and a prudent reserve. The amount of funds transferred from CSS will be reported in the CSS column as a negative amount. The funds transferred into WET, CFTN, or Prudent Reserve should be reflected as a positive amount. For each year reported, the amount transferred from CSS should equal zero when added to the funds transferred into WET, CFTN, or Prudent Reserve.

[5] Payments from the MHSA Fund should be reflected in the Adjustments section as a negative amount. Receipts into the MHSA Fund should be reflected in the Adjustments section as a positive amount.

[6] Total Unspent funds in the Local MHS Fund will auto populate for each Fiscal Year.

[7] The FFP amount represents the estimated FFP revenue generated in FY 2014-15 and attributable to MHSA funds.

Community Program Planning Process (CPPP)

FY 17/18 MHSA Three-Year Plan Community Program Planning Process Meetings

Date / Time	Group Host / Location	City	Number of Attendees
10/6/2016 9:00 AM	South Lake Tahoe Mental Health Cooperative - Aspen Room at Lake Tahoe Community College	South Lake Tahoe	18
10/11/2016 4:00 PM	Drug Free Divide - The Hut	Georgetown	7
10/20/2016 9:30 AM	Commission on Aging - Diamond Sunrise Apartments	Diamond Springs	13
11/1/2016 5:30 PM	NAMI El Dorado Western Slope El Dorado County Bldg. A, Conference Room A	Placerville	8
11/16/2016 8:00 AM	ACEs Collaborative Health and Human Services Agency - Sierra Room	Placerville	45
10/25/2016 5:00 PM	Diamond Springs Wellness Center	Diamond Springs	0

Summary of MHSA FY 2017-18 Three-Year Plan Community Survey Responses

Please rate your familiarity with the following Behavioral Health programs:						
Answer Options	**Extremely familiar**	**Moderately familiar**	**Somewhat familiar**	**Slightly familiar**	**Not at all familiar**	**Response Count**
Children's Services	32	38	29	21	28	148
Transitional Age Youth (TAY) Services	14	28	18	27	63	150
Parenting Education and Classes	24	30	31	24	41	150
School-Based Prevention Programs	16	28	24	41	39	148
Adult Services	32	41	31	23	24	151
Older Adult Services	15	26	31	36	39	147
Latino Outreach Programs	14	17	14	23	83	151
Native American Programs	3	12	14	26	94	149
Community Education Programs	10	30	33	39	36	148
Alcohol and Drug Programs	28	41	42	21	18	150
Crisis Response Services	29	47	25	17	31	149
answered question						**152**
skipped question						**2**

As a whole, please rate MHSA-funded programs serving the following:						
Answer Options	**Excellent**	**Good**	**Neutral**	**Fair**	**Poor**	**Response Count**
Children 0-5	10	28	41	16	26	121
Youth 6-12	8	30	37	31	16	122
Teens 13-17	6	26	35	34	18	119
Adults 26-59	14	31	36	21	23	125
Older Adults 60+	5	14	52	29	23	123
Latinos	4	16	57	23	21	121
Native Americans	3	18	56	17	25	119
Veterans	1	17	57	18	24	117
LGBTQ	2	14	55	15	36	122
Homeless	3	16	32	27	46	124
Those with serious mental illness	9	24	24	29	37	123
Individuals at risk for mental illness	3	15	35	20	51	124
answered question						**129**
skipped question						**25**

Populations or groups of people not adequately served by current MHSA programs in El Dorado County	**Percent**
Persons experiencing homelessness	57%
Persons experiencing mental health crisis	38%
Jail releases and clients on probation	34%
Persons with disabilities	34%
LGBTQ individuals	33%
Veterans	33%
Older adults	29%
Transitional age youth (TAY)	28%
School-aged children	27%
Adults	26%
Children 0-5	26%
Native Americans	22%
Hispanic or Latino	21%
Other population(s) (please specify) * Co-occurring drug / alcohol and mental health * Other minority populations * Foster children * Uninsured and underinsured people * Isolated adults	9%

Based on your answers in the previous question, please identify who you feel are the three most underserved groups:	
Priority Populations	
17%	Persons experiencing homelessness
13%	Children (ages 0-5, school-aged and foster youth)
10%	Transitional Age Youth (TAY), including First Episode Psychosis
9%	Adults with serious mental illness, including co-occurring substance abuse
9%	Older adults
8%	Persons with disabilities
7%	Jail releases and clients on probation
6%	Persons experiencing mental health crisis
5%	Veterans
5%	LGBTQ individuals
5%	Hispanic or Latino
5%	Other populations, including isolated persons, person with mild to moderate mental illness, and Native Americans
100%	

What issues make it more challenging for consumers and their families to receive mental health services (please check all that apply)?		
Answer Options	**Response Percent**	**Response Count**
Lack of transportation to appointments	70.2%	99
Appointment availability	53.9%	76
Cost of services	56.0%	79
Location of the clinics or service providers	44.0%	62
Clinic office hours and / or days open	36.2%	51
Lack of referrals to other programs or services	42.6%	60
Services are not provided in the consumers' primary language	22.0%	31
Actively using illegal or controlled substances	44.0%	62
Stigma around mental illness in the community	55.3%	78
Lack of insurance or lack of understanding regarding insurance eligibility	66.0%	93
Providers do not respect consumers' cultural background	14.9%	21
answered question		**141**
skipped question		**13**

Please rate the following:							
Answer Options	**Extremely**	**Moderately**	**Somewhat**	**Slightly**	**Not at all**	**I don't know**	**Response Count**
How effective do you feel prevention efforts are in reducing the prevalence of untreated mental illness in our community?	12	25	30	30	18	27	142
How effectively are we meeting the needs of people with serious mental illness in our community?	6	26	41	35	12	21	141
How effective are crisis response services in our community?	10	27	36	24	9	32	138
answered question							**142**
skipped question							**12**

My age group is:		
Answer Options	**Response Percent**	**Response Count**
Under 15	5.5%	8
Age 16-25	3.4%	5
Age 26-39	22.1%	32
Age 40-59	49.7%	72
Age 60-84	19.3%	28
Age 85+	0.0%	0
answered question		**145**
skipped question		**9**

My preferred language is:		
Answer Options	**Response Percent**	**Response Count**
English	91.0%	131
Spanish	7.6%	11
Another language (please specify)	1.4%	2
answered question		**144**
skipped question		**10**

Which of the following Stakeholder group(s) do you identify with (please check all that apply)?		
Answer Options	**Response Percent**	**Response Count**
Mental health consumer	24.6%	35
Family member of a mental health consumer	27.5%	39
An interested member of the community	44.4%	63
Education agency	21.1%	30
Community-based mental health services provider	8.5%	12
Community-based non-mental health services provider	9.9%	14
County Behavioral Health staff	4.2%	6
Faith-based organization	6.3%	9
Hospital or health care provider	4.9%	7
Law enforcement	0.0%	0
NAMI El Dorado	3.5%	5
Other community-based organization	13.4%	19
Other County staff	10.6%	15
Student	12.0%	17
Substance abuse service provider	2.1%	3
Senior services	2.8%	4
Social services agency	12.7%	18
Veteran or veteran organization	3.5%	5
Other (please specify)	11.3%	16
answered question		**142**
skipped question		**12**

My race / ethnicity is:		
Answer Options	**Response Percent**	**Response Count**
American Indian or Alaska Native	2.1%	3
Asian	1.4%	2
Black or African American	2.1%	3
Caucasian or White	73.8%	104
Hispanic or Latino	13.5%	19
Native Hawaiian or Other Pacific Islander	0.0%	0
More than one race / ethnicity	5.7%	8
Another race / ethnicity (please specify)	1.4%	2
answered question		**141**
skipped question		**13**

My gender is:		
Answer Options	**Response Percent**	**Response Count**
Male	19.6%	27
Female	80.4%	111
Another gender identity, please specify; e.g., transgender, genderqueer, questioning or unsure of gender identity)	0.0%	0
answered question		**138**
skipped question		**16**

