

PLUMAS COUNTY MHSA

2015-2016 ANNUAL UPDATE



Incorporating MHSA's 5 Guiding Principles: Consumer and Family Involvement, Culturally Responsive, Community Collaboration, Integrated Service Delivery, Wellness and Recovery

<http://plumascounty.us/index.aspx?nid=2439>

**100 Lakes; 1000 Rivers
and a million acres of
National Forest**

Nestled in the eastern slope of the Sierra Nevada in Northern California, Plumas County is a bucolic wonder! Founded as a mining community in 1854, Plumas County has a long history of logging and milling. Plumas is the Spanish word for feather and the County is home to the Feather River Canyon with clean air, abundant water and scenic mountains. The County is one of the fifteen "frontier counties" of California. The majority of the 18,606 (2014 est.) residents live in or near the four small communities of Portola, the county's only incorporated city; Quincy, the county seat; Greenville; and Chester.

People Quick Facts

White alone 90.9%
Black or African American 1.2%
American Indian/Alaska Native 3.2%
Asian 1.1%
Native Hawaiian/Pacific Island 0.1%
Two or More Races 3.5%
Hispanic or Latino 8.4%
White, not Hispanic/Latino 84%

Population, 2014 est: 18,606
Population, 2010: 20,007
Persons under 5 years: 4.4%
Persons under 18 years: 17.2%
Persons 18 – 64 years: 54%
Persons 65 years and over: 24.7%
Veterans, 2009-2013: 2,276

Households, 2009-2013: 8,997
Persons per household: 2.13
Per capita income: \$29,806
Median household income: \$45,794
Persons below poverty level: 15.2%

Land area: 2,553 square miles
Persons per square mile: 7.8

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County Compliance Certification (form to be attached)

County Fiscal Accountability Certification (form to be attached)

Introduction

Plumas County is a small, rural county that lies in the far northern end of the Sierra Nevada at the southern end of the Cascade Range. More than 75% of the county's 2,553 square miles is National Forest. The Feather River, with its several forks, flows through the county. Quincy, the unincorporated county seat, is about 80 miles northeast from Oroville, California, and about 85 miles from Lake Tahoe and Reno, Nevada. State highways 70 and 89 traverse the county.

The county's population is approximately 18,606 (*US Census 2014 Estimates*). Its largest town is Portola, home to approximately 1,957 residents. Quincy, the county seat, has a population of 1,728 and with surrounding communities approximately 7,000. The population is comprised of 84% Caucasian, 8% Hispanic, 3% Native American, and the balance from other race and ethnicity groups. About 8.8% of the population speaks a language other than English at home, predominately Spanish. Plumas County has no threshold language, per the Department of Health Care Services (DHCS) formula, but offers services and materials in English and Spanish whenever possible. There are an estimated 2,276 veterans, representing 12% of the County population. Approximately 4% of the population is under 5 years of age; 17% are 6-17 years; 54% are 18-64 years; and 24% are over 65 years of age. As other rural and isolated communities, Plumas County has poor health outcomes due to social determinants of health. Mental and behavioral health issues were underscored in the 2008 report by Sierra Institute, *Re-visioning Rural Healthcare Service Delivery and Addressing the Needs of the Underserved in Plumas County*. Through key informant interviews with school administrators, teachers, rural healthcare providers, parents, and youth, children's behavioral services were identified as a priority need because of their impact on academic performance. Teachers lacked expertise to identify issues in the classroom, resources to conduct behavioral health assessments, and referrals were scarce. There was also significant concern from the Limited English Proficient (LEP) population about the lack of language access and cultural competency offered by the local provider organizations.

In 2012, Plumas County Public Health Agency began a countywide collaborative effort in response to key factors summarized below:

Socio-economic factors

- Plumas County has double the proportion of seniors as compared to the rest of California, the majority living largely on social security
- Single female-headed households with children under 18 comprise almost 36% of the county's households
- Plumas County has a smaller proportion of children compared to the rest of California but the percentage of children living in poverty (24%) has steadily increased and exceeds the state rate
- Employment in Plumas County is timber-based and seasonal in nature. As a result, the unemployment rate ranges from about 11% to double that rate during winter months. This has a major impact on the social and economic landscape
- 43% of housing units in Plumas County are vacant, compared to 8% in California and 12.8% in the United States

Health Behaviors and Mental Well-Being

- Alcohol, tobacco and substance use rates are alarming in the County as evidenced in a November 2011 Needs Assessment and the California Healthy Kids Survey
- Self-inflicted intentional injuries and the suicide rate among Native Americans exceed state rates
- Diabetes and obesity are also concerns

Local Public Health System Infrastructure

- County health and human services departments are operating in silos
- The county's three critical access hospitals are fiscally vulnerable and challenged to meet the requirements for electronic medical records, system and technological improvements, and leadership and management
- Health reform will require system improvements to broaden and deepen the involvement of multiple stakeholders on policy, service and assessment issues

One of the top 3 goals of the 2012 County Health Improvement Plan is to improve health behaviors and, more specifically, to address mental health issues by focusing on adolescent early identification and reducing suicide, depression, and feelings of hopelessness among high school students.

The Plumas County MHSA Three-Year Plan 2014-2017 and the Annual Update 2015-2016 were designed to address identified needs as described above and those prioritized during the MHSA community and stakeholder process. All components integrate MHSA's 5 Guiding Principles for Consumer and Family Involvement, Culturally Responsive, Community Collaboration, Integrated Service Delivery, and Wellness and Recovery. The community and stakeholder process is crucial for ongoing planning, communication of outcomes, and achieving community-based mental health services, responsive to local consumers and their families.

Community Program Planning Process

California Code of Regulations Title 9 (CCR) and Welfare and Institutions Code Section (WIC) 5847 state that county mental health programs shall prepare and submit Annual Updates for Mental Health Service Act (MHSA) programs and expenditures. Plans and Annual Updates must be developed with the participation of stakeholders, and the description of the local stakeholder process must be included in that plan or update. The county is to conduct a 30-day public review period of the draft Annual Update and the Mental Health board shall conduct a public hearing at the close of a 30-day comment period. Plans and Annual Updates must be adopted by the county Board of Supervisors and submitted to the California Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after adoption by the county Board of Supervisors.

1. *Briefly describe the Community Program Planning (CPP) Process for development of all components included in the FY 2015-2016 Annual Update. Include the dates of meetings and other planning activities; describe methods used to obtain stakeholder input.*

The Planning Process consisted of individual stakeholder meetings on May 13, 14, and 27, 2015; input from participants in two trainings on August 12 and 26, 2015 for Cultural Competency and Suicide Prevention, respectively; and stakeholder meetings on September 17, 2015 and October 15, 2015. At the October 15, 2015 meeting, the MHSA coordinator distributed copies of the draft Update, reviewed contents with the stakeholders, and obtained verbal comments. Stakeholders were provided an Annual Update 2015-2016 Comment Worksheet and requested to submit additional written and/or verbal comments during the 30-day public comment period. For the revised draft posted on the MHSA webpage on November 9, 2015, edits were received by e-mail from Plumas Rural Services, Plumas County Public Health Agency, Plumas Crisis Intervention and Resource Center, Plumas County Public Health Agency, First 5 Plumas, and Kemper Consultants. These comments were incorporated into the published draft.

