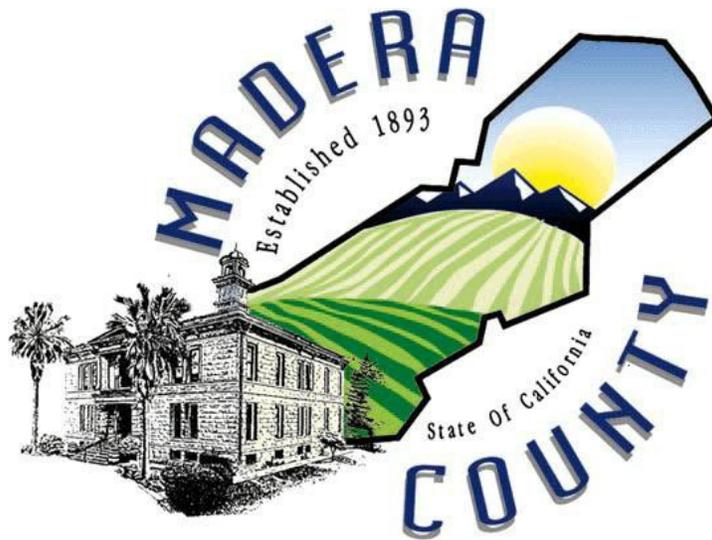


**MADERA COUNTY
BEHAVIORAL HEALTH SERVICES
MENTAL HEALTH SERVICES ACT
THREE YEAR PLAN**

FISCAL YEARS 2014-2017



**MENTAL HEALTH SERVICES ACT
THREE-YEAR PROGRAM AND EXPENDITURE
PLAN FY 2016-17 ANNUAL UPDATE
APRIL 15, 2016**

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MHSA COUNTY PROGRAM CERTIFICATION

County/City: Madera

- Three-Year Program and Expenditure Plan
 Annual Update

Local Mental Health Director	Program Lead
Name: Dennis P. Koch, MPA	Name: Debbie DiNoto, LMFT
Telephone Number: (559) 673-3508	Telephone Number: (559) 673-3508
E-mail: dennis.koch@co.madera.ca.gov	E-mail: debbie.dinoto@co.madera.ca.gov
Local Mental Health Mailing Address:	
Madera County Behavioral Health Services PO Box 1288 Madera, CA 93639-1288	

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 _____.

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.

Local Mental Health Director (PRINT)

Signature Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION¹

County/City: Madera

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

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Dennis P. Koch, MPA	Name: Todd Miller
Telephone Number: (559) 673-3508	Telephone Number: (559) 675-7703
E-mail: dennis.koch@co.madera.ca.gov	E-mail: Todd.miller@co.madera.ca.gov
Local Mental Health Mailing Address:	
Madera County Behavioral Health Services PO Box 1288 Madera, CA 93639-1288	

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.

Local Mental Health Director (PRINT)

Signature Date

I hereby certify that for the fiscal year ended June 30, , the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated for the fiscal year ended June 30, . I further certify that for the fiscal year ended June 30, _____, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

County Auditor Controller / City Financial Officer (PRINT)

Signature Date

¹ Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

COUNTY DEMOGRAPHICS BACKGROUND

Madera County is a small rural county in the center of California. It has two incorporated cities, Madera and Chowchilla. There are unincorporated population centers in the mountain region of the county. The primary industries, in order of primacy are: 1) government, 2) agriculture, 3) education, 4) health care, and social services, and 5) trade, transportation and utilities. The Medi-Cal eligibility threshold non-English languages for Madera County was Spanish (47.5%) in 2014. Please see chart below for further demographics.

Demographic Comparison of California and Madera County (US Census)		
	California	Madera
Total Population (2015)	39,144,818	154,998
Population % Change (2010 to 2015)	5.1%	2.7%
Persons under 5 years (2014)	6.5%	7.5%
Persons under 18 years (2014)	23.6%	27.6%
Persons 65 Years and Older (2014)	12.9%	12.8%
Female (2014)	50.3%	51.9%
Male (2014)	49.7%	48.1%
Black/African American (2014)	6.5%	4.3%
American Indian/Alaska Native alone (2014)	1.7%	4.5%
Asian alone (2014)	14.4%	2.5%
Native Hawaiian and Other Pacific Islander alone (2014)	0.5%	0.3%
Two or More Races (2014)	3.7%	2.4%
Hispanic or Latino (2014)	38.6%	56.1%
White alone (2014)	38.5%	35.8%
Veterans (2010-2014)	0.5%	0.6%
Foreign Born persons percentage change (2010-2014)	27%	21.8%
Language other than English spoken at home of persons 5 years+ change (2010-2014)	43.8%	44.0%
High School Graduate or Higher, % of persons age 25 Years+ (2010-2014)	81.5%	69.5%
BA degree or higher % of persons age 25 years+ (2010-2014)	31.0%	13.5%
With disability, under age 65 years (2010-2014)	6.7%	8.5%
Persons without health insurance, under age 65 years	14.0%	22.8%
Civilian labor force, total, % of population age 16 years+ (2010-2014)	36.4%	50.7%
Persons in poverty	16.4%	22.3%
Children, living in poverty	22.7%	32.4%

Other Demographics		
	California	Madera
Unemployment Rate (CA EDD 2015)	5.7%	9.9%
Social Security Disability (2013 CA DSS)	1,304,222	4,751
Households Food Stamps Recipients (2016 CA DSS)	276,003	2,001
TANF/CalWORKs Recipients (2016 CA DSS)	3.3%	5.7%

According to the data from our Electronic Health Record, Madera County Behavioral Health Services (MCBHS) served 2915 people during FY 14/15 with its outpatient mental health services. The age groups of the individuals served was:

- 997 Children/Youth (0-15 years)
- 608 Transition Age Youth (16-25 years)
- 1142 Adults (26-59 years)
- 168 Older Adult (60+ years)

MCBHS provides mental health services to CalWORKs recipients referred from the Madera County Department of Social Services. During FY 14/14, MCBHS served a total of 196 individuals in this program. The age groups for this group were:

- 80 Children/Youth (0-15 years)
- 40 Transition Age Youth (16-25 years)
- 99 Adults (26-59 years)
- 2 Older Adult (60+ years)

The threshold languages for county behavioral health services are English and Spanish.

Outpatient Race and Ethnicity for the Last Two Fiscal Years		
	FY 13/14	FY 14/15
American Indian or Alaskan Native	31	34
Asian	25	36
Black/African American	150	177
Hispanic	1,369	1,758
Multiple	9	10
Native Hawaiian /Other Asian Pacific Islander	4	8
Non-White Other	1,272	1,606
Unknown	50	38
White	793	943

COUNTY CHALLENGES

In the past decade the number of staff was reduced to half of the capacity it had in the mid 2000's, due to an economic downturn that reduce the tax revenue that funds the Madera County Department of Behavioral Health Services (MCBHS) operations. While the funding and staffing have increased, staff caseloads remain high. With available funding, the department was able to serve 47% of its mental health services target population in fiscal year 2014-15. MCBHS' Substance Use Disorder (SUD) services, which has less funding than MCBHS' mental health services, was only able to serve 10% of its eligible population in fiscal year 2014-15. In addition, there is little funding for outreach education to inform the community of MCBHS' services and eligibility requirements. This reduced the ability to engage people that would be eligible for MCBHS's services.