Please mark all of the following descriptions that apply to you.		
Answer Options	**Response Percent**	**Response Count**
Blind / Vision Impaired	0.6%	1
Deaf / Hard of Hearing	1.9%	3
Disabled	9.1%	14
Homeless	0.6%	1
LGBTQ	1.9%	3
Veteran	1.9%	3
answered question		**23**
skipped question		**131**

I live in:		
Answer Options	**Response Percent**	**Response Count**
Mid County (Camino, Cedar Grove, Kyburz, Pacific House, Pollock Pines, Riverton)	7.0%	10
North County (Coloma, Cool, Garden Valley, Georgetown, Greenwood, Lotus, Pilot Hill)	7.7%	11
Placerville Area (Diamond Springs, El Dorado, Kelsey, Placerville, Pleasant Valley, Swansboro)	35.0%	50
South County (Fairplay, Grizzly Flats, Mt. Aukum, Somerset)	0.7%	1
Tahoe Basin (South Lake Tahoe, Tahoma)	23.1%	33
West County (Cameron Park, El Dorado Hills, Rescue, Shingle Springs)	18.2%	26
Outside of El Dorado County	7.0%	10
Other (please specify)	1.4%	2
answered question		**143**
skipped question		**14**

County of El Dorado, Health and Human Services Agency
Behavioral Heath, Mental Health Services Act (MHSA)
Community Program Planning Process

Key Informant Interviews

January and February, 2017

MHSA Three Year Program and Expenditure Plan for FY 17/18 – 19/20

The Mental Health Services Act (MHSA) was passed by California voters in November, 2004. The MHSA taxes all California residents' income that is over $1 million at 1%. This tax money has gone to the MHSA fund to expand and develop multi-cultural, innovative, integrated services.

The purpose of the MHSA Three Year Plan is to document the County's vision for addressing mental illness through each of the MHSA's five components.

- Community Services and Supports (CSS): focused on community collaboration, cultural competence, client and family driven services and systems, wellness (recovery and resilience), integrated service experience for clients and families, as well as serving the unserved and underserved.
- Prevention & Early Intervention (PEI): to implement services that promote wellness, foster health and prevent the suffering that can result from untreated mental illness…the key is collaboration with clients and families.
- Innovation (INN): to increase access to services for the unserved and underserved individuals within the community, increase the quality of services, promote collaboration and increase access to services.
- Capital Facilities & Technological Needs (CFTN): provides the development and maintenance of Behavioral Health's integrated information system infrastructure including its' electronic health record, clinical assessment tools, tele psychiatry and videoconferencing capabilities and related equipment, training, administrative and technical support.
- Workforce Education & Training (WET): develops a competent workforce capable of meeting the needs of the community; provides for education and training for individuals providing services for or supporting the community mental health program.

We are interviewing individual stakeholders to better understand the needs for our community. The information you share will be used anonymously and will help inform the development of

the Three Year Program and Expenditure Plan. Your name will not be identified in association to your answers, but we would like to include your name in the list of participants in the key informant process.

May we include your name in the list of individuals who participated in the process?

Yes:

- Patricia Charles-Heathers – Director, Health and Human Services Agency
- Barry Harwell – Sierra Child and Family Services
- Jeanne Nelson – NAMI South Lake Tahoe
- Commander Kim Nida – Placerville Police Department
- Dr. Robert Price – Psychiatrist, Health and Human Services Agency, Behavioral Health Division

Do you have any questions before we start?

None.

1. **Please tell us about community you serve; geographic area, populations served and what makes your community unique?**
   The key informants in this process each brought a very unique perspective about the needs in the community, ranging from law enforcement and NAMI to people serving in the mental health field directly, both in the Health and Human Services Agency and at the contract provider level. The rural nature of El Dorado County makes it unique, with individual communities geographically distant and very diverse cultures in each community. The expectations, needs and wants from communities are different, especially in regards to mental health services.

2. **What are the mental health needs within the County? What influence do mental health needs have on the community?**
   The mental health needs vary greatly within the County. The following were some of the areas identified by the key informants:
   1) Homeless, including veterans with mental health issues.
   2) El Dorado County has and will continue to see a larger population of seniors compared to other counties. Our services will need to change to meet the needs of this population.
   3) Children and youth, including foster children. There are not enough resources to meet all the needs for this population, particularly with the mandates of the Continuum of Care Reform.
   4) Increasing number of co-occurring clients with mental health issues and substance use disorders. Socio-economic, transportation, and isolation issues make it increasingly difficult for people with mental health needs to access services.
   5) More providers necessary to serve people needing mild to moderate mental health services.
   6) Awareness of and access to services are ongoing needs, thus we need to identify more effective ways of providing comprehensive information regarding services and ensure the community knows how to access services. Moving to a model of "whole person care" and service integration will help to facilitate this process.

3. **What is your primary source of information regarding mental health needs in the County? (i.e. professional association/personal experience of family member or friend, etc.)**
   The key informants had a wide range of information sources, including personal experience, direct service experience working with clients and families, data received from the State, County Health assessments, and participation in various workgroups. Trends over the past few years indicate that there is much better collaboration overall between County agencies, law enforcement, hospitals, contract providers and others regarding mental health needs in our community, including CIT training for law enforcement.

4. **What mental health services are available in the County?**
   Specialty mental health services for children and adults, outpatient clinics in Diamond Springs and South Lake Tahoe, Psychiatric Health Facility (PHF), crisis line, and a variety of other services by contract providers.

   a) What services are working well (i.e., information about, access to, competency, staffing, etc.)?
      Some of the services working well include:
      1) Services for children needing specialty mental health services, there is great partnership between CWS and the BHD.
      2) The process at the hospitals for crisis services is working well. Having a crisis worker in the hospitals has allowed faster assessments, better stabilization in a shorter period of time and alleviates the need for law enforcement to have to stay in the hospital
      3) ICM team is doing exactly what needs to be done to serve our more acute clients. There are fewer inpatient placements as a result of their efforts.
      4) There has been more participation in collaborative groups within the county and better dissemination of information, including the monthly report provided to the Mental Health Commission and monthly reminders.
      5) DBT classes provided in the high schools have been very successful.
      6) Peers having a more active role in the Wellness Centers.

   b) What challenges and/or barriers exist? Are they consistent or do they change?
      1) Providing mental health services to the outlying areas of the County remains a considerable challenge. Isolation, lack of transportation, and lack of providers/ groups in the remote areas makes it challenging for people to get needed mental services. Individuals may often go without services as a result of these barriers.
      2) The 5150 process can be challenging because clients admitted to the PHF are released too quickly. This sometimes results in law enforcement and other community partners dealing with the same individuals and issues repeatedly.
      3) There needs to be a fully implemented FEP program that is comprehensive, better packaged and better advertised.
      4) The children's service provider contracts are too rigid and need to be modified to allow more flexibility when circumstances with the child or family change.

The assessment process for children's services is often inadequate or not in depth enough.

5) Need to implement better outcome measurements for mental health programs, including specific metrics which are consistent.
6) There is a great need for mild to moderate service providers in all areas of the County for children and adults.
7) There is a lack of adult service providers and alcohol and drug providers for co-occurring clients with mental health issues and substance use disorders.
8) Law enforcement has limited access to Behavioral Health staff, officers don't know who to contact for follow-up. Pre-established contacts, additional communication and collaboration could make a big difference and facilitate more favorable process and potential results.

c) Are current services sufficient to meet the needs? If no, what specific services are needed?