The 30-day Public Comment period opened on November 9, 2015 and closed on December 9, 2015. The Public Hearing on the draft Annual Update was conducted on December 9, 2015 by the Plumas County Mental Health Commission. Written and verbal comments were integrated and a final Update submitted to the Plumas County Board of Supervisors for approval on December 22, 2015. The Annual Update was submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on December 28, 2015.

The CPP builds upon the initial planning process for the Three-Year Plan that included 10 focus groups, 4 community forums, 231 stakeholder participants, and 599 completed surveys via Survey Monkey and hard copy responses. The Three-Year Plan was approved by the County Board of Supervisors (BOS) in December 2014. However, in March 2015, the county Mental Health Director resigned before implementing the Plan. As the Mental Health Department had been experiencing several changes in management in recent years, the BOS hired Kemper Consulting Group (KCG) to review components of Department operations, the potential to

consolidate alcohol and drug programs into a combined Behavioral Health Department, and review the MHSA Three-Year Plan Budget and progress in implementation. KCG and the Interim Mental Health Director solicited program proposals from community agencies in Plumas County to support and maintain the intent of the approved Three-Year Plan but strengthen the emphasis on community-based service delivery. A total of \$1.635 million in community program contracts were approved by the BOS on June 16, 2015. These contracts provide the foundation for a community-based service strategy that supports the integrated programming approach of the new department and helps make the mental health of the county a broad-based community responsibility, not just the responsibility of county mental health staff.

2. *Identify the stakeholders involved in the Community Program Planning (CPP) Process (i.e., the name, agency affiliation, population represented, age, race, ethnicity, client/family member affiliation, primary language spoken, etc.). Include how stakeholder involvement was meaningful.*

Stakeholders included representatives from community-based organizations, agencies, mental health consumers and families, and other community members. Stakeholders involved in the CCP provided valuable comments to the plan approved in December 2014 and were integral in re-shaping the components from fully county-staffed programs and operations into community-based programs and wellness centers. Stakeholders were English-speaking and White, representing the majority county population; Roundhouse Council participants are Native Americans, representing several tribes from Plumas, Siskiyou, and Shasta counties. The following chart describes the cross-section of agencies and organizations that were meaningfully involved.

<i>Agency/Organization</i>	<i>Affiliation</i>	<i>Population represented</i>	<i>Client/Family member affiliation</i>
Community Connections/Plumas Rural Services	Community based organization	Adults and Seniors	Serve under-served, senior populations
First 5 Plumas	Funded program	Serve 0-5 years old and families	Serve consumers and families
Veterans Services	Funded program	Veterans	Serve mental health consumers
Mental Health Commission	Former NAMI member	Transitional Age Youth	Parent of consumer
Senior Services Program	Funded Program	Seniors	Consumer and Service Provider
Alcohol and Other Drug Program	Collaborative Partner	All ages, service consumers	Service Provider and consumers
Mental Health Dept	Staff and partner	All ages, seniors	Service Provider
First 5 Plumas	Funded program	Serve 0-5 years old and families	Service Provider to children and families
Plumas Rural Services	Funded program	Children and families	MFT intern
SafeBase for Youths	Funded program	Youth 13-18 years old	Service Provider/Prevention

Plumas Rural Services	Funded program	Children and families	LMFT service provider
Plumas Crisis Intervention and Resource Center	Funded program	All ages, families	Family Resource and Wellness Center, Consumers
Community Member	Youth advocate	Transition Age Youth	Youth activities/volunteer
Plumas Unified School District	Funded program	Children and Families	Service provider
Roundhouse Council	Funded program, Indian Education	Native American families	Service provider, consumer advocate
PUSD School Psychologist	INN Funded program	Children and Families	Service provider, Referrals
Student Services Coordinators/ PUSD	INN Funded program	Children and Families	Service provider
Head Start Program	Collaborative partner	Children and families	Service provider
Alternative Sentencing Program/District Attorney's Office	Collaborative Partner	Adults, TAY, Criminal Justice Population	Service provider
Jail Commander	Collaborative Partner	Jail population	MH service recipients
Volunteers	Collaborative partner	Greenville Suicide Prevention Team	Community leaders
Teachers	Public, charter, community schools	Children and Families	Referrals, Needs identification
Placer County Office of Education	INN Collaborative Partner	Children and families	Trainer, prevention services

3. *Describe the methods used to circulate, for the purpose of public comment, the annual update.*

The draft Annual Update hard copies were made available at the October 15, 2015, MHSA Stakeholder meeting. On the same day, the draft report was e-mailed to funded programs and other stakeholders including members of the 20,000 Lives Initiative (a community health improvement collaborative), agencies and collaborative partners; the Mental Health Commission; and the Community Corrections Partnership. At the County Board of Supervisors meeting on Tuesday, October 13, 2015, a Form to Request a Copy of the Draft Annual Update was distributed. Information on the availability of the draft Annual Update, how to receive a copy, and how to provide Comments was published in all copies of the Feather River Publishing weekly newspaper in Portola, Quincy, Greenville, and Chester. At the October 15, 2015 Stakeholder meeting, it was agreed the 30-day public comment period would be shifted to November 9 to December 9, 2015, to give the department more time to include internal programs and budgets.

4. *Include substantive comments received during the stakeholder review and public hearing, responses to those comments and a description of any substantive changes made to proposed annual update that was circulated. The county should indicate if no substantive comments were received.*

Substantive comments will be added from the December 9, 2015 public hearing.

5. *Introduction of components included in Plumas County's Annual Update.*

Community Services and Supports (CSS)

Wellness Centers and Rural Community Service Expansion

The establishment of Wellness Centers is an integral part of the community-based service delivery model that Plumas County Mental Health is moving toward. Community Services and Supports programs will be provided through and within the Wellness Centers and will include comprehensive assessment services; wellness and recovery action planning; case management services; individual and group mental health services; crisis services; medication vouchers; education and employment support; training and anti-stigma events; linkages to needed services; and housing support.

MHSA CSS funds support a contract with the California Mental Health Services Authority (CalMHSA) to provide oversight and support to a local non-profit organization subcontractor, Plumas Crisis Intervention and Resource Center (PCIRC), in the establishment and ongoing operation of Wellness Centers in each of the county's four population centers. In some cases these Wellness Centers will be developed within existing Family Resource Centers, and will reflect characteristics and needs of the respective communities. General features of all Wellness Centers, as well as some community specific information are summarized below:

- Facility locations that are *consumer-friendly*, and provide a *community-based alternative* to a traditional clinic atmosphere.
- Full time site coordinator at each location
- Ancillary services (to be informed by the local community and PCMH)
- Tele-psychiatry space with necessary high-speed internet capacity and privacy (to be phased in per site as requested by PCMH)
- Training to support peer support staffing
- Space for PCMH licensed staff and alcohol and drug counselors to provide clinical services
- Localized outreach and engagement efforts

1. Quincy

- a. County seat
- b. Quincy Wellness Center status: Well-established Resource Center (computers, meeting areas, showers, food and clothing pantry), therapy rooms; an annex could be equipped for tele-psychiatry; PCIRC currently holds a 15 year lease.
- c. Health care: Plumas District Hospital. Some integrated behavioral health care provided in that setting. Quincy is the main site of Plumas County offices including Public Health, Mental Health and Alcohol and Drug Services.