INTRODUCTION

The Mental Health Services Act

Proposition 63 was passed in 2004 and became the Mental Health Services Act (MHSA) law in 2005. This law generates funding for public mental health services through a 1% tax on personal income over \$1 million. Over the past 11 years MHSA has funded new and innovative mental health services. During the recent economic downturn it became the largest funding source for public mental health outpatient services and without it, MCBHS's staffing might have been reduced to as much as a third of what it was before the downturn. It helped increase access to mental health care by underserved communities by providing funds for outreach and education activities that engage underserved populations in services, using culturally appropriate service modalities.

MHSA Legislative Changes

AB 100 was passed into law in March of 2011. This law eliminated the State Department of Mental Health (DMH). In addition, it reduced and changed the oversight responsibilities of the Mental Health Services Oversight and Accountability Commission (MHSOAC). The oversight entity for MHSA services was replaced with the "State" for the distribution of MHSA funds. Furthermore, due to the State's fiscal crisis, AB 100 allowed some MHSA funding for FY 11/12 to be used for non-MHSA programs, and for \$862 million dollars to be redirected to fund Early Periodic Screening, Diagnosis and Treatment (EPSDT), Medical Specialty Managed Care, and Education Related Mental Health for students.

On June 27, 2012, the AB 1467 trailer bill made additional changes to state law, including amendments to MHSA and new requirements for MHSA Innovation (INN) plans. It retained the provision that county INN and Prevention and Early Intervention plans be approved by the MHSOAC, the MHSA three-year plans and annual updates be adopted by local county boards of supervisors and submitted to the MHSOAC within 30 days after board adoption. The bill also required that plans and updates to include: 1) certification by the county mental health director to ensure county compliance with pertinent regulations, laws and statutes of the Act, including stakeholder engagement and nonsupplantation requirements, and 2) certification by the county mental health director and the county auditor-controller that the county had complied with any fiscal accountability requirements, and all expenditures were consistent with the MHSA.

Purpose of the Plan

The Mental Health Services Act Three-Year Plan (Three-Year Plan) describes the MHSA services and resources that will be provided to communities. County mental health departments are required to develop a Three-Year Plan or Three-Year Plan update, which includes descriptions of MCBHS' MHSA services, for community stakeholder review and recommendations. This plan provides a progress report for the MCBHS' services for the previous fiscal year, an overview of proposed MHSA services for the current Three-Year

Plan, program descriptions and outcomes from FY 14-15 (pages 20 - 46) and projected expenditure for FY 16-17 (pages 31, 38, 43, and 48)

Direction for Public Comment

MCBHS is releasing its current Madera County's Mental Health Services Act Three-Year plan for public review. The plan is based on legal requirements public review. The 30 day public review will be from April 13, 2016 to May 13, 2016. A copy of the Plan may be found at <http://www.madera-county.com/index.php/mental-health-services-act-information> and will be available at the Behavioral Health Services front desk. You may request a copy by contacting David Weikel at (559) 673-3508. A Public Hearing regarding this plan will be held during the Behavioral Health Board meeting on May 18, 2016 at 11:30pm at Madera Community Hospital, 1250 E. Almond Ave., Shebelut Conference Room, Madera, CA 93637. You may comment in the following ways:

1. At the Public Hearing
2. By fax: (559) 675-4999
3. By telephone (559) 673-3508
4. By E-mail to debbie.dinoto@co.madera.ca.gov
5. Writing to:

Madera County Behavioral Health Services
Attention: Debbie DiNoto, LMFT
Madera, CA 93639

STAKEHOLDER PROCESS

CCR § 3300 & § 3315 states this section of the Plan shall include a description of the Community Program Planning and Local Review Process. The following is a brief description of these processes, which were a part of this plan's development.

Community Program Planning

1. A description of the local stakeholder process including date(s) of the meeting(s) and any other planning activities conducted.

The Community Program Planning Process for Madera County Behavioral Health Services (MCBHS) MHSA services includes an update and review of the following MHSA components: Community Services and Supports (including housing), Prevention and Early Intervention, and Innovation. The community was engaged in the planning process through focus groups, individual contacts, questionnaires, and agency meetings. The draft plan was posted to our website and the link to the plan was widely distributed electronically.

The stakeholder meeting dates for 2016 were as follows:

- March 8th Madera Library 1pm - 3pm
- March 9th North Fork Library 1pm - 3pm
- March 15th Chowchilla Library 1pm - 3pm
- March 16th Oakhurst Library 1pm - 3pm
- March 22nd Madera Ranchos Library 5pm - 6pm

Meetings were held at the county library sites because they have handicap accessible buildings with adequate parking. Interpreters (language and sign) are made available for free, upon request. Water and snacks were also provided for participants in an effort to attract more people to attend meetings.

[Sections 2, 3 and 4 regarding stakeholder involvement will be completed in the final plan document after the stakeholder process is completed.]

Local Review Process

1. The draft plan was distributed electronically for public comment to community stakeholders and any other interested party who requested a copy of the draft plan. This was distributed for print at the county sites and allied partner agencies.

The **Local Review Process** of the draft plan was from April 18, 2016 to May 18, 2016. The majority of the circulation of planning information was by e-mail which announced the dates, times and location of the community stakeholder meetings announcements. The announcement included an electronic survey link with information about MHSA services, non-MHSA mental health services, and substance use services provided by MCBHS. This information was distributed to the county Departments of Social Services, Public

Health, Probation, Libraries and Corrections. In addition, it distributed to the Madera County Community Action Partnership, Madera County's First 5, Madera County Office of Education, Madera County Workforce Connection, Family Health Services, Camarena Health, MCBHS' clinic sites in Madera, Chowchilla and Oakhurst and law enforcement. Each of these departments distributed this information internally and through their email distribution lists. This information was also sent to the Madera Tribune, Chowchilla News, Fresno Bee, and Sierra Star (which announced the meetings in their community calendars).

Community Program Planning Process

The **planning process**, including the draft plan circulation, lasted from February 2016 through May 2016. Community meetings were announced, scheduled and conducted at the Madera County Library locations where MHSA information was presented. This process was also conducted at partner agencies. The information presented included MHSA (FSP, PEI, INN, WET, and MHSA Housing), MHSA priority service populations, non-MHSA mental health services and substance use services. The information included mental health policy related to MHSA, program planning activities, program implementation, and service outcomes/monitoring including quality improvement information, evaluation, budget allocations (all funding streams for mental health and substance use services). At the end of the presentations surveys were provided to participant for services recommendations. A total of **178 people** received this information during the meetings, but some participants did not complete a survey. A total of **101 surveys** were completed. Most of the surveys were completed by meeting attendees, but a few were completed by individuals that completed them online. The table below provides information regarding where the meetings were held. Future MHSA community meetings were announced at each meeting and requests to present at other community meetings were given.