The general consensus among the key informants interviewed was that current services overall are not sufficient to meet the needs. Specific recommendations include:

1) Consistent, comprehensive awareness campaign to include resources and how to access services.
2) Greater and more immediate access to the BHD for services. If a person needs mental health services and has to wait three weeks for an appointment, our window to catch them has passed.
3) A better triage process for intake is needed. People calling for services often get "blocked" or are told that they need to call someone else. There needs to be a navigator type person available to help get people directly to the services that they need. Without the navigator, individuals fall through the cracks.
4) We need to do a better job utilizing existing resources, like the New Morning shelter, to ensure a smooth transition and continuity of services. Additionally, making Avatar (electronic health records) available to contract providers would allow for better and faster exchange of information and more efficient and timely services.
5) There is a need for inpatient services for children and foster family agencies locally.
6) Dedication of a clinician or a psychiatric technician to ride along with law enforcement once a week to establish more collegial relationships, increase everyone's knowledge of what is happening in our community, foster better collaboration and opportunities for a preventative approach to services.
7) Direct liaison between Law Enforcement and Behavioral Health so law enforcement can call to follow up on a situation and vice versa.
8) Reorganize services in the outpatient clinic to focus on the level and needs of the clients and staff strengths, including moving towards peer run Wellness Centers and peer led groups.

5. **If you were speaking with another professional from another County, how would you describe the Mental Health Services in the County? Would you recommend County mental health services?**
   Yes and no. Despite the challenges that we face, the County and contract provider staff are doing an excellent job serving clients in our community. We have made strides in the last few years, but remain challenged in many areas and do the best we can with the available resources. The demand for services exceeds our present capacity. There is a need for more "boots on the ground" and services in the field, as well as improve immediate access to mental health services.

6. **What trends or changes have you observed or experienced?**
   There are many people in the community with undiagnosed mental illness who are self-medicating with drugs and alcohol. There is a perception among youth and young adults that marijuana is an herb that is good for you, when it is actually a gateway to other drugs and there are still many young teenagers smoking cigarettes despite everything that is known about the harm of tobacco use. Amphetamine use among the 20-30 age group is on the rise. There continues to be a need across the board for more mild to moderate services. On a more positive note, there has been an increase in group participation at the outpatient clinics, an increase in the use of long lasting injectables, and more engagement and activities in the Wellness Centers.

7. **What are the most significant mental health needs for El Dorado County during the next three years?**
   Some of the most significant needs in the next three years include moving to a whole person model of care, addressing the chronically homeless in our community, establishing a formal FEP program with metrics, serving our growing senior population more effectively, providing services to the outlying areas in our community, providing more comprehensive services to children to meet the required mandates, and educating the community on what services are available and expanding access to services.
   - What specific groups in the community struggle with mental health issues the most (demographic and other factors which may have an influence)?
     Chronically homeless individuals, veterans, and individuals with co-occurring mental health issues and substance use disorders.

8. **In order of greatest need, please rank the priority populations in the County?**
   The key informants identified the following populations (in no particular order): Children, chronically homeless, older adults, mild to moderate, co-occurring clients with mental health issues and substance use disorders, and veterans.

9. **Are there policies, laws or regulations which exist which impact the service delivery within the County? If yes, what are they and what is the impact?**
   Potential changes to the ACA, 5150 release process and LPS process that affect what mental health services can be provided, consistent drug testing in the BHC program, limitations on uses of MHSA and other funding, and inconsistent use of established procedures.

10. **Can you recommend 1 or 2 additional people, groups or organizations you think it would be most important to speak to regarding the mental health needs in the County?**
    Several individuals were suggested who were either part of the community wide meetings or focus groups.

11. **Is there anything else you would like to share with us regarding about the mental health needs and services within the County that have not been addressed?**
    Establishment and use of better, evidence-based outcome measurement tools and list specific measurement tools used, change the format for reports like the Behavioral Health monthly report to the Mental Health Commission to utilize more graphs and trend analysis, develop a mechanism to allow use of a shared electronic health record with all providers, and more informational materials and brochures in the community.

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. Comments on other Behavioral Health Division programs or general topics of discussion are outside the scope of this Plan and therefore not addressed below.

The MHSA project team encourages greater discussion regarding these items and other topics impacting mental health services in El Dorado County during the next MHSA Community Planning Process.

General	
1.	*Note:* Throughout the document, references to the Plan Update being a "draft" or projects being "proposed" have been changed to reflect their status after adoption of the Plan Update. Other grammatical, typographical, and non-substantive wording issues have been corrected.
2.	*Comment:* Health and Human Services Agency must incorporate the science of mental health and addiction into MHSA services/supports. The programs are not actually teaching brain science (genetics and addiction and what to do and not do when you have a predisposition.) We need to raise the performance bar of those doing the trainers across all the programs.
	Response: The MHSA Plan does not preclude the Behavioral Health Division from incorporating varied modalities into the services and supports it provides. Not every group activity, individual intervention or training topic is identified in the MHSA Plan. However, the request for more science-based education, services and/or supports has been noted.
3.	*Comment:* The governance is inadequate for the MHSA programs. If it were adequate the data metrics and basic "requirements" set by the county to obtain funding would be tightened up to "guide" inclusion of more science-oriented services/supports.
	Response: As stated above, the request for more science-based education, services and/or supports has been noted. The MHSA programs continue to expand their reporting each year, and measurements are not limited to those identified in the MHSA Plan. Good governance is not measured solely by whether or not science-oriented services/supports are provided, rather it must be considered in terms of the overall implementation of the MHSA Plan, including issues such as legal requirements/frameworks, accountability, protocols, collaboration with the public/community-based organizations, responsiveness, effectiveness, and compliance with standard measurements.

4.	*Comment:* I'd like to see a section on programs that are ongoing that would benefit from "general fund" contributions.
	Response: MHSA funding does not require a general fund contribution. As a general statement, additional funding is helpful to expand current services or offer new services. However, the type of funding (e.g., directed to a specific program, one-time only, uncertain annual contribution) and available infrastructure (either current or expansion) determines the benefit it would provide.
5.	*Comment:* Every county program and every MHSA program governed by the county should have very transparent highlights and lowlights. The lowlights should openly acknowledge where gaps exist and where funding could help improve the gaps. Today's climate within the county seems to be a trend to want to "market" how great we are but not look at opportunities for improvement. The road to funding comes from stating gaps and justifying what occurs not having said gaps filled.
	Response: Currently, annual PEI reports from contracted providers require information related to "any major accomplishments and challenges". This request will be noted for next year's MHSA Plan Update.
6.	*Comment:* I would like our mental health plans to not be a list of programs and costs, but a reflection of the Behavioral Health Division mission and vision (new Strategic Plan?) and how this will be implemented through these programs. I would like to see it openly reflect the knowns (data) and the unknowns (challenges).
	Response: This request will be noted for next year's MHSA Plan Update.
7.	*Comment:* Director's Letter - There is a reference to "significant changes" but no mention of what they are. A brief mention of what the changes are would alert and interest the reader and avoid raising unanswered questions.
	Response: Clarifications have been made to the Director's Letter.
8.	*Comment:* Individual Component Goals and Objectives for Prevention and Early Intervention and Community Services and Supports should reflect the requirements and guide the development of programs to support those goals and objectives. The way the plan reads now, it looks like we attempt to fit programs into requirements, rather than developing programs that will produce desired results based upon OUR goals and objectives.
	Response: Programs within the MHSA Plan are developed based upon input received from the public during the Community Planning Process. The goals and objectives are developed to address the identified needs and expectations for the programs. Just as community needs and gaps change over time, the MHSA Plan is a living document that is updated annually to address those changing needs. However, there are certain types of programs that must be provided through MHSA, and at certain funding levels, and this Plan includes those requirements and identifies the required elements within the program description. Required programs include services for all age ranges, Full Service Partnership programs, an early intervention program, an outreach program for increasing recognition of early signs of mental illness, a prevention program, an access and linkage to treatment program, and a stigma and discrimination