2. Greenville

- a. Ranching community; large Native American community
- b. Greenville Wellness Center status: Current Resource Center site would have to be moved to new site (site TBD) to accommodate renovations for Wellness Center needs.

- c. Healthcare: Greenville Hospital no longer in service; Eastern Plumas Health District provides services at a satellite clinic. The Greenville Rancheria provides medical and dental care for Native American families but will serve all populations on a fee basis. Plumas County Mental Health provides individual counseling at the current Resource Center site but limited by available office space.

Also in Greenville, Roundhouse Council, the Native American Indian Education Center, received MHSAs funds for community outreach and engagement services that include youth leadership and native cultural activities for adults, facilitation of cultural competency training, and mental wellness promotion. Additionally, Roundhouse Council is developing referral protocols with PCMH and other integrated medical care providers when mental health needs are identified. Community engagement activities are to include but not be limited to Family Nights, Elders Luncheon, and Cultural Activities including Dance, Youth Talking Circles, Teen Leadership, Positive Indian Parenting, and Women's Wellness programs.

Because of Roundhouse Council's emphasis on youth engagement and on prevention/early intervention activities, it was determined that these efforts should be split between CSS and PEI MHSAs funding on an equal 50/50% basis. This is a change from the approved Three-Year MHSAs Plan that projected 100% CSS MHSAs funding for Roundhouse Council activities.

3. Portola

- a. Largest Spanish-speaking community; used to be a large railroad community
- b. Portola Wellness Center status: Is currently undergoing renovations to become ADA compliant through other non-MHSAs funding; PCIRC will own the building within 2 years through a lease-to-own program.
- c. Health care: Eastern Plumas Health Care (EPHC) provides hospital and outpatient care. Outpatient services currently include limited mental health therapeutic and telemedicine services. Plumas County Mental Health services are currently provided at a nearby office location approximately 4 days per week; service provisions will be co-located at the Wellness Center once renovations are completed.

Eastern Plumas Health Care received MHSAs CSS funds for planning and site preparation work for the integration of behavioral health services into their outpatient medical care delivery system. Funds will be used to remodel space and develop a feasibility plan for more comprehensive integration of behavioral health and medical care.

While the Three-Year MHSAs Plan included the intention to develop a "new focus on integrating mental health service with health care services to promote health and wellness" and the intention to "help clients and family members to learn how to manage chronic health conditions," the Three-Year Plan CSS budget did not allocate any specific funding to this effort. Once the feasibility plan is completed, PCMH will consider additional financial support to assist Eastern Plumas Health Care in the development of integrated services to better serve mentally ill clients in Portola and in their Greenville satellite clinic location. If successful, other medical care clinics in other regions of the county will be considered for the development and furtherance of integrated care models.

4. Chester

- a. Seasonal tourist community; those living there long-term may be dependent on tourist economy
- b. Chester Wellness Center status: Not currently established although the need is great
- c. Medical care: Seneca Hospital is a Rural District hospital that also provides outpatient clinic services. Plumas County Mental Health currently provides therapy four days per week at the Courthouse/Sheriff's substation. Upon establishment of the Wellness Center, PCMH services will be co-located at the Wellness site.

Full Service Partnership Program

Full Service Partnerships make up a significant portion of funding in the CSS Component. Services are predominately carried out by PCMH staff currently, but with the development of more contracted services, the goal is to support more community services for high need individuals. Programs are designed to provide comprehensive, recovery-based services to the highest-need clients in the system:

- Serious Mental Illness/Disorder – partners served in FSPs are living with SMI or a serious emotional disturbance in addition to often having a history of homelessness, incarceration, and/or institutionalization
- Recovery-Oriented – FSPs are designed to provide comprehensive, recovery-based services to the highest-need clients in the public mental health system
- Intensive – FSPs provide intensive case management on a 24/7 basis, doing “whatever it takes” for the client to promote progress on their road of recovery
- Comprehensive – Services may also focus on crisis response and de-escalation, medication evaluation, establishment of benefits, and preparation for education and/or employment

FSPs receive both mental health and non-mental health services as allowed expenditures, per the California Code of Regulations (CCR), Title 9 Chapter 3620. Mental health services include but are not limited to: alternative and culturally specific treatments, peer support, wellness centers, supportive services to assist the client and, when appropriate, the client's family in obtaining and maintaining employment, housing, and/or education. Non-mental health care includes but is not limited to food, clothing, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, transitional and temporary housing, cost of health care treatment, cost of treatment of co-occurring conditions, and respite care.

The Plumas County Mental Health FSP program currently includes 14 outpatient partners (11 adults and 3 youths). The program includes personal service coordination/case management to assist the client and, when appropriate, the client's family to access needed medical, educational, social, vocational, rehabilitative, other community services, needs assessment, crisis intervention and stabilization services, and family education services. PCMH FSP developed a referral form and criteria checklist including medical necessity rating to identify consumers eligible for FSP services. Case managers, mental health therapists and substance use disorders specialists forward referral forms on a daily basis to the FSP Intake team for review. Requests for services are expedited as efficiently as possible to provide “whatever it takes” to individual and family consumers.

MHSA funds provides staff support at the Sierra House, the county's board and care facility currently occupied by 12 SMI residents, and the Drop-In Center that is utilized by FSP. The Division Director provides oversight for the Drop-In Center and for the Sierra House, the Board and Care Facility, co-located on the county owned premises. The Division Director is responsible for overall staff management and scheduling, coordination with county services and multi-disciplinary partners, consumer/family engagement and satisfaction, budget, transportation, grievance process, and achievement of program goals.

An Associate MSW, a Master's graduate and recently completed internship, is located full time on-site to provide services including assessments, resource, referral, and individual and group facilitation. Two Case Managers are available to provide transportation; liaison with employment training, primary care appointments, rehabilitation, community events; and tele-psychiatry appointments. A Nurse is available to provide medications management, monitor symptoms and liaison with primary care/psychiatrist as needed, and assist in tele-psychiatry appointments. A Fiscal Technician provides budget and clerical duties, reception services, data gathering, attendance, and assist with peer and staff activities and a calendar of events.

PCMH developed a screening tool to determine eligibility for the FSP program and a referral protocol. Individuals referred into the FSP program must meet the criteria in the Welfare and Institutions Code (WIC) 5600.3(a), (b), and (c) for seriously emotionally disturbed children or adolescents, adults with serious mental disorder; or adults or older adults who require or are at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental health disorder with symptoms of psychosis, suicidality or violence, **and** one additional criteria specified for children, transition age youth (TAY), adults, older adults as described below.