	Organization and Community Meeting	Number	Date	MHSA Only	All
1	Madera County Interagency Children and Youth Services Council	18	2/4/2016	1	
2	Madera Community Action Partnership - SALT meeting	16	2/11/2016	1	
3	Madera Workforce Connection Staff Meeting	26	2/12/2016	1	
4	Madera County Behavioral Health Board	16	2/17/2016	1	
5	Madera City Council	32	2/17/2016	1	
6	Madera County Public Health - Community Advisory Board Meeting	14	2/25/2016	1	
7	Madera Unified School District - Nursing Staff	16	2/29/2016		1
8	MHSA Community Stakeholder Meeting - Madera	6	3/8/2016		1
9	MHSA Community Stakeholder Meeting - North Fork	3	3/9/2016		1
10	MHSA Community Stakeholder Meeting - Chowchilla	3	3/15/2016		1
11	MHSA Community Stakeholder Meeting - Oakhurst	3	3/16/2016		1
12	MHSA Community Stakeholder Meeting - Madera Ranchos	7	3/22/2016		1
13	Hope House	9	3/23/2016		1
14	Hope House	9	3/24/2016		1

Interagency Meetings

The first interagency meeting, where an MHSA presentation was conducted and surveys were taken, was provided at the Interagency Children and Youth Services Council. This group is comprised of leaders from Madera County Departments of Behavioral Health Services (mental health and substance use), District Attorney's Office, Probation, Public Health, Social Services, Office of Education, County Board of Supervisors, Sheriff's and Superior Court. In addition, it includes the following community organizations: Big Brothers/Big Sisters, Camarena Health (FQHC), Court Appointed Special Advocates, Child Abuse Prevention Council, Community Action Partnership of Madera County, general community members, Cornerstone Family Counseling Services, First 5 Madera County, Madera City Housing Authority, local child care providers, Madera City Parks and Recreation, and Valley Children's Hospital.

The second interagency meeting where MHSA information was provided was the Madera Community Action Partnership's SALT meeting, which has a wide range of stakeholders. The SALT meeting where MHSA was presented and surveys completed also included presentations from the Mexican Consulate and Migrant Health. The SALT group includes representatives from the general community, Madera County schools, the County Department of Social Services, the Chamber of Commerce, Madera First 5, Chowchilla Police Department, faith based organizations, City of Madera, Employment Development Department, Madera County Board of Supervisors, Workforce Connection, Madera Food Bank, and Madera County Veterans Services.

An MHSA presentation was conducted at the Madera City Council meeting. This meeting had general community members, Madera City Police Officers and Fire Fighters in attendance.

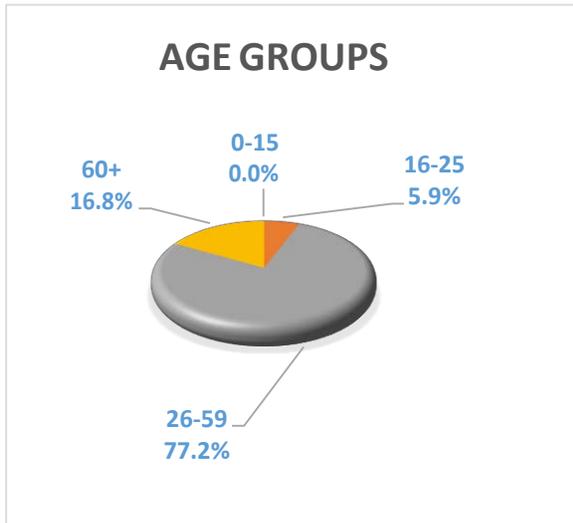
Madera County Public Health Department's Community Advisory Board had representatives from organizations that were not included in the other two collaborative groups previously mentioned. An MHSA presentation was conducted at this meeting and surveys were completed and collected.

The information regarding the community planning meetings at the local libraries was disseminated at these two inter-organizational groups. In addition, the information was disseminated to their email lists.

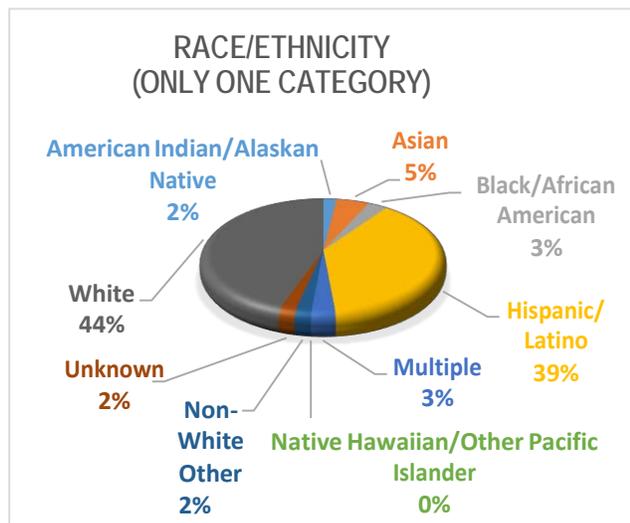
The county library setting were chosen for the community meetings because these sites are non-stigmatizing sites and have handicap access. Presenting information and discussion at ongoing collaborative meeting allowed MCBHS to connect with underserved populations and other stakeholder that don't typically attend MCBHS' meetings.

The Hope House and Oakhurst and North Fork community meetings included consumer and family members. The Oakhurst meeting also had a veterans advocate in attendance.

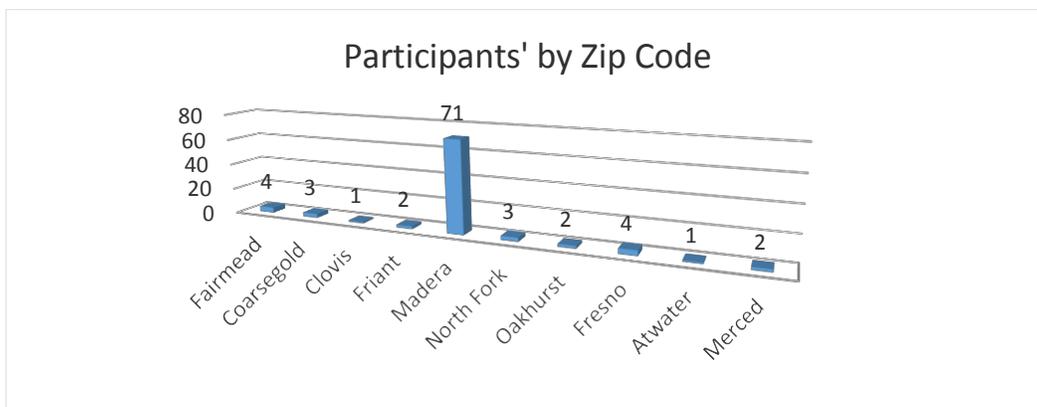
Stakeholder Feedback Results



101 Response



101 Responses



93 Responses

The people that listed their residence in a one of the neighboring counties were likely employees of the MCBHS or other county agency. It is common for employed of Madera County government services to reside in a neighboring county.

Stakeholders indicated the importance of each child/youth/transition age mental health issue listed below by numbering 1 as the most important area through number 6 as the least important area

Answer Options	1	2	3	4	5	6	Rating Average	Response Count
Inability to Obtain Education	20	8	16	7	12	25	3.66	88
Juvenile Justice/Incarceration	11	15	14	20	16	12	3.58	88
Out-of-home placement	9	22	10	19	13	15	3.57	88
Social Isolation	15	13	14	16	21	10	3.51	89
Juvenile Justice/Involvement	9	18	20	19	16	9	3.46	91
Homelessness	27	14	16	9	10	14	3.03	90
	(adjusted 25)		(adjusted 17)					

94 people responded to this question. The adjusted scores were reduced to see if questions for 88 responses would still hold their place in the ranking.