	program. Although a suicide prevention program is not required, the number of suicides in El Dorado County was an area of concern identified in past Community Planning Processes and the program has been incorporated into the MHSA Plan.
9.	*Comment:* Crosswalk – This is helpful and necessary to understand the changes in program titles. This could be combined with the program cost (increases/decreases), and if possible, some sort of easy method of success rating.
	Response: Changes to the program crosswalk have been incorporated within the program descriptions and added to the *"Expenditure Plan and FY 2017-18 Budget"* section.
10.	*Comment:* Other concerns the plan does not address directly – Programs for clients utilizing greater science based education, integration of services for dual diagnosis and for those recently incarcerated and recently returning to the community are important, but not noticeably prioritized.
	Response: The MHSA Plan does not describe the full range of Specialty Mental Health Services available in El Dorado County. Rather, it only addresses services funded through MHSA. As stated above, the request for more science-based education, services and/or supports has been noted. Integration of services for individuals with a dual diagnosis of chronic and severe mental illness and a substance use disorder is occurring within the Behavioral Health Division but the details may not be reflected within the MHSA Plan because those services are occurring under existing MHSA programs or funded through Traditional (non-MHSA) funding. Mental health services for incarcerated individuals is provided through the California Forensic Medical Group (CFMG). Please see Community Services and Supports (CSS) program "Community-Based Mental Health Services Project" for more information about services available through MHSA for individuals recently released from jail and/or on probation. Recently incarcerated individuals may also receive Specialty Mental Health Services via other Behavioral Health Division programs. Note, MHSA funds may not be utilized to provide services to individuals who are on parole from prison. Additional services, beyond Full Service Partnership services, are available in the South Lake Tahoe area for individuals with both a chronic and severe mental illness diagnosis and a history of criminal offending, the majority of whom also have a co-occurring substance use disorder. These services are available through a Mentally Ill Offender Crime Reduction (MIOCR) grant, which would not be reflected in the MHSA Plan.

11.	*Comment:* I'm unclear why the county is not mandating measures that show "percentage of program hours" spent on mental health training that includes genetic assessments to emphasize that most mental health issues and substance abuse issues have a genetic component (BBR Foundation.org research and PsychU.org and some University resources such as Stanford provides helpful scientific studies illustrating the estimates on genetic predisposition impacts.) For example of those that get diagnosed with Schizophrenia some 75% of the cases had a genetic predisposition. Similarly, what percentage of program hours are spent building resiliency? It is the basic resiliency skills coupled with brain science of why antipsychotics work in low doses in FEP.
	Response: MHSA does not require separate tracking of percentage of program hours spent on training or building resiliency. Attempting to capture the time spent building resiliency would be very difficult to capture due to the unique manner in which services are provided to each individual. Mental illness may be caused by genetic and/or environmental factors and the sole focus of practice should not rely 100% on either of those considerations. The unique service needs of each individual is assessed is determined. Behavioral Health Division is researching how other counties incorporate science-based education, services and/or supports into their MHSA programs.
12.	*Comment:* The intent of MHSA was to meet the needs of the "Severely Mentally Ill". It appears there is little change from the last 3 year plan.
	Response: The MHSA, Section 3, states the purpose and intent of the MHSA is: (a) To define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care. (b) To reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness. (c) To expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness. (d) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs. (e) To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public. The MHSA requires Counties to develop and implement programs within the following components: • Prevention and Early Intervention (PEI)

	• Community Services and Supports (CSS) • Innovation (INN) • Workforce Education and Training (WET) • Capital Facilities and Technology Needs (CFTN) Within CSS, there is one new program, and one program has been split into two programs. Please see pages 18-20 for more details. Within PEI, some programs have been consolidated, one program has been discontinued and other programs have been expanded. Please see the PEI Crosswalk, starting on page 35, for more details. There are two continuing Innovation programs that became effective in August 2016. There are no changes to WET programs. There is one new CFTN program, which establishes Capital Facility funding for a community-based wellness center. Please see pages 28-29 for more details.
Fiscal / Budget	
13.	*Comment:* There is concern for the full three-year budget of the Draft FY 17-18 MHSA Three-Year Plan showing diminishing fund balances in the final fiscal year of the Three-Year Plan.
	Response: Although the estimated fund balances as of July 1, 2020 appear low, the MHSA programs in El Dorado County have traditionally been underspent, which has resulted in a higher than anticipated fund balance at the start of this Three-Year Plan. The revenues and expenditures are continually monitored and the budget adjusted annually through the MHSA Plan/Plan Update to address any budget concerns. Please see pages 33-34 for additional information.
14.	*Comment:* Prudent Reserve – Set to insure viability of programs should there be a shortfall for how long? This number needs to be updated with each plan based upon cost of programs and overhead rather than a percentage. It is realistic?
	Response: At this time, the Prudent Reserve is $1,898,284, which would provide services for a very limited period of time in the event all other MHSA revenues were to stop. The County does not anticipate the need to access of the Prudent Reserve during this Three-Year Plan. While the County could contribute to its Prudent Reserve, concern has been expressed for both under-spending in MHSA, as well as for over-extending MHSA expenditures to an unsustainable level. Therefore, current excess funding has been placed into "Appropriations for Contingencies," which provides greater flexibility in accessing those funds than exists from the Prudent Reserve. In the event there is a significant fund balance remaining at the end of FY 2017-18, a contribution to the Prudent Reserve may be considered during the next Community Planning Process for the FY 2018-19 MHSA Plan Update.
15.	*Comment:* Some explanation would be helpful of the over-estimating of revenues and the Prevention and Early Intervention programs that failed to launch. Having money tied to so many programs that never get off the ground is disconcerting.

	Response: MHSA revenues are dependent upon tax revenues on personal income above $1,000,000. While El Dorado County estimates the anticipated MHSA revenues based on the best available data, the County does not know the actual revenues until the end of the fiscal year. Some years the revenues are higher than anticipated, just as some years the revenues are lower than anticipated. Regarding the Prevention and Early Intervention programs that failed to launch, the number of programs has been consolidated from 20 programs to 14 programs, and each program that has not yet been implemented will be assigned a program lead to ensure implementation.
16.	*Comment:* I'm witnessing hundreds of thousands of dollars being sprinkled around without anyone raising the performance bar of the providers receiving the money for services/supports. This is not okay. There is a financial responsibility that goes with dolling out dollars. People are saying "EDC" just takes the easy route by giving money over to those agency's that will manage themselves. HUGE MISTAKE.
	Response: The Behavioral Health Division continues to monitor programs and providers for outcomes and performance, and implements improvements to this process on a continual basis.
17.	*Comment:* With the passage of AB-403, the mental health system will be inundated with youth coming from group homes, mainly teenagers, and PEI funds for adolescents should be focused on high risk teens already identified.
	Response: Prevention and Early Intervention funds are utilized for programs to prevent a mental illness from becoming severe and disability and to prevent one of the seven negative outcomes of untreated mental illness (homelessness, incarceration, unemployment, school failure or drop out, removal of children from the home, suicide and prolonged suffering). PEI funding cannot be transferred into another MHSA component and must be utilized for PEI programs. Services for youth who have been diagnosed as severely emotionally disturbed or having a serious mental illness are provided with services through the Community Services and Supports component. Prevention and Early Intervention programs that directly address the needs of teenagers are: Early Intervention for Youth in Schools and Mental Health First Aid (when provided in the high schools to students or when the Youth Module is provided to adults). Other MHSA programs that may benefit teenagers include: Latino Outreach, Wennem Wadati, LGBTQ Community Education, Statewide PEI, Community Education and Parenting Classes, Community-Based Outreach and Linkage and Suicide Prevention and Stigma Reduction. Community Services and Supports programs that directly address the Specialty Mental Health Services for teenagers are: Transitional Age Youth Full Service Partnership and TAY Engagement, Wellness and Recovery Services. Other MHSA program that may also serve teenagers, depending upon their age range are: Children's Full Service Partnership, Adult Full Service Partnership, Outreach and Engagement Services and Community-Based Mental Health Services.