- **For children (0-17 years old)**, criteria are homeless or at risk of being homeless; at risk of out-of-home placement; at risk of school failure (e.g., suspension, expulsion, failing classes, excessive absences, or dropping out); high risk behaviors (e.g., self-injurious behaviors, multiple sexual partners within the last 12 months, exposure to sexual abuse); foster care placement(s), involvement in criminal justice system; at risk of involuntary hospitalization or inpatient hospitalization; at risk of placement in residential treatment; or substance abuse.
- **For TAY (16-24 years old)**, criteria are homeless or at risk of being homeless; at risk of out-of-home placement; at risk of school failure (e.g., suspension, expulsion, failing classes, excessive absences, or dropping out); high risk behaviors (e.g., self-injurious behaviors, multiple sexual partners within the last 12 months, exposure to sexual abuse); have experienced a first episode of serious mental illness; foster care placement(s), involvement in criminal justice system; at risk of involuntary hospitalization or inpatient hospitalization; at risk of placement in residential treatment; substance abuse; aging out of the child/youth mental health system; aging out of child welfare system; aging out of juvenile justice system.
- **For adults (25-59 years old)**, criteria are homeless or at risk of being homeless; at risk of out-of-home placement; high risk behaviors (e.g., self-injurious behaviors, multiple sexual partners within the last 12 months, exposure to sexual abuse); involvement in

criminal justice system; at risk of involuntary hospitalization or inpatient hospitalization; at risk of placement in residential treatment; substance abuse; frequent user of hospital and/or emergency room services as the primary resource for mental health treatment.

- **For older adults (60+ years old)**, criteria are homeless or at risk of being homeless; at risk of out-of-home placement; high risk behaviors (e.g., self-injurious behaviors, multiple sexual partners within the last 12 months, exposure to sexual abuse); experiencing a reduction in personal and/or community functioning; at risk of nursing home or out-of-home care; involvement in criminal justice system; at risk of involuntary hospitalization or inpatient hospitalization; at risk of placement in residential treatment; substance abuse; frequent user of hospital and/or emergency room services as the primary resource for mental health treatment

Other eligibility criteria to consider for any age group include:

- Dual diagnosis (co-occurring substance abuse disorder)
- Institution for Mental Disease (IMD)/State hospital discharge
- Readiness to get off conservatorship
- Motivation to participate
- Level of function – multiple areas needing assistance
- Medical Necessity Score

Other Community Services and Supports Services and Programming

Community Connections

Plumas Rural Services (PRS), the largest non-profit human services organization, received MHSA CSS funding to expand its Community Connections Program countywide. Community Connections is a service exchange “time bank” program and will coordinate volunteer services for persons with mental illness. CSS funding is intended to expand current programming to include volunteer services for and by persons with mental illness. The mental health focused Community Connections program will promote anti-stigma efforts for those living with mental illness, link mentally ill individuals with needed services, and support prevention and early intervention work with older adults including homebound seniors. Services offered to time-bank Members may meet basic needs, such as transportation, meal preparation, or grocery shopping, or may meet higher level needs, such as meal planning, budget preparation, handyman jobs, etc. This effort is consistent with the approved Three-Year MHSA Plan.

Administrative and Other MHSA Support Services

Some limited administrative staff expenses and equipment were included the approved Three-Year MHSA Plan to support MHSA funded services. In FY 2014-2015, six four-wheel drive vehicles were purchased to increase PCMH outreach and availability in more rural areas of the county, particularly in winter months when snowy roads make travel difficult. Computers to support new MHSA staffing were also financed through MHSA CSS funds, with costs distributed on a per-full time equivalent basis as part of a larger PCMH Department computer upgrade. A portion of administrative staffing cost was also charged to both CSS and PEI MHSA budgets in recognition of the oversight and management of MHSA efforts and programming. These costs

were attributed to MHPA budgets as 10% of direct MHPA expenditures. In addition to these administrative costs, consultants were hired with MHPA funding to assist PCMH with cost report development (the MHPA interface); MHPA trust fund management and expenditure calculations; MHPA Plan development; MHPA reversion avoidance including assisting with community contract development; and general Department and MHPA operational support. All of these costs are consistent with the approved Three-Year MHPA Plan.

CSS Coordination and Challenges

CalMHPA has been funded for two years through MHPA CSS funds to provide technical assistance to Plumas Crisis Intervention and Resource Center (PCIRC) to successfully implement the Wellness Centers and design appropriate SMI/SED programming. CalMHPA will work with PCIRC to build staff capacity and upgrade existing community-based resource centers or establish new centers in Quincy, Greenville, Portola, and Chester.

Changes to the Three-Year MHPA Plan

- In the approved Three-Year Plan, Wellness Center development was a major emphasis within the Community Services and Support component; however, it was anticipated to be predominately county staff and county-leased or lease-to-own space. While keeping with the intent, this Annual Update describes the shift to external community partners in development of the Wellness Centers within the context of existing PCIRC Resource Centers.
- As noted earlier, the Three-Year Plan and Budget does not specify financial resources for medical care/behavioral health integration but states “there will be a new focus on integrating mental health service with health care services to promote health and wellness for all clients”. Funding Eastern Plumas Health Care will help achieve this intent and is very much in alignment with national efforts to integrate and/or coordinate behavioral and medical care for improved health outcomes of the SMI population. Future MHPA efforts will build on the feasibility and planning process, and may include additional clinics and/or healthcare providers.
- Parent-Child Interaction Therapy equipment and programming was originally in the CSS portion of the Three-Year Plan, but has been moved to the Prevention and Early Intervention (PEI) section with this Annual Update. As the PCIT program component primarily deals with at-risk young children and their parents, it seemed better categorized under PEI as the majority of these children do not yet have SED designation. Please see the PEI section for more information.
- Sierra House improvements and Sierra House financial supports for individual clients were not explicitly identified in the Three-Year MHPA Plan. While not listed in the Plan narrative however, the CSS budget does include client support expenses that include housing and other whatever-it-takes services in support of full service partnerships (FSP). In addition, supportive housing and emergency lodging programming is included as a separate line item in the CSS budget. Because Sierra house is PCMH owned and operated, expenses to support some SMI FSP persons in residence may be attributable to MHPA funding. In addition, expenditures for renovations and improvements in the PCMH owned Sierra House

facility have been included in the Capital Facility and Technology section of this Annual Update.

Approved CSS Programs Yet to be Developed

A number of programs included in the Three-Year MHSA Plan are yet to be implemented. It is anticipated that efforts to initiate these programming efforts will occur in 2015-2016. These programs include:

- Tele-psychiatry and Tele-conference capacity, and Tele-psychiatry/health Org. Provider
- Social Club/Consumer Employment Programming
- Marketing/Public Relations Campaign and Website Enhancement
- Consumer Group Mentoring Support
- Supportive Housing and Emergency Lodging Contracted Service
- Criminal Justice Programming

Prevention and Early Intervention

Prevention and Early Intervention programs are designed to prevent the development or escalation of a mental health condition, or lessen its severity through early identification and connection to treatment. Additionally, PEI programs are intended to reduce suicides, incarcerations, school failure and dropout, unemployment, prolonged suffering, homelessness and removal of children from families. Community-based organizations and service providers supported with MHSA PEI funds are summarized below:

1. First 5 Infant Mental Health Program

The Infant/Early Development Mental Health Program developed by the First 5 Plumas Commission serves children ages 0-5 and their families/caregivers. Services are provided primarily in the home by a licensed marriage and family therapist and an early childhood development specialist. The licensed therapist also provides consultation services to preschool and transitional kindergarten teachers with a focus on children exhibiting difficult or violent behaviors in school-based settings. The goal is to provide classroom behavior management techniques by offering on-site and phone support, strategies, and tools so that children ages 3-5 exhibiting difficult or aggressive/violent behaviors are not ultimately removed from school settings.