The additional recommended populations/strategies noted are listed below	
1	Former and Current Foster Care Youth
2	East Asian
3	Special needs as referred to in state education code to coincide with county office of educators programs- "at risk" youth and "special needs"
4	Mental health training for teachers and law enforcement
5	Mentally disabled or slow learner or educationally disabled
6	Mothers in pregnancy crisis
7	ALL SPECIFICALLY MENS SUPPORT-BACKGROUND DISINFORMATION
8	Mental illness
9	Black Mexican White
10	LGBT, Adults and Older Adults
11	Homeless population
12	Sober living
13	Mentally Developmental disabled people
14	0-5 YEARS OF AGE
15	TAY age, Veterans, and Families who cannot (for personal or other reasons? access care at VA sources
16	Pre-natal
17	Pregnant teens
18	Emancipated minors
19	0-5 year olds
20	Gang members in the case of older teens those who need to work cannot find work and turn to illegal activities
21	Adolescents for prevention
22	Mental illness
23	Youth in general
24	First nations people (Native Americans)
25	Pregnant & parenting teens
26	Oaxaca
27	Single parents men and women
28	Pregnant youth drug & alcohol advice
29	Grief counseling abuse or violated women x2
28	Teen pregnancy and child abusive pop

77 people responded to this question

Stakeholders Indicated the importance of each adult/older adult mental health issue listed below. Start with number 1 as the most important through 6 as the least important area.

Answer Options	1	2	3	4	5	6	Rating Average	Response Count
Homelessness	41	15	7	9	4	9	2.38	85
Reduction of Isolation	11	16	10	15	21	11	3.62	84
Reducing Incarcerations of Mentally Ill Adults	9	25	19	10	11	9	3.19	83
Involuntary Treatment/Hospitalization	11	16	14	21	16	6	3.39	84
Out-of-Home Placement/Institutionalization	4	12	19	17	20	13	3.89	85
Inability to Obtain Education	12	4	17	11	10	32	4.15	86

90 people responded to this question.

The adjusted number indicates a score if only 83 respondents answered the question; as a means of prioritizing options.

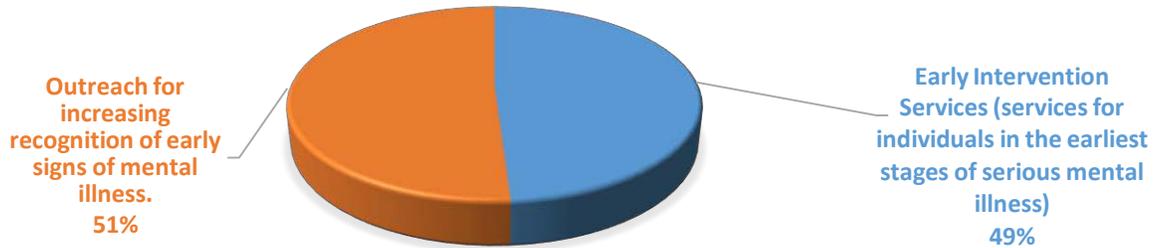
The additional Adult/ Older Adult recommended populations/strategies noted are listed below
Mothers who have been incarcerated, Domestic Violence Victims
Special needs to coincide with adult education and special needs programs CWIC
Teachers law enforcements need in mental health training
Veteran outreach
Single parent family skills
Elders men and women very hard to break into stigma
Alcoholics and drug addicted disabled people
Any veteran and families who can't/ access VA care for any reason

35 people answered this question

The additional Adult/Older Adult recommended populations/strategies noted are listed below
Substance Abusers
ALL HOWEVER AS THE MALE POPULATION HAS TRAITS OF VIOLENCE-COMPLETE CHECK ON BACKGROUND
OAKHURST
Young adults
Sober living
Keep doing work that has been done. Word will get out much faster than newspaper.
Mentally disabled developmentally disabled
All
Homeless alcoholism
Elementary students
Older adult/elderly
Any veteran and families who can't/ access VA care for any reason
Prenatal/pregnant women
The chronically unemployed substance abusers
First nations people (Native Americans)
Pregnant & parenting
Single parents men and women
Unemployed populations long term unemployed older workers-55+up
Veterans

52 people responded to this question

PLEASE WRITE IN THE POPULATION/ISSUE THAT SHOULD BE THE FOCUS OF: EARLY INTERVENTION SERVICES AND OUTREACH FOR INCREASING RECOGNITION OF EARLY SIGNS OF MENTAL ILLNESS.



28 people responded to these questions

The additional PEI recommended populations/strategies noted are listed below

Early Intervention Services (services for individuals in the earliest stages of serious mental illness)	Outreach for Increasing Recognition of Early Signs of Mental Illness
Families dealing with Mental Illness	Families dealing with Mental Illness
Asian	Asian
Juveniles	Juveniles
Peer support	List of warning signs
Jail inmates or people mentally unstable more organizations	Need of services
School and church groups	Training education community leaders
Pregnancy/pre-teen/pre adult	SUPPORT AND OVSERVE
SUPPORT OBSERVE THE PROBLEM	ENTIRE COMMUNITY
Catch them at an early age	Homeless x 2
TAY POPULATION, NON-ENGLISH SPEAKING	Community All Ages
Education	Low income areas. Schools.
Youth x 2	Suicide
Discrimination	Substance/Drug Abuse
Homeless	Home visitations
Social support / day center	Going to talk with community broad meetings
keeping medication apt	Hippies drug issue
Families with school age children	High school students
0-5 years of age	Same as above
Coping skills/identifying supports	0-5 years of age
Education on mental illness plus treatments	Parenting
Education through schools and libraries	Education in local media
Self-esteem promotion/ training	Early education
Veterans and families	Web Presences, e.g. Facebook
	Older Adults

Stakeholders indicated the importance of each mental health Prevention Program Options beginning with 1 as the most important through 4 as the least important.

Answer Options	1	2	3	4	Rating Average	Response Count
Stigma and Discrimination Reduction	18	11	18	23	2.64	70
Suicide Prevention	20	15	15	19	2.48	70
Access and Linkage to Treatment	17	23	18	12	2.38	70
Improve Timely Access to Services for Underserved Populations	15	23 (adjusted 21)	18 (adjusted 16)	16	2.49	72

72 people responded to this question Question adjusted to 70 responses to prioritize options

The additional PEI recommended populations/strategies noted are listed below
Crisis Team
Asian
Hispanics/Asians
veterans because they come home with issues
participation into the observation of the problem nurture to our reality and the criminal activity that may be directed at an individual of difference in observation
RELIGIOUS GROUPS/LEADERS
Justice system advocacy and education
transportation to resources
Significantly more clinical training in the area of how maladaptive/pathological care prior to 3 years of age significantly impacts an individual mental health for the rest of their life.
Use the local media, newspapers, radio, TV
Early intervention services-for children outreach-for children prevention-families
More services for parents of children struggling w/behavioral management, pre and post natal depression. Mental wellness
postpartum depression-prenatal
pregnant & parenting
children whose parents or caretakers recently died or were incarcerated
prevention of teen pregnancy groups post-partum pregnancy developmental delayed adults that have depression