Community Planning Process	
18.	*Comment:* 12 years ago the county had 5 people in an Institute of Mental Disorder, today that number is never under 25. 12 years ago there were no children in Juvenile Hall for murder, today there are 5. Both terribly expensive programs in dollars and human toll. Originally a lot of public attended scoping meetings, not now as meetings are monopolized by vendors, over the course of 10 years it appears programs are in place with no intention of making changes.
	Response: Efforts to engage the public included emailing the MHSA Distribution List, issuing a press release, seeking out organizations to host MHSA meetings, and performing key informant interviews. Please see pages 7-9 and pages 65-78 for additional information. The MHSA Plan/Plan Updates are modified annual to comply with new MHSA requirements and to incorporate public input received. There may not be significant changes to a program from year-to-year if it continues to meet the needs of the community. Please also see the response to Comment 12, above.
Outcome Measures	
19.	*Comment:* I like the focus on metrics but there is a lot of room for improvement in the county ensuring the "right" metrics in order to ensure programs are actually focused on higher value mental health and substance abuse activities. Historically it appears these programs are getting funded with little oversight on quality of mental health and substance abuse.
	Response: The MHSA programs continue to expand their reporting and program oversight each year, and measurements are not limited to those identified in the MHSA Plan. MHSA does not provide funding for standalone Substance Use Disorder programs. Those services are funding through the Behavioral Health Division's Alcohol and Drug Programs (ADP). However, MHSA programs may serve individuals who have a co-occurring diagnosis of a severe mental illness and a substance use disorder.
20.	*Comment:* I also would like to see incorporated the outcome measures with each program, rather than separately. I think it would cut down on duplication of material and make it easier to understand the scope of the program.
	Response: The Outcomes were placed into a separate document to be able to update outcomes from the previous fiscal year sooner, making the information available to the public before or during the Community Planning Process.

21.	*Comment:* Use Outcome Measures as required by the State and apply them consistently for each program. Additional subjective measurements like satisfaction surveys and anecdotal reports can be added if desired by providers, but having two sets of objective measurements, mandated and provider driven, only adds more work, confusion, and makes it harder to compare programs. By using consistent standardized outcome measures, all programs are on the same page. Allow providers some flexibility to add a few measurements that they feel are indicators of success. Program descriptions could include how it is going to fulfill the goals and objectives for the component, the results of previous years program outcome measurements (if continuing) with any changes and improvement clearly stated for the next 3 year plan. Outcome measures need to be standardized, simplified and data driven. Having so many different ways of measuring outcomes makes it difficult to assess success in programs or to track their progress. Anecdotal reports and satisfaction surveys are helpful, but difficult to quantify.
	Response: The MHSA Project Team will continue to conform MHSA outcome measures with State requirements and based upon public comment.
Demographics	
22.	*Comment:* Important to include colorful graphs as part of the plan. The graphs provided, however, do not have any direct mention of mental illness: rates, prevalence, distribution, severe vs. mild to moderate, percentage receiving services, trends from previous year's plans, etc., and so do not add any information that would be helpful in understanding mental health needs in our county and who in particular this plan serves.
	Response: To the extent the data is available, this information will be included in the FY 2018-19 MHSA Plan Update.
PEI and CSS Program Structure	
23.	*Comment:* It is a little difficult to compare the costs between the FY 16-17 MHSA Plan Update and the Draft FY 17-18 MHSA Three-Year Plan due to the crosswalk document not providing numbered projects for the Draft FY 17-18 MHSA Three-Year Plan.
	Response: Changes to the program crosswalk have been incorporated within the program descriptions and added to the *"Expenditure Plan and FY 2017-18 Budget"* section.
PEI – General	
24.	*Comment:* Schizophrenia and bipolar disorder are genetic and cannot be prevented, the first break generally occurs when children leave parental oversight generally from 18 to 24 years. This plan continues to send hundreds of thousands to children under 18, even targeted to 0 to 5 years of age.

	Response: Services for youth who have been diagnosed as severely emotionally disturbed or having a serious mental illness are provided with services through the Community Services and Supports component. Prevention and Early Intervention funds are utilized for programs to prevent a mental illness from becoming severe and disability and to prevent one of the seven negative outcomes of untreated mental illness (homelessness, incarceration, unemployment, school failure or drop out, removal of children from the home, suicide and prolonged suffering). PEI funding cannot be transferred into another MHSA component and must be utilized for PEI programs.
25.	*Comment:* PEI funds should target children in adolescents and the prime first break age of 18 to 24 instead of grammar school and 0 to 5 years of age. I believe TAY should receive more PEI funds as this is the prime age for the first psychotic break.
	Response: Prevention and Early Intervention funds are utilized for programs to prevent a mental illness from becoming severe and disability and to prevent one of the seven negative outcomes of untreated mental illness (homelessness, incarceration, unemployment, school failure or drop out, removal of children from the home, suicide and prolonged suffering). PEI funds are utilized when such interventions can prevent the onset of a mental illness, but also for other activities relating to education, linkage to services, outreach, and stigma reduction. Focusing services only on ages 18-24 would leave those between ages 0-17 without access to PEI services. Individuals experiencing a first break receive services through Community Services and Supports.
26.	*Comment:* The Juvenile Hall has 40+ kids all there for "Extreme-Severe" charges, and 5 are incarcerated for murder. Staff facilitates family reunification and could far better use PEI funds to transition youth returning home. I see no targeted funds for these youth with obvious "Severe Mental Illness", other than inadequate vendor services.
	Response: Prevention and Early Intervention funds are utilized for programs to prevent a mental illness from becoming severe and disability and to prevent one of the seven negative outcomes of untreated mental illness (homelessness, incarceration, unemployment, school failure or drop out, removal of children from the home, suicide and prolonged suffering). PEI funds are utilized when such interventions can prevent the onset of a mental illness, but also for other activities relating to education, linkage to services, outreach, and stigma reduction. Mental health services within the Juvenile Hall are provided by California Forensic Medical Group (CFMG). Reunification and post-release services are coordinated with Probation and/or the Child Welfare System. MHSA funding cannot be utilized to supplant other funding sources to provide the same services. In the event that a minor meets the eligibility requirements for Specialty Mental Health Services, the minor would be enrolled in services. Those services are funded by Community Services and Supports, not Prevention and Early Intervention.