The Program utilizes a collaborative practice model that requires interagency collaboration at the case and systems levels. Referrals come from multiple government and non-profit agencies and other service providers with the goal of providing the earliest intervention possible with environmentally at-risk children and their families.

This program was not included in the approved Three-Year MHSA Plan, but is intended to be funded through June 2017.

2. Parent Child Interaction Therapy (PCIT)

Under contract with Plumas Rural Services (PRS), Plumas County Mental Health and PRS clinicians will be trained by UC Davis Children's Hospital to conduct assessments and provide parents real-time tools to "engage with" and parent their child. Funds are included for equipment and training. While the initial MHSA funding was anticipated to equip one-site, expansion into other PCMH approved facilities may be contemplated before June 2017 with additional funding.

Although included in the approved Three-Year MHSA Plan in CSS, this program has been moved to PEI and the funding expanded. The approved PCIT budget included in the Three-Year MHSA Plan was insufficient to support the development of even one PCIT site.

3. SafeBase Youth Services

Under contract with Plumas Rural Services, this program targets youth 13-18 in each community and provides funds for a .30 FTE Coordinator and 1.0 FTE Youth Paraprofessional Counselor to provide weekly support groups for youth in Charter and Community schools. Staff works closely with schools and community organizations to promote wellness, resiliency, and healthy relationship skills in our youth.

As the Innovation (INN) program (described later in the Update) supports services in public schools, this effort is seen as complementary for charter and alternative school youth.

TAY engagement was included in the Three-Year MHSA Plan and anticipated the hiring of a PCMH based case-manager to perform these functions. While a case-manager for TAY has been hired, this program additionally supports a community organization with existing school relationships to provide youth engagement activities. The development of protocols for referral of youth who appear to have more serious mental health needs will ensure PCMH is notified and can become involved as appropriate.

4. Veterans Outreach

This program is designed to increase outreach, advocacy, referral, and care coordination for veterans at-risk of or experiencing mental health illness, substance abuse, suicide, unemployment, incarceration, school failure, homelessness, loss of children, or any prolonged suffering. Veterans have a higher incidence of mental health symptoms compared to the general population, and there are very few services available to them in Plumas County. The program provides funds for a Veterans Services Representative (Plumas County Public Health subcontract) to provide care coordination, supportive services, and advocacy to help at-risk veterans become and remain stable both emotionally and physically. This funding also provides a new four-wheel drive vehicle to help outreach into more rural areas of the community, as well as transport clients to needed local and regional services. It is estimated that this program will serve at least 30 veterans each year.

While included in the PEI portion of the Three-Year MHSA Plan, this outreach and service connection program for combat veterans already experiencing mental health symptoms impacted by past military service might be more appropriately described as a Community Services and Supports (CSS) effort. Future reporting will describe these costs under CSS.

5. Senior Services

This program is an expansion of the Senior Nutrition Program and will serve about 100 seniors who are isolated at home, plus an additional 300 seniors who participate in the congregate meal program at the senior sites throughout Plumas County.

Home-Bound Senior Services - A Senior Services Registered Nurse and trained staff will work with home-bound seniors in each community providing medications/prescriptions education, health screenings, and other health related services. Each home-bound client will receive a yearly at-home assessment that includes screening for depression and other mental health symptoms, as well as follow-up by nursing or trained staff to connect clients with services and support as needed. About 100 non-duplicated seniors will be provided this service each year.

Senior Whole-Health - Working in conjunction with the congregate meals provided with Senior Services, staff will provide space, time and transportation for older adults to meet together weekly in each population center of Plumas County. Activities will be offered to approximately 300 seniors to enhance senior and community connectivity, increase mental

engagement, and promote health and wellness. Approximately 300 seniors throughout Plumas County will be provided opportunity, education, and tools needed to be more active in the community-at-large through healthy activities, volunteering, and community service. Additional screenings or services provided by nursing staff will be offered to this population on an as needed basis.

6. Community Mental Health Training

Feedback from the community focus groups repeatedly requested training for community members on reducing stigma and developing skills in recognizing signs and symptoms of mental health and/or suicidal behavior. This prevention program will contract with a provider to conduct community trainings in ASIST and Mental Health First Aid, both Evidence-based Practices (EBPs). The trainer will conduct ASIST and MH First Aid training in all four regions of the county. Trainings will be offered to school personnel, first responders (including criminal justice), and interested community groups. Approximately 100 individuals will be trained in one or both EBPs each year.

Two Mental Health First Aid Trainings were completed in FY2014-15 with 30 participants on each occasion: (1) for health and human services agencies, Veterans Services, Senior Services, Community-Based Organizations, Sheriff's Office, Social Services in Quincy in February 2015 and (2) for Feather River Community College staff and adult education partners in July 2015.

7. Contribution to Statewide PEI Efforts (CalMHSA)

MHSA funding supports Plumas County's membership in CalMHSA's Joint Powers Authority for Statewide Prevention and Early Intervention Phase II and participation in the Each Mind Matters campaign. Each Mind Matters provides a branded comprehensive campaign and recognized messaging across the state to support a movement in California to promote mental health and wellness and reduce the likelihood of mental illness, substance use and suicide among all Californians. The initiative brings together three current initiatives of Suicide Prevention, Sigma and Discrimination Reduction and Student Mental Health.

Changes to the Three-Year Plan

- The Three-Year MHSA Plan states that "specialized services for children ages 0-7 and families will be available regionally" presumably through the hiring of county staff housed in the Wellness Centers or other local venue. Instead in this Annual Update, these services are contracted through the First 5 Infant Mental Health Program and provide home-based one-on-one services for prevention and early intervention by a Licensed Marriage and Family Therapist. Services are coordinated with an Early Childhood Educator and two MFT interns, supervised by the LMFT.
- The Three-Year MHSA Plan includes regional development of Parent Child Interaction Therapy and includes equipment costs in the CSS budget. In this Annual Update, the training and equipment costs are contracted out to Plumas Rural Services instead of a

county staff delivery and equipment purchase undertaking. In the future, expansion of PCIT to additional locations may be attempted.

- Plumas County Mental Health's Therapeutic Wilderness Program targets a dozen youth, 10-15 years of age, receiving mental health services. Experienced staff participants are fully qualified therapists and wilderness professionals who work with youth to find solutions to problems that arise during wilderness program activities. MHSA funds support staffing and ancillary services not funded by Medi-Cal or Realignment budgets. Some consumers are SED and services are captured under CSS although the program is under PEI.

PEI Programming Yet to be Developed

Anger Management

Innovation – Plumas County

PUSD School-Based Response Team

Program Number/Name: Plumas Unified School District (PUSD)

1. Select one of the following purposes that most closely corresponds to the Innovation Program’s learning goal and that will be a key focus of your evaluation.