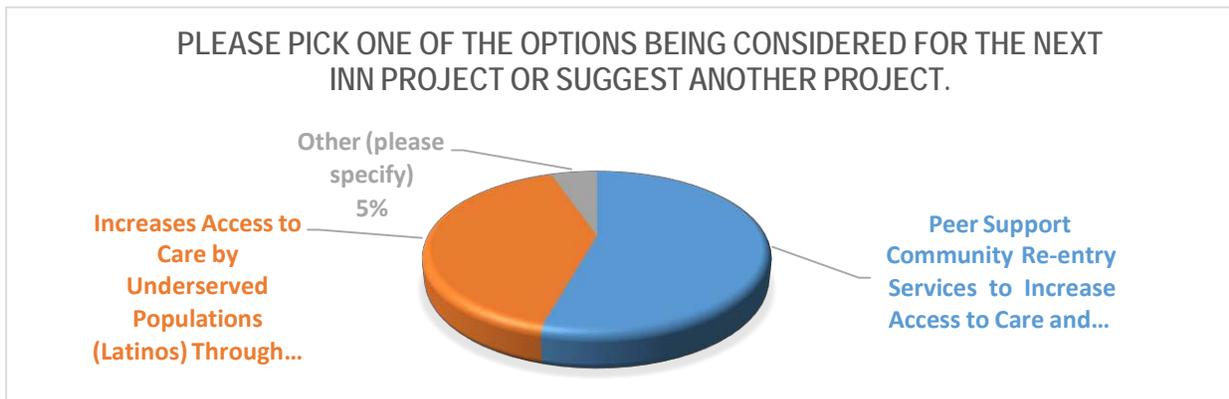
40 people responded to this question

Stakeholders rated the importance of the Innovation projects below, beginning with 1 as the most important, and continuing through 4 as the least important.

Answer Options	1	2	3	4	Rating Average	Response Count
Increase access to mental health services to underserved groups	20	14	13	6	2.09	53
Increase the quality of mental health services, including measurable outcomes	10	9	15 (adjusted 14)	20	2.83	54
Promote interagency or community collaboration related to mental health services, supports or outcomes	14	15 (adjusted 14)	14 (adjusted 13)	11	2.41	54
Increase access to mental health services	10	17 (adjusted 15)	12	16	2.62	55

56 people responded to this question

Question adjusted to 53 responses to prioritize options



57 people answered this question

Other INN recommendations
Community education adults and teen son what to do after MH is identified
Involvement by law enforcement
Sometimes the "underserved" are not in a specific cultural group, but rather in an age group. The more we effectively understand how mental illness starts (in the first 3 years of a child's life, including in-utero) then we will never fully understand how to treat mental illness, for anyone.

Other INN populations and/or strategy recommended
Families dealing with Mental Illness
African American population
Children under 6. Collaboratively with other Agencies who work with children of same age group and who fully understand how we grow and develop in connection to our learning domains. Because that is what makes us grow healthy.
Foster youth/foster parents/bio-parents
people released from incarceration
Continue outreach & education need more temp/transitional housing (housing first model) Stop sending people back to same environment. need more safe positive environments for teens/young adults; especially those not in school

15 people answered this question

Any other recommendations for Mental Health Services Act services?
Mental Health should include the whole family unit to be involved in services to ensure that there will be a more positive outcome for persons with mental health issues
Promote faith base collaboration
Justice system education
Emergency treatments-housing
Stop wasting the money where it isn't working. Think outside the box. Mental illness has absolutely no boundary, none. But you do not have to look too far to see where it begins to take place.
No
drug and alcohol for students either at local agencies and/or non-profit organizations

7 people answered this question

Substance Use Services

Please leave any recommendation or comments regarding BHS' substance use Treatment services here.
Substance Use Education and Dual Diagnosis Intervention
More variety of groups-different times& places
Peer support training to increase inclusion of AOB and now AOD clients-hold the line with care
Continue to bring to wellness centers
Seems to help clients but seems like we all need more help have more help in schools county or school organizations
Make it available or inform the consumer that BHS offers this service
Early teen prevention on abortion/what we do after the pro-choice decision
Be sure they attend NA/AA groups sponsorship is also important. Doing great with education.
Confront psychological misdirection and confront pharmaceutical remedies of low involvement
Have all service access to everyone on below poverty level
Awareness of substance to substance users and aftercare ongoing-checkup and check in, especially parents with children
Tough love, greyhound, dawn
NEED MORE OUTREACH TO ADVERTISE THE AVAILABLE SERVICE
Direct linkage from jails to resources; reducing time between both
Provide better service when it's a dual diagnosis
although I appreciate the presentation of data I am not sure if many community stakeholders would share this value
More groups for voluntary clients
Coordinate care between AOD & MH for Co-occurring conditions treatment

18 people answered this question

Add any other comments regarding substance use prevention here.
It would be nice to start a satisfactory comment/ unsatisfactory complaint system for clients who receive services. There should be surveys Clients take every few months so that Behavioral Health Services can measure how their programs are affecting the clients that receive services and where there is a need to make any improvements within the programs.
Add the faith based community to help with prevention services and mental health services they are helpful
Adult mentor/peer support mentor is a great idea
Big brothers/big sisters-serve on their board as a Madera County Liaison
We need to have more activates more places to go to
A focus on reality and the criminal implications that may be involved in guiding a person down the wrong path law enforcement.
Show all high school and Jr. high what alcohol and as well as drugs can do to their lives
Treatment needs to include help with addressing risk factors
I will be contacting your office for a school presentation
You need to have education and classes at community centers, parks, schools, churches

12 people answered this question

Summary and Analysis of Substantive Recommendations Received During 30-Day Public Comment Period and the Resulting Actions, Including Any Substantive Change Made to the Annual Update in Response to Public Comments

Any additional information gathered during the plan review will be added in the final plan

The information in this summary included the stakeholder feedback gathered from the planning process and will be used to prioritize service strategies and populations served during the upcoming fiscal year. The priority is determined by the frequency (more than one response) of the same or closely related populations and/or strategies.

Community stakeholders ranked the state designated top three of the priority populations for the Child/Youth/Transition Age Youth FSP (FSP 1) as people with serious emotional disturbance/illness experiencing:

- 1) Homelessness
- 2) Out of Home Placement
- 3) Juvenile Justice/Involvement

Specific recommendations for certain populations, in order of priority were:

- 1) At-Risk Youth (current or former foster youth, youth experiencing academic failure, emancipated youth, pregnant and parenting teens, school age children, gang members/older teens that can't obtain employment, youth that use drugs and alcohol, youth experiencing abuse, TAY age youth and their families that can't access the Veteran's Administration's services)
- 2) Ethnic minorities (East Asian, Black, Mexican, Native Americans, and immigrants from Oaxaca)

Community stakeholders ranked the state designated top three of the priority populations for the Adult/Older Adult FSP (FSP 2) as people with serious illness experiencing:

- 1) Homelessness
- 2) Incarceration
- 3) Out of Home Placement/Institutionalization

Specific recommendations for certain populations, in order of priority were:

- 1) Substance users (alcoholics, drug addicts, homeless alcoholics, chronically unemployed substance users)
- 2) Veteran's that can't access VA services
- 3) Pregnant and parenting women; including incarcerated mothers

Community stakeholders indicated that the overall priority for PEI service for the next year should be Outreach for Increasing Recognition of Early Signs of Mental Illness. The stakeholders ranked the state designated top three of the state designated priority populations for the Prevention and Early intervention Services, in order of priority as:

- 1) Suicide Prevention
- 2) Access and Linkage to Treatment
- 3) Stigma Reduction

The recommendations for Early Intervention services were, in order of priority:

- 1) Jail Inmates
- 2) Youth and Young Adults (Pregnant and Parenting Teens/Pre-adult)
- 3) Families (Dealing with Mental Illness, Families of Veterans, Families of School Age Children)

The recommendations for Outreach for Increasing Recognition of Early Signs of Mental Illness services were, in order of priority:

- 1) Community Leaders (Training and Education, Community Board Meetings)
- 2) High School Students
- 3) 0-5 years
- 4) Families of People Experiencing Mental Illness (Parenting and Early Education)
- 5) Homeless

Specific recommendations for certain populations, in order of priority were:

- 1) Perinatal Mental Health Services (Postpartum depression, Pregnant and Parenting, Teen Pregnancy, Family Outreach Services)
- 2) Parenting (Parents of Children with Mental illness, Children Whose Parents Have Died, Children Whose Parents are Incarcerated)

Community stakeholders ranked the top three of the state mandated priority populations for Innovation as:

- 1) Increase Access to Mental Health Services to Underserved Groups (not just ethnicity)
- 2) Increase Access to Mental Health Services
- 3) Increase the Quality of Mental Health Services, Including Measurable Outcomes

Two options for future projects were discussed with community stakeholders and the majority (54%) of the stakeholders responded that a project focusing on Peer Community Re-entry Services to Increase Access to Care and Resources (after hospitalization) was their preference.

While there were no other recommendations for innovation projects, educating, training, and working more closely with law enforcement was mentioned in every MHPA service category.

In summary, stakeholders recommended that the Full Service Partnerships focus of individuals experiencing homelessness, due to serious emotions disturbance/mental illness, out of home placement and justice systems involvement. The specific populations indicated for FSP 1 includes at-risk youth and ethnic minorities. The specific populations for FSP 2 would include individuals with co-occurring mental illness and substance use disorders, veterans unable to access Veterans Administration services, and pregnant and parenting women, including incarcerated women. The later will make sure that the justice involved women are within the limitations of the MHPA's designated population.

The Prevention and Early Intervention Services will focus on Outreach for Increasing Recognition of Early Signs of Mental Illness, with an emphasis on suicide prevention, access and linkage to treatment, and stigma reduction. Specialized services will focus on individuals involved in the justice systems (within the limitations of PEI services

regulations), youth and young adults that are pregnant or parenting teens and young adults, and families that have members experiencing mental illness. The Outreach for Increasing Recognition of Early Signs of Mental Illness Services will focus on awareness raising and community development will target community leaders, high school students, children ages 0-5 years old, and individuals experiencing homelessness. In addition, there will be an emphasis on parenting and perinatal mental health services for children and families at risk of serious emotional disturbance/illness.

Community stakeholders emphasized the following three services for Innovation services: increasing access to mental health services for underserved groups, increasing access to mental health services, and increasing the quality of mental health services, including measurable outcomes. The current Innovation project is currently addressing these areas, but is focused on learning how to affectively collaborate with our partner agencies as a means of producing these types of outcomes. The preferred future project for Innovation involves peer support services facilitating community re-entry services from acute hospitals beginning with video conferenced peer support and in person follow up when clients return to the community.

PROGRAMS AND PERFORMANCE OUTCOMES

WIC § 5847 states the MHSA Plan and Plan Updates shall describe the following programs: Community Services and Supports, Prevention and Early Intervention, Innovation, Capital Facilities and Technology, Workforce Education and Training needs related to staff shortages and staff development needs, and information related to the County’s Prudent Reserve funding.

Community Services and Supports (CSS)

The CSS services include intensive outpatient services, regular outpatient services and short-term emergency housing. MCBHS has two Full Service Partnership (FSP) teams that provide intensive services for people with the greatest behavioral health outpatient needs. There have been no changes to FSP services. Madera County’s Department of Corrections, in partnership with MCBHS, was able to obtain a Mentally Ill Offender Crime Reduction Act (MIOCR) grant, which is being used to launch a Behavioral Health Court (BHC). The Adult/Older Adult FSP is providing services to for individuals processed through the BHC that need FSP level services.

The **Children/TAY Full Service Partnership**, serves children and youth ages 0 – 25, including foster youth and their families, who are experiencing serious emotional and behavioral disturbances. This team provides wrap-around/system of care like services, in concert with multiple organizations. As defined in WIC § 5851, these children and youth experience serious emotional and behavioral disturbances, which compromise their ability to meet their daily living needs.

The Number of Children, Youth and Transition Age Youth Served by The Program		
Total FY 2013-14	Child	45
Total FY 2013-14	TAY	48
Total FY 2014-15	Child	54
Total FY 2014-15	TAY	36

The cost per person: \$16,663

The second FSP is the **Adult/Older Adult Full Services Partnership**, which serves Transition Age Youth (TAY), adults and seniors with serious and persistent mental illness. The number of TAY, adults and seniors served by program and the cost per person is listed below. The services provided comply with WIC § 5806 and WIC § 5813.5 and are modeled after the Assertive Community Treatment model and MIOCR services.

The Number Served by the Program		
Total FY 2013-14	TAY	4
Total FY 2013-14	Adult	60
Total FY 2013-14	Older Adult	8
Total FY 2014-15	TAY	2
Total FY 2014-15	Adult	58
Total FY 2014-15	Older Adult	9

The cost per person: \$16,657

The CSS services also include System Development (SD) funding for expanding, enhancing and supporting the overall mental health services. This program has helped to build and retain MCBHS' capacity to provide treatment services and accommodate addition administrative burden related to increases in direct services. There are two SD components, **Expansion and Supportive Services and Structure**. Expansion serves all ages and is intended to accommodate increased demands for services related to community outreach and community education and other community factors that would increase the demand for services. Supportive Services and Structure provide administrative staff time, and other resources such as supportive housing. CSS funds are not be used for person incarcerated in state prison or paroles from state prison. Madera County stakeholders previously identified the following priority populations for CSS services, which are experiencing one or more of the following:

Children/Youth/Transition Age Youth FSP

- Inability to Obtain Education
- Juvenile Justice Involvement/Incarceration
- Out of Home Placement
- Social Isolation
- Homelessness

Community stakeholders identified the top three priority groups for the C/Y/TAY FSP, in order of importance, as: 1) Homelessness, 2) Out-of-Home Placement, and 3) Juvenile Justice/Involvement

Adult/Older Adult FSP

- a. Involuntary Treatment
- b. Adult or Juvenile Criminal Justice Involvement
- c. Out of Home Placements
- d. Isolation
- e. Homelessness
- f. Inability to Obtain Education and/or Employment
- g. Lack of Transportation

Community stakeholders identified the top three priority groups for the A/OA FSP, in order of importance, as: 1) Homelessness, 2), and 3) Out-of-Home Placement/Institutionalization

Prevention and Early Intervention Program (PEI)

MCBHS' PEI services have been reconfigured to comply with the new PEI regulations. The two new program configurations are the Prevention Program and the Early Intervention Program.

Prevention Program. The Prevention Program services focus on 1) reducing risk factors that contribute to the development of serious mental illness/serious emotional disturbance, and 2) building protective factors that promote holistic wellbeing. These are conceptually divided into Primary, Secondary and Tertiary prevention services.