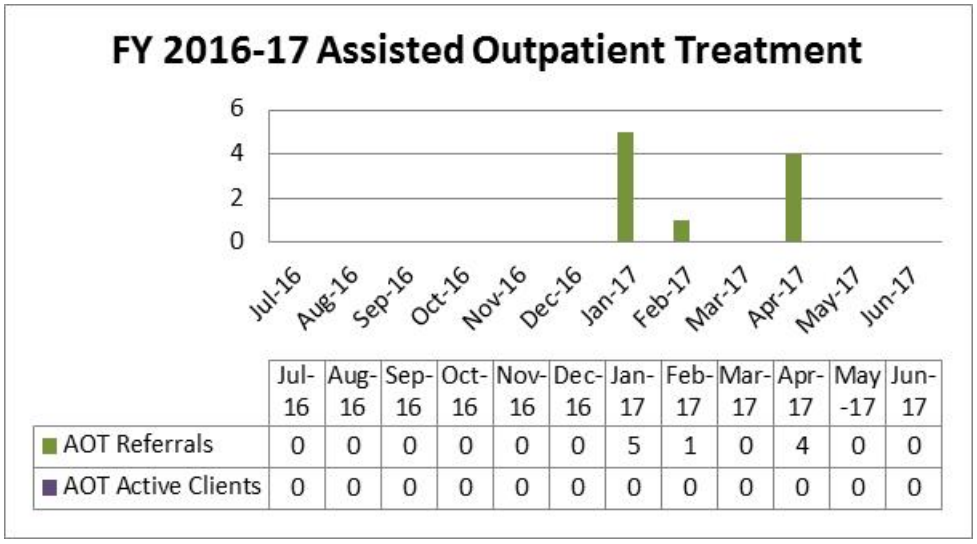
PEI – Latino Outreach	
27.	*Comment:* a) This program does not meet criteria for "Wellness, recovery and resiliency focused" advise against funding this and all programs that do not have evidence-based criteria. This Latino Outreach does not meet criteria for "evidence-based outcome measures" because their measures are "client-sat surveys!" That is not a reasonable metric. b) Has county verified that the program trainers are qualified and not just promoting methods that may be harmful to clients with early psychosis? c) How is the county assessing quality? Have you tried contacting them as a consumer family member to assess how their agency can help? What metrics are used? Has county checked the actual materials being used for "mental health and substance abuse?" d) Measurement 3 "Increased engagement in traditional MH services" How is this actually measured? e) What is the definition of "traditional?" f) I would rather see a qualified clinician from the county actually providing the training to some of these agencies than the county doling out money without governance. Do you recall the CA AB-488 (Kiley, 2017-2018) aimed at providing external oversight on MHSA spending by counties? This is a prime example of why such oversight has been proposed.
	Response: a) Pursuant to the PEI regulations, PEI programs can be evidence-based practice; promising practice; and/or community and/or practice-based evidence. b) This PEI program is a Prevention program, therefore Promotoras do not provide treatment services. Although Clinical staff are able to provide limited early intervention services for individuals through this program, individuals experiencing a psychiatric emergency are directed to the County's Psychiatric Emergency Services team for assessment. c) This PEI program is monitored in the same manner as other PEI programs with monthly, quarterly and annual reporting requirements. d) Penetration rates for the community served by this program are provided to the Behavioral Health Division on an annual basis during the External Quality Review process. The Behavioral Health Division is refining its process for calculating this information internally on a quarterly basis. Penetration rates are the number of individuals meeting a specific criteria (e.g, individuals who identify as Latino) who are receiving services from the Behavioral Health Division, divided by the total number of individuals meeting the specific criteria who are El Dorado County Medi-Cal beneficiaries. e) Traditional mental health services is treatment provided to individuals with a mild, moderate or chronic/severe mental illness by an individual who is licensed, waivered or registered professional. Prevention and Early Intervention programs do not require an individual to be a licensed, waivered or registered professional. f) MHSA requires the provision of culturally competent services. Each culturally distinct group of individuals may have a different manner of designing and implementing services. What may be considered the norm by one culturally distinct group may be considered

	unusual, ineffective, or unnecessary by another culturally distinct group. The MHSA programs must take this into consideration when developing programs.
PEI Project: Older Adults Enrichment	
28.	*Comment:* Who is ensuring the "trained volunteers" are actually qualified to identify mental health and substance abuse and are qualified to address social isolation? Shouldn't there be minimum requirements such as completing a NAMI Family-to-Family course or equivalent? What are the standards that the county is expecting to be met in this regard? I mean can literally any volunteer qualify? Think about what this should look like and how to raise the performance bar!
	Response Similar to the Senior Peer Counseling program, volunteers will receive an initial training and ongoing supervision by a licensed mental health professional. The specific training program will be vetted during the procurement process.
PEI Project: Primary Intervention Project (PIP)	
29.	*Comment:* Funds going to elementary schools for play therapy with aids are directed to selected schools, Black Oak Mine has had a large decline in enrollment yet continue to be fully funded, funds should be distributed thru Department of Education for all county schools. I would like to see data on benefits to the "Severely/Seriously Mentally Ill" and play therapy.
	Response: Prevention and Early Intervention funds are utilized for programs to prevent a mental illness from becoming severe and disability and to prevent one of the seven negative outcomes of untreated mental illness (homelessness, incarceration, unemployment, school failure or drop out, removal of children from the home, suicide and prolonged suffering). Services for individuals who have been diagnosed as severely emotionally disturbed or having a serious mental illness are provided with services through the Community Services and Supports component. For information on the outcomes of this program, please see pages 20-34 of the *El Dorado County Mental Health Service Act Outcomes For the FY 2014-15 MHSA Plan* document.
PEI Project: Wennem Wadati	
30.	*Comment:* Same comment as provided above in the Latino Outreach (Comment 27). Who from the county is ensuring these are "evidence-based practices?" How many referrals to the PHF or County MH have come from this program?
	Response: Please see response to Comment 27, above.

PEI Project: Children 0-5 and Their Families	
31.	*Comment:* Presently PEI funds for 0 to 5 years focusing on "infant massage", parenting classes for feeding, colic, and sleep issues seem frivolous. Dysfunctional families that these programs are designed for do not attend of their own volition, these parents avoid the system at all cost. Mentally ill adults rarely seek services, even more rare for them to have children and seek mental health services for an infant. I would like to see data on benefits to the "Severely/Seriously Mentally Ill" for this program. I find no correlation between 0 to 5 year old programs and Prevention and Intervention of Schizophrenia or Bipolar Disorder..
	Response: Prevention and Early Intervention funds are utilized for programs to prevent a mental illness from becoming severe and disability and to prevent one of the seven negative outcomes of untreated mental illness (homelessness, incarceration, unemployment, school failure or drop out, removal of children from the home, suicide and prolonged suffering). Services for individuals who have been diagnosed as severely emotionally disturbed or having a serious mental illness are provided with services through the Community Services and Supports component. For information on the outcomes of this program, please see pages 2-10 of the *El Dorado County Mental Health Service Act Outcomes For the FY 2014-15 MHSA Plan* document.
PEI Project: Parenting Classes	
32.	*Comment:* Who from the county is assessing if mental health and substance abuse is actually being covered?
	Response: PEI programs do not have to provide direct mental health and/or substance abuse services as it relates to dual diagnosis. Rather, PEI programs are provided to avoid one or more of the seven negative outcomes of untreated mental illness (homelessness, incarceration, unemployment, school failure or drop out, removal of children from the home, suicide and prolonged suffering), and/or to keep a mental illness from becoming severe and disabling. The three parenting programs that have been offered most frequently are: The Parent Project, Incredible Years, and the Nurtured Heart Approach. More information about these primary programs can be found at: http://www.parentproject.com/ http://www.incredibleyears.com/ https://childrenssuccessfoundation.com/about-nurtured-heart-approach/ MHSA does not provide funding for standalone Substance Use Disorder programs. Those services are funded through the Behavioral Health Division's Alcohol and Drug Programs (ADP). However, MHSA programs may serve individuals who have a co-occurring diagnosis of a severe mental illness and a substance use disorder.

PEI Project: Suicide Prevention	
33.	*Comment:* What are the qualifications of the actual trainer? Do they cover mental health and substance abuse? If we did a high quality mental health and substance abuse training we may not need to have a parsed out "suicide prevention" training as a separately funded program. This is the "least" popular brochure in the SLT kiosks. They provide a support group monthly in SLT. Perhaps encourage this provider to leverage volunteers with lived experience to run their programs as is done on the WS by "Survivors of Suicide."
	Response: Services are provided through Tahoe Youth and Family Services via their partnership with the Suicide prevention Network (www.spnawareness.org). Suicide prevention has been identified as a need in our County during previous MHSA Community Planning Processes and this is an ongoing project. As is the case with other PEI programs, this program is subject to monitoring of the effectiveness of the program per the outcome measures required by the State for Suicide Prevention PEI programs.
PEI Project: Statewide PEI Projects	
34.	*Comment:* CalMHSA Board took action in February 2017 for target funding of 4% from local PEI funds or the equivalent amount from other funding sources. Based on MHSA Revenue Projections in April 2017 and MHSA County Allocation Percentages, the PEI funding for this project should be $58,282.80.
	Response: Within the MHSA Plan, anticipated revenues for PEI are $1,375,000, and 4% of those revenues equals $55,000. The PEI budget has been updated to reflect the increased funding level without significant impacts to other PEI projects.
CSS Project: Children's Full Service Partnership	
35.	*Comment:* Lack of referrals in Foster Care Service? Putting this sort of information without explanation creates ambiguity around the programs providing these services.
	Response As identified on page 80 of the *El Dorado County Mental Health Service Act Outcomes For the FY 2014-15 MHSA Plan* document, the number of children's referrals decreased in FY 2015-16. The reduction in children referrals for Specialty Mental Health Services is likely due to the increased availability of mild-to-moderate mental health services through the Medi-Cal Managed Care Plans and increased assessment of children directly by the Child Welfare System.
CSS Project: Adult Wellness Centers	
36.	*Comment:* Having office hours for Coordinated Entry staff to do intakes with mentally ill consumers who are also homeless could be valuable.
	Response: Coordinated Entry staff are not funded through MHSA and therefore that function is not discussed in this Plan. However, this is a service that can be offered at Wellness Centers in collaboration with the provider to work towards more efficient homeless assistance systems.