- Increase access to underserved groups
- Increase the quality of services, including better outcomes
- Promote interagency collaboration
- Increase access to services

2. Describe the reasons that your selected primary purpose is a priority for your county.

The goal of the Plumas Unified School District (PUSD) Innovation Program is to improve response to and decrease occurrence of potential threats in Plumas County schools, including presentation of suicidal ideation, reported self-harm behaviors and reported bullying behaviors, by improving communication and sharing of resources across agencies and improving school climate.

Plumas County has had school threat situations in each of the past three years. In addition, there is a high incidence of suicidal ideation and cutting behavior among children and youth and high incidence of bullying. School staff feels helpless and does not have a plan of action to resolve these threats and lack a systematic response to bullying behavior. During TAY stakeholder focus groups, youth reported that school threats, suicidal ideation, and bullying were significant issues in the schools. Youth also described the increased number of students who are cutters and that cutting can be a gateway to drug use.

Objective 1 - Establish School-Based Response Team

The first objective is to establish a School-Based Response Team (SBRT) consistent with the Local Control and Accountability Plan, Uniform Behavior Expectations and Comprehensive Safety Plans for each school.

Activities include:

1. Establish a School-Based Response Team (SBRT) consistent with the Local Control and Accountability Plan, Uniform Behavior Expectations and Comprehensive Safety Plans for each school as a collaborative effort between Plumas County Sheriff’s Office, Plumas Unified School District/Plumas County Office of Education, Plumas County Mental Health/Alcohol and Other Drug Program, and Plumas County Probation Department.
2. Develop protocol for response to reported suicidal ideation, self-harm and bullying behaviors with the schools in accordance with Uniform Behavior Expectations and the Comprehensive Safety Plan. Protocol shall include response and follow-up/referral/disposition after intervention and shall be developed in collaboration between

Plumas County Sheriff's Office, Plumas Unified School District/Plumas County Office of Education, Plumas County Mental Health/Alcohol and Other Drug Program, and Plumas County Probation Department.

3. Establish Memorandum of Understanding (MOU) across agencies, including Plumas County Sheriff's Office, Plumas Unified School District/Plumas County Office of Education, Plumas County Mental Health/Alcohol and Other Drug Program, and Plumas County Probation Department, for actions appropriate within established protocols for response to suicidal ideation, self-harm and bullying behaviors within the school system.
4. Establish and maintain Student Services Coordinators within each major community in Plumas County - Chester/Lake Almanor; Greenville/Indian Valley; Quincy Area; and Portola/Graeagle Area – to provide social and emotional support of student body and families; parent advocacy; school and home connectivity; linkage to needed non-academic services; coordination of services for students and families; and, social skills training and development within student body.
5. Conduct evaluation of Prevention/Early Intervention Program and the collaborative efforts of participating agencies based upon identified key data elements. Produce an evaluation report to Plumas County Mental Health and all collaborating agencies.

In an effort to further improve outcomes for the children and youth involved in these incidents, the School-Based Response Team will also follow-up with each student, classroom, teacher, and/or family member, to deliver brief therapy and assess the need for additional follow-up services. When a student needs ongoing treatment, the School-Based Response Team will link the individual to ongoing mental health, co-occurring treatment, or probation services to ensure the incident is fully resolved. The team will also use evidence-based practices to offer suicide assessment and prevention, train school staff on bullying prevention, and provide the clinical services needed to address any identified issues.

Collaboration across agencies is difficult to measure and may fluctuate, depending upon management, funding resources, key events, and individual incidents. With this understanding, we will measure collaboration across our agencies using a tool used by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and the University of South Florida to evaluate collaboration in Children's System of Care agencies and other federal grant projects. This Interagency Collaboration Activities Scale (IACAS) will be distributed to partner agency staff at the beginning of the project and annually. This survey asks the question: "To what extent does your organization SHARE with other child serving agencies?" A number of variables are measured, including funding, services, facility space, data, program evaluation, and staff training.

Objective 2 – Improve School Climate

Activities include:

1. In collaboration with Plumas County Mental Health, establish metrics to measure School Climate and identify data points that are indicators of School Climate.

Progress: PUSD and PCMH met to establish data points to measure School Climate. Agreed upon data points to measure are: California Healthy Kids Survey School Climate and Social Emotional Wellness modules; suspensions; tardies; absences; Behavioral Referrals broken down by problem behaviors; defiance, disrespect, disruption, fighting, physical aggression, abusive language, property damage, dress code, electronic violation, inappropriate display of affection, harassment/tease/ taunt, truancy, cheating/forgery/theft; and percentage of D's and F's in Junior and Senior High School students across community.

2. Administer established metrics at each school site in PUSD and gather identified School Climate indicator data.

Progress: PUSD and PCMH established that data points will be collected at the end of each school year throughout the Innovation Program.

3. Establish qualified Lead Student Services Coordinator for ongoing training and supervision of paraprofessional service delivery to student body and families.

Progress: Qualified Lead Student Services Coordinator has been established and has begun providing ongoing training and supervision of paraprofessional service delivery.

4. Provide staff training for development of skill in the areas of: local resource availability and appropriate referral processes; social and emotional support skills and social skills training for student body and families; screening for appropriate referrals to outside agencies; screening for potential threats (peer conflict, self-harm behaviors, suicidal ideation and bullying behaviors); interventions for early identified threats and protocol for consultation; bullying prevention, suicide prevention and early intervention; positive social skill development; and, other identified relevant training needed as project progresses.
5. Continue implementation across school sites of Positive Behavior Interventions and Supports. School sites will participate in site evaluations conducted by Placer County Office of Education who provides coaching and training on the implementation of PBIS.
6. Conduct evaluation of Prevention/Early Intervention Program based upon identified key required data elements and produce evaluation report to Plumas County Mental Health and all collaborating agencies.

3. ***Which MHSa definition of an Innovation Program applies to your new program, i.e., how does the Innovation Program a) introduce a new mental health practice or approach; or b) make a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community; or c) introduce a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting? How do you expect your Innovation Program to contribute to the development and evaluation of a new or changed practice within the field of mental health?***

This Innovation Project will make a change to the evidence-based practice model by developing a collaborative response team in each unique community within the county to specifically address school and community potential threats for this small rural community. The School-Based Response Team will be available throughout the communities in the county to address many of the key issues identified on our MHSa surveys and in our focus groups. The School-Based Response Team will respond to all potential threat situations and; conduct school threat assessments after protocol established through the PUSD/PCMH contract; identify situations of bullying; and provide follow-up referrals for treatment, brief therapy, and case management services, as needed. If an individual and/or family needs ongoing treatment, they will be linked to relevant services and/or mental health and/or co-occurring services through a warm handoff, when appropriate.

The learning goal of this project is to assess the effectiveness of this collaborative team approach, using limited resources in a very small rural environment. We will adopt a proven model of response to use in the schools, to address potential school threats and bullying incidents. We will evaluate the effectiveness of this enhanced collaboration, to determine the effectiveness when agency staff may differ, with each potential threat situation, depending upon the time of day, or shift. The expected learning outcomes will be to understand the collaborative process, training needs of all team members, and success in resolving potential threat situations, school threats, bullying, suicide prevention, and treatment strategies. School-Based Response Team members will be available to triage each situation, provide the needed services, link the individual and/or family to ongoing supportive services, as needed, and perform after action reviews to make improvements in the response as appropriate.