Primary prevention includes universal, selective and indicated preventive interventions. Primary prevention seeks to reduce the incidents of serious mental illness and related disability. Secondary prevention is aimed at reducing the number of people that develop serious mental illness and related disability through early detection and treatment of diagnosable mental illness (prevention does not provided treatment services, but increases access to treatment service). Tertiary prevention works on reducing the consequence of developing a disability related to serious mental illness, enhance rehabilitation and prevent relapses and recurrences of mental illnesses.

Mental Health and Wellbeing Promotion is continually provided before Primary prevention through Tertiary prevention. Mental health promotion is provided across the spectrum of Prevention to increase the social and personal factors that contribute to mental health and wellbeing. Its intervention promote the mental wellbeing of those who are not at risk, those who are at increased risk, and those who are suffering or recovering from mental health problems (World Health Organization's report Prevention of Mental Disorders: Effective Interventions and Policy Options, 2004, paged 16-17).

The Prevention program will provide the following services Information Dissemination, Education, Problem Identification and Referral, Community Based Process, Alternatives, and Environmental.

- Information Dissemination includes the distribution of information (e.g. speaking engagements, brochure distribution, resource directories, public service announcements) regarding mental illness and mental health treatment services to general audiences such as health fairs and community events. This is a one way communication aimed at raising awareness and providing accurate information about mental illness and mental health service access.
- Education service provide two way communication and is aimed at increasing knowledge and skill development related to identifying individuals with mental illness in community settings (school class rooms, parenting classes, peer lead groups, and trainings), providing appropriate social support, access to community resources, and how to access to treatment when indicated.
- Problem Identification and Referral (Access and Linkage to Treatment) services facilitate access to mental health treatment services clinical intake assessment when it appears an individual is experiencing serious mental illness. PEI staff will facilitate the intake process and follow up to confirm the referred individual attended their assessment appointment as the first treatment service.

- Community-Based Process services include participating in community based collaborations with organizations that serve the same target population as mental health but provide other services to individuals that are at risk of developing mental illness or are currently experiencing serious mental illness (e.g. advisory boards, task forces, interagency collaborations, strategic planning, and neighborhood action groups). This process facilitates the development of mental health protective factors by increasing access to community resources.
- Alternatives are strategies that include settings that are designed to purposely reduce the risk of developing or exacerbation of mental illness symptoms and provide protective factors through skill and resource development (e.g. social, basic needs, vocational, educational).
- Environmental strategies seek to change focus on changing community standards and attitudes, and promoting personal safety in community settings (e.g. addressing NIMBY issues related to fair housing and safe neighborhoods).

The specialized programs under the Prevention Program are 1) Access and Linkage to Treatment Services, 2) Outreach for Increasing Recognition of Early Signs of Mental Illness, 3) Stigma and Discrimination Reduction, 4) Suicide Prevention, 5) Improving Timely Access to Mental Health Services for Individuals and/or Families from Underserved Populations.

1. Access and Linkage to Treatment Services (Problem Identification and Referral) are used when an individual (and when appropriate their family) comes in contact with PEI staff members, appears to be experiencing symptoms of serious mental illness, is not in treatment services, and appears that they would benefit from receiving treatment services.

The individual will be given the phone number to call to schedule an intake assessment and PEI staff will follow up with the individual and/or treatment staff to confirm the individual attended the assessment appointment. Upon request and when feasible, PEI staff will educate and assist the individual with assessment access.

2. Outreach for Increasing Recognition of Early Signs of Mental Illness services are specialized forms of Information Dissemination and Education and Education services listed above. However, these services help community members recognize and respond effectively to the needs of people that exhibit early signs of serious mental illness.
3. Stigma and Discrimination Reduction services are specialized Information Dissemination and Education services listed above. These services focus on reducing and eliminating the negative attributions associated with mental illness (such as criminalization and dangerousness), which are a barrier to accessing mental health services, housing, employment, education, positive peer influence, other basic needs and general social acceptance. This service helps to change the misperceptions of individuals with mental illness to reduce the risk and protective factors related to promoting wellbeing.

Examples of activities are: social marketing, speakers' bureaus, targeted education/training, anti-stigma advocacy, web-based campaigns, multiple stigmas (e.g. race, gender, age, regional). These programs will be culturally adapted when needed, facilitate access to treatment when appropriate, and be provided in non-stigmatizing and easily accessible sites.

4. Suicide Prevention services are specialized Information Dissemination and Education services listed above which are applicable to Promotion through Tertiary PEI services. Its focus is on reducing suicidality risk. Examples of activities include: public information campaigns (targeted at specific), suicide prevention networks, capacity building (e.g. Community-Based process interventions), cultural adaptations, peer informed models, screening programs, training/education, access and linkage to treatment and improving access to underserved communities.
5. Improve Timely Access to Mental Health Services for Individuals and/or Families from Underserved Populations are a specialized service of the Problem Identification and Referral (Access and Linkage Services) listed above. This service focuses on increasing access to appropriate mental health services as early in the onset as practicable, through program features such as accessibility, cultural and language appropriateness, transportation, family focus, hours available, and cost of services for an individual or family from an underserved population, as defined in Title 9 California Code of Regulations Section 3200.300, who need mental health services because of risk or presence of a mental illness. The services are provided in a cultural appropriate, easily accessible and non-stigmatizing and non-discriminatory site for the individual, and family when appropriate.

The specialized services under the Prevention Program will be tracked as subcategories of the five main categories of services.

Early Intervention Program. The Early Intervention Program will be the bridge into treatment services. It will include treatment, other interventions and relapse prevention to overcome mental illness related disability early in its emergence. If the person's mental illness has never been treated, treatment staff, in partnership with the client, will estimate the time between onset of the mental illness and access to outpatient mental health treatment. For individuals experiencing first onset of mental illness and do not have symptoms indicative of psychosis, treatment will be provided up to 18 months. For persons with symptoms indicative of psychosis the individual will be provided with up to 4 years of treatment. If it is determined that the individual required an extended time period, they will be transferred to the next level of care that is indicated.

Performance Outcomes: WIC § 5848 states that MHSA Plans and Plan Updates shall include reports on the achievement of performance outcomes for MHSA services. Below are the CSS service results (evaluations/performance outcomes) for FY 2013-14.