CSS Project: TAY Engagement, Wellness and Recovery Services	
37.	*Comment:* Regarding lower than anticipated TAY caseloads, is this a limitation due to the number of schools participating in the program? This is an important area of growth in services and should reflect the forward thinking of the Behavioral Health Division.
	Response: Services for transitional age youth are a focus of the Behavioral Health Division, and this MHSA Plan continues to incorporate TAY-specific services, including the Mental Health Block Grant First Episode of Psychosis and Dialectical Behavior Therapy (DBT) in high schools programs. The lower than anticipated TAY caseloads is not due to a limitation in the number of schools participating in the program. The DBT program on the West Slope actually increased its presence in the current schools in FY 2016-17 (Independence Continuation High School and Charter Community School) and anticipates expanding to an additional high school in FY 2017-18. As identified on page 80 of the *El Dorado County Mental Health Service Act Outcomes For the FY 2014-15 MHSA Plan* document, the number of requests for services from transitional age youth has decreased over the past two years and that trend appears to be continuing into FY 16/17. The reasons for this could be many, including the increased availability of mental health services through physical health care providers or the Managed Care Plans.
38.	*Comment:* The TAY project goals related to housing should be "increased linkage to available safe and adequate housing" opposed to simply saying "safe and adequate housing."
	Response: The project goal has been updated to reflect "Increased linkage to available safe and adequate housing". It is important to note that the County is experiencing a shortage of affordable housing due to limited housing stock and increasing rents. The Behavioral Health Division welcomes and participates in opportunities to improve the availability of affordable housing in El Dorado County.
CSS Project: Housing Projects	
39.	*Comment:* Regarding Local Housing Assistance, can that be utilized to fund Permanent Supportive Housing through the Coordinated Entry system? (Of course, only serving mentally ill chronically homeless, providing funds for housing assistance.)
	Response: This program is funded through the unencumbered MHSA Housing funds that were awarded to the County approximately 10 years ago. The MHSA Housing funds helped to fund two affordable housing developments, one in South Lake Tahoe and one in Shingle Springs, that provide a total of 11 apartment units for Permanent Supportive Housing. The unencumbered housing funds that were returned to the County totaled $13,126 and are insufficient to establish new Permanent Supportive Housing, approximately $4,800 remain available of these funds. However, there is new MHSA funding that will become available through a competitive process for the "No Place Like Home" program, which will provide funding for Permanent Supportive Housing. The Notice of Funding Availability will be issued once the program parameters are established.

CSS Project: Assisted Outpatient Treatment	
40.	*Comment:* What kind of baseline data to track success of this program will be used? Why so few in it? How are we informing the community about this program? Why is it taking so long to gain some traction?
	Response: During the program development period, the County determined that there may be an estimated 8 to 12 individuals who met basic criteria for this program on an annual basis. There are so few who meet the basic eligibility criteria because the law is very specific on who can qualify for Assisted Outpatient Treatment services. Implementation of Assisted Outpatient Treatment involved coordination with multiple County Departments and the development of policies and procedures. Assisted Outpatient Treatment began accepting referrals in January 2017.  One individual accepted voluntary participation in treatment. Five individuals either did not meet criteria or have moved out of the County. The April referrals were in the review process as of May, 2017.
CSS Project: Housing	
41.	*Comment:* I suggest adding the average length of "wait list" as I believe the wait is upwards of 4-6 years in some cases. You gain credibility with transparency. There should be an alternative contact for those seeking low-income housing that are on a waitlist (not to provide an immediate house solution but to coach individuals into next steps they can take.)
	Response: It is not possible to determine the average length of the wait list due to the variations in apartment sizes, income limits established by federal programs, and other site-specific issues. The MHSA Housing in Shingle Springs and South Lake Tahoe is permanent supportive housing, therefore the individuals who live in MHSA units are not required to move out within a specific period of time. As of May 2017, the number of individuals on the wait list for Trailside Terrace is: 1-bedroom: 13; 2-bedroom: 5; 3-bedroom: 1. The Aspens at South Lake have 2 individuals on the wait list. Unlike Trailside Terrace, MHSA units at The Aspens at South Lake vary in size based on next available units and MHSA-eligible household size. The difference between how the

	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
AOT Referrals	0	0	0	0	0	0	5	1	0	4	0	0
AOT Active Clients	0	0	0	0	0	0	0	0	0	0	0	0

	developments handle MHSA units is a result of variations in the funding sources utilized by each development.
42.	*Comment:* Data is needed on housing needs and trends. For example, what percent of individuals with a serious mental illness are housed, homeless or in insecure housing and where, and include transitional house data including length of stay and subsequent placements. Housing insecurity and affordability will continue to be a huge challenge. Keeping on top of where we are and anticipating future needs will give the county more leverage and agility in responding to any changes in demand. The need for a Mental Health Rehabilitation Center (MHRC) is widely perceived as an important way to bring out-of-county placements back to El Dorado County, which would save money and staff monitoring time. A large percent of MHSA funds go toward housing in some form or other.
	Response: MHSA funds are not utilized for out-of-county placements. Traditional funds would be utilized for an in-county MHRC. To the extent the data is available, additional housing-related information will be included in the FY 2018-19 MHSA Plan Update.
Innovation Project: Outpatient Restoration of Competency	
43.	*Comment:* I'd like to see a summary of "lowlights" on where last year's pilot innovative spends on ROC for example have not gone well and what lessons were learned. Again the $ has been spent but what are the key lessons learned and how have those lessons been incorporated into this year's planning process?
	Response: There is insufficient data at this time to provide an in-depth analysis of the program. When the outcome information was gathered, there were no clients enrolled. As of May 24, 2017, there is one client enrolled. Current lessons learned would include that there is currently a lower than anticipated referral rate to this program at this time. It remains to be seen whether the referrals increase after the outcomes for the first client are analyzed.
44.	*Comment:* What kind of baseline data to track this program will be used?
	Response: Baseline data will include the number of individuals placed in locked facilities for Restoration of Competency and their length of stay. This will be compared to the number of individuals in the Outpatient Restoration of Competency program and their length of stay. To the extent possible, engagement in Specialty Mental Health Services once restored to competency will be measured.
Innovation Project: Community Hubs	
45.	*Comment:* Concern for the development of a directory of providers by First5 as duplicating work done by others.
	Response: MHSA funds are not provided to First5 under this program. However, this concern will be passed along to First5.
46.	*Comment:* Are the hubs prepared to route people into adults services within the county? Do they have training in mental health and substance abuse? Will the county be tracking referrals from the hubs?