4. ***Include a description of how the project supports and is consistent with the applicable General Standards as set forth in CCR, Title 9, Section 3320.***

The School-Based Response Team model of collaboration and timely response to critical incidents supports and is consistent with the MHSa General standards. We will develop, measure, and test an approach to small county collaboration that works in a rural county, adopting a proven model to use in the schools to address school threats and bullying incidents. This community collaboration will strengthen our multi-agency partnerships, develop opportunities to share funding, service planning, evaluations, celebrate positive outcomes, and make constructive improvements to response services.

Our services will be culturally-competent and available in English and Spanish, whenever possible (Plumas County does not have a threshold language). As we work closely with the

schools to reduce school threats and bullying, we will also offer supportive services to high-risk youth and their families. We are developing a mental health service delivery system that focuses on wellness, recovery, and resilience through the community-based Family Wellness Centers. The School-Based Response Team will help promote collaboration and integrated services in the schools and with allied agencies.

4b. If applicable, describe the population to be served, number of clients to be served annually, and demographic information including age, gender, race, ethnicity, and language spoken.

The target population for the Innovation Program shall include students in all four communities:

- Total Student Population: 1800
- Children, Families, Transitional Age Youth (TAY)
 - Estimated number of TAY to be served: 140-175
- All race and ethnic backgrounds within existing population
- Male and female
- Vulnerable populations within the student body

It is expected that we will serve approximately 10% Hispanic, 80% Caucasian, and 10% other race/ethnicity groups. Approximately 50% will be females. The majority of youth will speak English. We anticipate that approximately 3% of the individuals or family members utilizing the School-Based Response Team will identify Spanish as their primary language.

5. Describe the total timeframe of the program. In your description include key actions and milestones related to assessing your Innovation and communicating results and lessons learned. Provide a brief explanation of why this timeline will allow sufficient time for the desired learning to occur and to demonstrate the feasibility of replicating the Innovation.

We will develop, implement, and evaluate the effectiveness of the modified School-Based Response Team's collaboration across the three-year time period. This period will allow ample time to hire and train staff; develop and test standard tools for threat assessments and timely response to crisis and critical events; and develop and test protocols for responding to the bullying behavior. We anticipate that we will start to implement components of this program within the first three months of funding; however, full implementation and collaboration of services will occur by the end of the first year. This strategy will allow two additional years to fully implement and study the effectiveness of this approach and share our learnings with other counties.

Evaluation activities will be developed in the first three months, and collected and analyzed monthly. Evaluation outcomes and lessons learned will be shared with the School-Based Response Team and at the Mental Health Quality Improvement Committee, MHSA Committee, and management meetings. In addition, we will share our experience of collaboration in a rural county, so other counties will be able to implement similar strategies, within their limited resources.

After the three-year timeframe, the success of the project will be determined through the evaluation activities and stakeholder input. If deemed successful, the project will be transitioned it to another category of MHSA funding, such as PEI.

6. Describe how you plan to measure the results, impacts, and lessons learned from your Innovation, with a focus on what is new or changed. Include in your description the expected outcomes of the Innovation program, how you will measure these outcomes, and how you will determine which elements of the Innovation Program contributed to successful outcomes. Include in your description how the perspectives of stakeholders will be included in assessing and communicating results.

We will collect data on both client level outcomes and measure the effectiveness of the Innovation Project and sources of collaboration. Client level outcomes will include the number of children and TAY referred; number served; number of crisis response situations and school threat assessments; outcomes of each critical incident; and ongoing need for follow-up services. The number of individuals receiving ongoing case management and numbers referred for ongoing services will be measured. In addition, key events such as the number of suicide attempts, school threats, referrals for bullying, and crisis response situations will be measured. Program effectiveness will measure the collaboration activities of the allied agencies prior to development of the School-Based Response Team, and ongoing collaborative activities as the School-Based Response Team is implemented.

The Collaboration across agencies is difficult to measure and may fluctuate, depending upon management, funding resources, key events, and individual incidents. With this understanding, we will measure collaboration across our agencies using a tool used by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and the University of South Florida to evaluate collaboration in Children's System of Care agencies and other federal grant projects. This Interagency Collaboration Activities Scale (IACAS) will be distributed to partner agency staff at the beginning of the project and annually. This survey asks the question: "To what extent does your organization SHARE with other child serving agencies?" A number of variables are measured, including funding, services, facility space, data, program evaluation, and staff training. By asking agency staff to describe how their organization shares different indicators with other child-serving agencies, we will have information from both managers and staff on a number of variables including funding, purchasing of services, facility space, data, program evaluation, and staff training.

Our evaluation activities will be developed and implemented with guidance from the Plumas County Mental Health Quality Improvement Committee with oversight by the Plumas County Mental Health Commission. Outcomes and lessons learned will be shared with the School-Based Response Team and at the Quality Improvement Committee, MHSA Committee, management meetings, and at regional and/or statewide meetings that involve other small, rural counties.

7. Describe how the County will decide whether and how to continue the Innovative Project without Innovation funds.

After the three-year timeframe, the success of the project will be determined through the evaluation activities and stakeholder input. If deemed successful through the stakeholder and community program planning process, the project will be transitioned to another category of MHSA funding, such as PEI.

8. If applicable, provide a list of resources to be leveraged.

In addition to MHSA funding, we will utilize Medi-Cal revenue, whenever possible, to support the School-Based Response Team, as well as funding ongoing mental health treatment services delivered to youth and family members identified through the School-Based Response Team activities. PUSD/PCOE provides in-kind support for the INN program for staffing and training. Additionally, the district supports statewide CalMHSA and Department of Education training through Placer County Office of Education's multi-year collaboration for Positive Behavioral Interventions and Supports including data systems development, incentives, and refresher trainings.

9. Please provide projected expenditures by each fiscal year during the program time frame, including both the current and future funding years. Please also describe briefly the logic for this budget: how your proposed expenditures will allow you to test your model and meet your learning and communication goals.

Phases 1 and 2 (Years 1 and 2): \$269,500

Phase 3 (Year 3): \$269,500

While the Three-Year MHSA Plan included cumulative funding of 9 years of INN, subsequent discussions with MHSOAC clarified the availability of only 5 years of funds. As a result the current INN plan approved by MHSOAC in April 2015 reflects a downsized scope and activities of the original INN plan proposed by Plumas Unified School District.