	Response: The Community Hubs will refer individuals of all ages with whom they interact to the Behavioral Health Division, as appropriate. Referrals may also be made to providers of mild-to-moderate mental health services, substance use disorder treatment, physical health care providers, and other community supports. Public Health Nurses meet the education and training requirements established by the State for their associated license(s). The Public Health staff will not be providing direct behavioral health services, rather they will be screening individuals to determine appropriate referrals and referrals to the Behavioral Health Division will be tracked.
47.	*Comment:* PHN's perform MH screenings (state what screening methodology as county is looking to simplify and standardize.)
	Response: Public Health Nurses routinely screen parents with newborn children using the Edinburgh Depression Screening. Additional mental health screening tools, including the Beck Anxiety and Depression Scale and the WHO Disability Assessment Schedule 2.0, are under review.
48.	*Comment:* Make Innovation funding for the Hub project more flexible to cover more program costs, such as the Community Health Advocates, because Public Health Nurses are so difficult to hire in our County. This will allow us to maximize the funding, support the community, and minimize the risk of reversion of funds.
	Response: The Behavioral Health Division will explore whether this can be accomplished through this MHSA Plan solely or whether this change would need to return to the MHSOAC for approval, and will be incorporated to the extent possible. There will be no change to the budgeted expenditures for this program in making this change.
49.	*Comment:* A graphic showing the collaboration and support systems would be helpful. Again, what are the goals and objectives for this component and how do ROCS and HUB support them.
	Response: 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. Through previous Community Planning Processes, the public expressed the desire to have Innovation programs that were service focused rather than administrative focused. A graphic reflecting collaboration and support systems will be developed and included in future Innovation Plan updates.
CFTN: Community Wellness Center	
50.	*Comment:* Moving to a peer-run model apparently "in response to feedback from the public." Where is the public feedback summary within the MHSA plan? It feels very much like the county decided this in a vacuum.
	Response: Please see the "Summary of MHSA FY 2017-18 Three-Year Plan Community Survey Responses" (pages 67-73) Additionally, input was received from the External Quality Review performed by Behavioral Health Concepts in March 2016 that more peer involvement in the Wellness Centers was recommended.

51.	*Comment:* There is concern for the $500,000 proposed for transfer from Community Services and Supports to Capital Facilities and Technology Needs because there is inadequate information to determine how those funds will be utilized.
	Response: The proposed transfer of $500,000 from Community Services and Supports (CSS) to Capital Facilities and Technology (CFTN) is to support a community based, peer run, Wellness Center with a separate on-site housing component for the County's identified chronic homeless population who have chronic/severe mental illness. A percentage of MHSA funds from CSS may be transferred to CFTN as needs are identified, not to exceed the amount specified by MHSA as identified in the MHSA Plan, to support the facility. For this project to move forward, property/space would need to be identified as appropriate, improvements made to accommodate the program, determine management and operations structure (County or contractor), identify and train Peer Support Specialists from our graduated Peer Leadership Academy, develop classes and groups, identify community partners willing to participate, and review funds for sustainability of the program, including MHSA, grants or other funding possibilities. <u>Community Based Wellness Center</u>: • Wellness Focus: example: life skills, employment development • Structured Environment: scheduled classes, groups, and presentations via a monthly calendar • Voluntary Activities: sign in sheets for those tracking their attendance • Orientation/Interview: screening tools as indicated and wanted by the individual for the purpose of connecting them to appropriate services • County resident requirements • Peer Support Specialists (paid, stipend or hourly wage) • County or Contracted Management: for oversight of the program • Advisory Council <u>On-site Community Partnership</u>: • Health and Human Services Agency partners/eligibility • Path Grant Program (connect services to the homeless population) • Veteran's Outreach • Crisis Intervention Team • NAMI • HUD/County Housing Program <u>Housing Components</u>: • Individuals with chronic homelessness and chronic/severe mental illness: • Partnerships with a housing program • Kitchen/life skills training • Laundry facility/life skills training • Verified county resident • Collaboration with Behavioral Health Division Intensive Case Management Team

52.	*Comment:* When we asked if International Guidelines for Clubhouses would be used at a Mental Health Commission meeting, the feedback given by the county was "no, we intentionally do not want clubhouses as we don't want them to become a flophouse." Have you toured some of the better known clubhouses? They are not "flophouses." Have you read the International Standards for Clubhouses? How will you govern quality?
	Response: The term "clubhouse" was removed in the previous MHSA Plan to focus on the "Wellness" aspect of the program rather than the social nature frequently associated with the term "clubhouse". Regardless of the name of a program or location, the International Guidelines for Clubhouses is one option for establishing the structure and quality review of the program. However, the program is in concept development only, so no final decisions have been made regarding the actual structure of the program.
53.	*Comment:* How do these programs support and help implement the goals and objectives of the Plan – #1 Integration of programs/providers; and #2 Managing data for outcome/performance measurement
	Response: As identified above, it is anticipated that the Community-Based Wellness Center would be a partnership between the County and multiple community-based organizations with a target population of those who are chronically homeless and have a chronic/severe mental illness . It would be anticipated that the data obtained through this project could be utilized in its aggregate form to assist with grant applications, quality review, and program improvement. However, the program is in concept development only, so no final decisions have been made regarding the actual structure of the program or the data to be collected.
54.	*Comment:* The Wellness Center provides support for CSS programs and component goals and objectives (if we had them). Are we collecting data on the Wellness Center other than attendance that would provide important information should there be a Community Wellness Center down the road? How will the Community Peer run Wellness Center/Clubhouse support the CSS goals? A community run center is very different than what is currently provided. What will the target population be? If it is to include mild to moderate (unlikely to be successful without) how will this coordination occur? Before moving $500,000 from CSS, this needs more clarity and development.
	Response: Please see the description provided in response to Comment 51, above. However, the program is in concept development only, so no final decisions have been made regarding the actual structure of the program.
WET Project: Workforce Development	
55.	*Comment:* The outcome measure of the number of bilingual healthcare workers is not a reasonable metric.
	Response: This outcome measure should have been deleted in the Draft Plan and has been corrected in this final MHSA Plan.

56.	*Comment:* The focus should be on increasing Mental Health and Substance Abuse knowledge.
	Response: The WET component includes education and training programs and activities for prospective and current public mental health system employees, contractors and volunteers. Please see pages 98-99 of the *El Dorado County Mental Health Service Act Outcomes For the FY 2014-15 MHSA Plan* document for a list of the trainings that occurred in FY 2015-16.
57.	*Comment:* The County should be training employees in process efficiencies to reduce wait times for psychiatrists and therapists. Where are those operational metrics and target improvements? What training is essential to reduce such wait times? Focus more on public transparency about wait times for therapists and educating public on where to go when they are mild-to-moderate.
	Response: Reducing the wait times for access to services is the subject of the Behavioral Health Division's Non-Clinical Program Improvement Project. The Program Improvement Project is managed through the Quality Improvement Team and the details of the project are provided in the External Quality Review process, which is separate from MHSA. When individuals contact the Behavioral Health Division for services, the Access Team Clinicians provide the individuals with community-based resources and linkage with their Medi-Cal Managed Care Plan if they do not meet criteria for Specialty Mental Health Services.
58.	*Comment:* Identify trainings needed to accomplish specific MHSA component goals and objectives.
	Response: It is difficult to identify the specific trainings necessary to accomplish each component goals due to the variations in trainings (e.g., topic, availability). Trainings are generally focused on services provided through the Community Services and Supports component. Please see pages 98-99 of the *El Dorado County Mental Health Service Act Outcomes For the FY 2014-15 MHSA Plan* document for a list of the trainings that occurred in FY 2015-16.
59.	*Comment:* "lack of identified trainings" - Research in mental illness and treatments is ongoing. Is BH/MHD taking advantage of every possible method of providing up to date training on the latest research: webinars, TED talks, field trips, conferences, etc. If the county expects "evidence based" programs, staff needs to have the education and knowledge of what evidence based services are. This would empower staff and enhance program quality.
	Response: The WET Coordinator seeks out possible sources of training in addition to the online training available to all Behavioral Health Division staff; County, Health and Human Services Agency, and Behavioral Health Division trainings; and training provided by contracted providers. The MHSA WET Coordinator distributes information regarding outside training to the Behavioral Health Division Managers and Supervisors, which enables them to register their staff for outside trainings. Additionally, the WET Coordinator researches possible topic-specific training opportunities when a training need is identified.

	The public is invited to provide information regarding upcoming trainings that may benefit Behavioral Health Division staff to the WET Coordinator via email: MHSA@edcgov.us. Please see pages 98-99 of the *El Dorado County Mental Health Service Act Outcomes For the FY 2014-15 MHSA Plan* document for a list of the trainings that occurred in FY 2015-16.