INN - NEW ANNUAL PROGRAM BUDGET					
	Type of Expenditure	FY 2015	FY 2016	FY 2017	Total
1.	Personnel expenditures, including salaries, wages, and benefits				
2.	Operating expenditures				
3.	Non-recurring expenditures, such as cost of equipping new employees with technology necessary to perform MHTSA duties to conduct the Innovation Program				
4.	Contracts (Training Consultant Contracts)	16,571	252,929	269,500	539,000
6.	Other expenditures projected to be incurred on items not listed above and provide a justification for the expenditures in the budget narrative				
	Total Proposed Expenditures	16,571	252,929	269,500	539,000
B. REVENUES					
1.	MHTSA Innovation Funds	16,571	252,929	269,500	539,000
2.	Medi-Cal Federal Financial Participation				
3.	1991 Realignment				
4.	Behavioral Health Subaccount				
5.	Any other funding (specify)				
	Total Revenues	16,571	252,929	269,500	539,000
C. TOTAL FUNDING REQUESTED (total amount of MHTSA Innovation funds you are requesting that MHTSOAC approve)		16,571	252,929	269,500	539,000

Workforce Education and Training (WET)

1. Provide a program description.

PCMH WET funding provides staff and consumer training and development, including onsite and regional training across an array of topics, including wellness, recovery, resiliency, and cultural and linguistic skills; and mental health first aid and ASIST train-the-trainer modules (in PEI portion of Plan). This funding also provides staff and volunteers access to online training courses. WET funding in this category also designates local discretionary funds for each regional Wellness Center (Chester, Indian Valley, Portola, and Quincy) to choose training in mental health topics that are relevant to the local population.

A TAY and Consumer Work program supports clients in obtaining county mental health employment. Funds allow consumers to gain the skills and experience necessary to become an employee of Plumas County Mental Health.

Transition Age Youth Training Program

The PCMH TAY work program started on June 14, 2015. During the summer months, participants will work weekly up to 4 days per week. As participants attend to school responsibilities hours will be reduced. Projects slated for the completion by the program include space maintenance and beautification of the cemetery, gazebo construction at the Drop in Center, cleaning and painting of the telemed office at the Drop in Center, and organization of the Plumas County Museum's storage facility, as well as landscape maintenance and enhancement of the Sierra House, the PCMH Board and Care facility.

WET funding will allow PCMH to provide financial support to staff through loan repayment opportunities and stipends for pursuing advanced degrees that will benefit Plumas County Mental Health. One of the PCMH Case Managers will complete her Registered Addiction Specialist training with supervised hours by the Alcohol and Other Drug Clinician Supervisor.

2. Describe any challenges or barriers, and strategies to mitigate.

Through CSS funding, we plan to address the shortage of consumer staff through the expansion of the number of positions for Transition Age Youth Peer Mentors and Adult Consumer Advocates. We will utilize WET funds to offer training on wellness and recovery, Motivational Interviewing, development of consumer-run services, and other promising practices, to staff and consumers. Our initial step is to train staff in the principles of MHSA; consumer culture; consumer empowerment; and how to integrate consumer staff into the system of care. Individuals from other community and partner agencies will also have access to these trainings, whenever possible.

3. List any significant changes in Three-Year Plan, if applicable.

Capital Facilities/Technology (CFTN)

1. Provide a program description.

Facility improvements/acquisition for Wellness Centers were described in the original approved Three-Year Plan under the CFTN component. However, with the change of county-owned and operated sites to community-based Wellness Centers, the funds for renovations will come from the CSS component. As appropriate, MHSA CFTN funds will be used for County-owned space and plans are being drawn up to support a major upgrade of the Sierra House Board and Care Facility and for the Drop-In Center in FY2015-16.

The program is considering longer term CFTN use and will put aside some funds, approximately \$200,000, or up to 10% of the 5 year average of CSS and PEI. Once reserved, these funds can be used for a period of 10 years. In addition, CFTN will support staffing and its electronic health records system (Kingsview's Anasazi) through a portion of the CFTN component.

	MHSA Funding				
	A	B	C	D	E
	CSS	PEI	INN	WET	CFTN
A. Actual FY 2014/15 Funding					
1. Estimated Unspent Funds from Prior Fiscal Years	3,900,186	997,871	596,100	264,472	276,036
2. New FY2014/15 Funding	1,858,387	495,570	123,892		
3. Transfer in FY2014/15 ^{a/}	(355,737)			337,773	17,964
4. Access Local Prudent Reserve in FY2014/15	0	0			
5. Available Funding for FY2014/15	5,402,836	1,493,441	719,992	602,245	294,000
B. Actual FY2014/15 MHSA Expenditures	2,506,419	410,881	116,000	42,550	7,101
C. Estimated FY2015/16 Funding					
1. Estimated Unspent Funds from Prior Fiscal Years	2,896,417	1,082,560	603,992	559,695	286,899
2. Estimated New FY2015/16 Funding	1,520,925	405,580	101,395		
3. Transfer in FY2015/16 ^{a/}	0				
4. Access Local Prudent Reserve in FY2015/16	0	0			
5. Estimated Available Funding for FY2015/16	4,417,342	1,488,140	705,387	559,695	286,899
D. Estimated FY2015/16 Expenditures	3,755,888	628,523	168,850	101,200	1,250,000
E. Estimated FY2016/17 Funding					
1. Estimated Unspent Funds from Prior Fiscal Years	661,454	859,616	536,537	458,495	(963,101)
2. Estimated New FY2016/17 Funding	1,636,275	101,395	109,085		
3. Transfer in FY2016/17 ^{a/}	0				
4. Access Local Prudent Reserve in FY2016/17	0	0			
5. Estimated Available Funding for FY2016/17	2,297,729	961,011	645,622	458,495	(963,101)
F. Estimated FY2016/17 Expenditures	2,536,329	464,398	296,450	92,000	1,250,000
G. Estimated FY2016/17 Unspent Fund Balance	(238,600)	496,613	349,172	366,495	(2,213,101)

Mental Health Services Act
As Revised September 2013
Selected Excerpts

Section 2: Findings and Declarations

Mental illnesses are extremely common; they affect almost every family in California. They affect people from every background and occur at any age. In any year, between 5% and 7% of adults have a serious mental illness as do a similar percentage of children – between 5% and 9%. Therefore, more than two million children, adults and seniors in California are affected by a potentially disabling mental illness every year. People who become disabled by mental illness deserve the same guarantee of care already extended to those who face other kinds of disabilities.

Failure to provide timely treatment can destroy individuals and families. No parent should have to give up custody of a child and no adult or senior should have to become disabled or homeless to get mental health services as too often happens now. No individual or family should have to suffer inadequate or insufficient treatment due to language or cultural barriers to care. Lives can be devastated and families can be financially ruined by the costs of care. Yet, for too many Californians with mental illness, the mental health services and support they need remain fragmented, disconnected and often inadequate, frustrating the opportunity for recovery.

Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Children left untreated often become unable to learn or participate in a normal school environment. Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs.

In a cost cutting move 30 years ago, California drastically cut back its services in state hospitals for people with severe mental illness. Thousands ended up on the streets homeless and incapable of caring for themselves. Today thousands of suffering people remain on our streets because they are afflicted with untreated severe mental illness. We can and should offer these people the care they need to lead more productive lives.

Section 7:

Planning for services shall be consistent with the philosophy, principles, and practices of the Recovery Vision for mental health consumers:

1. To promote concepts key to the recovery for individuals who have mental illness: hope, personal empowerment, respect, social connections, self-responsibility, and self-determination.
2. To promote consumer-operated services as a way to support recovery.
3. To reflect the cultural, ethnic, and racial diversity of mental health consumers.
4. To plan for each consumer's individual needs.