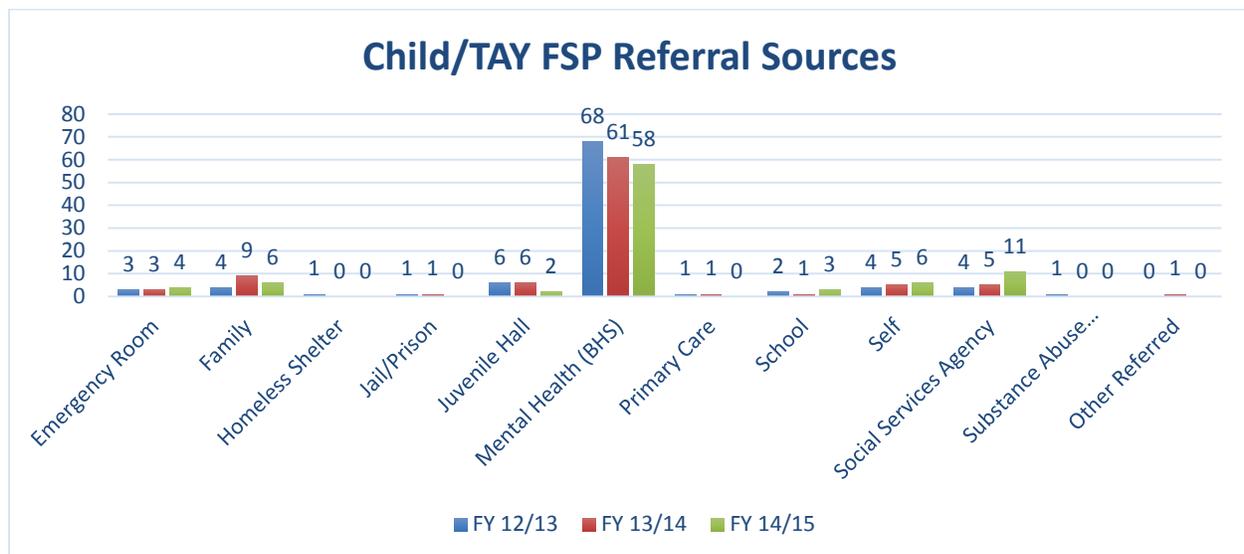
Full Service Partnerships

Below is a comparison of the information from FY 2012-13 and 2013-24. It is presented in charts and graphs to more easily see the trends for each.

Children/TAY Full Service Partnership

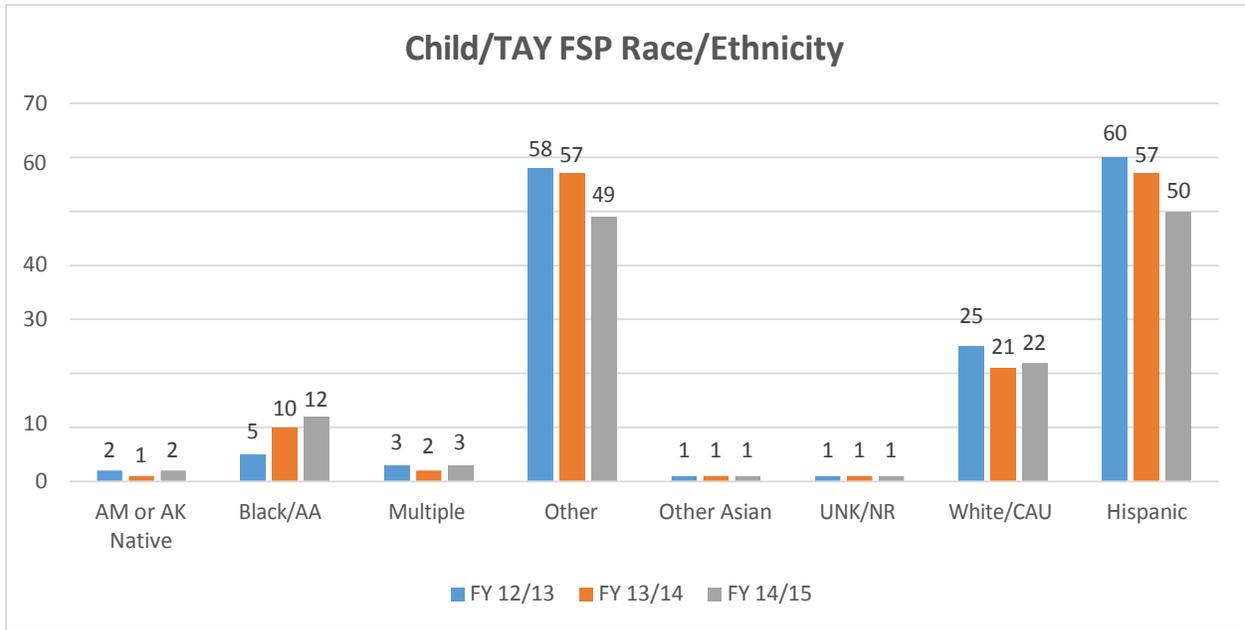
The majority of participants in FSP 1 for FY 2012-13, FY 2013-14 and FY 2014-15 were male: 55%, 61% and 62.2% respectively.

The graph below shows the referral sources for this program. While it appears that referrals are largely internal referrals from the outpatient clinic, referrals are often completed by MCBHS staff to expedite service access when the original source was actually an external to MCBHS.

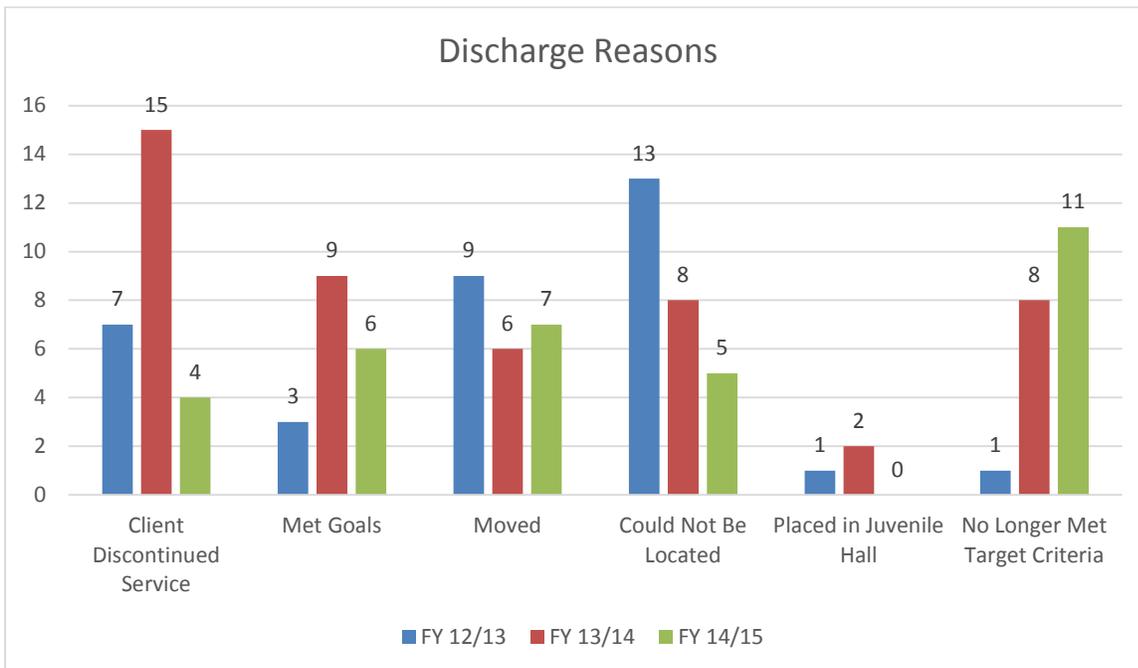


The three largest groups in FSP 1, by race/ethnicity, identified as Other, Hispanic and White. For FY 2012-13, 61% identified as Other, 63% as Hispanic and 26% as White. In FY 2013-14, 44% identified as Other, 61% as Hispanic, and 22% as White.

In FY 2014-15, 54.4% identified as other, 55.6% Hispanic, and 24.4% White. Because people are required to choose a race category before they can choose an ethnicity category, it is likely that those of Hispanic descent chose Other or White before choosing Hispanic. This is likely because, when the categories are counted together, they exceed 100% of the total participant count and the Other and Hispanic counts are almost identical.

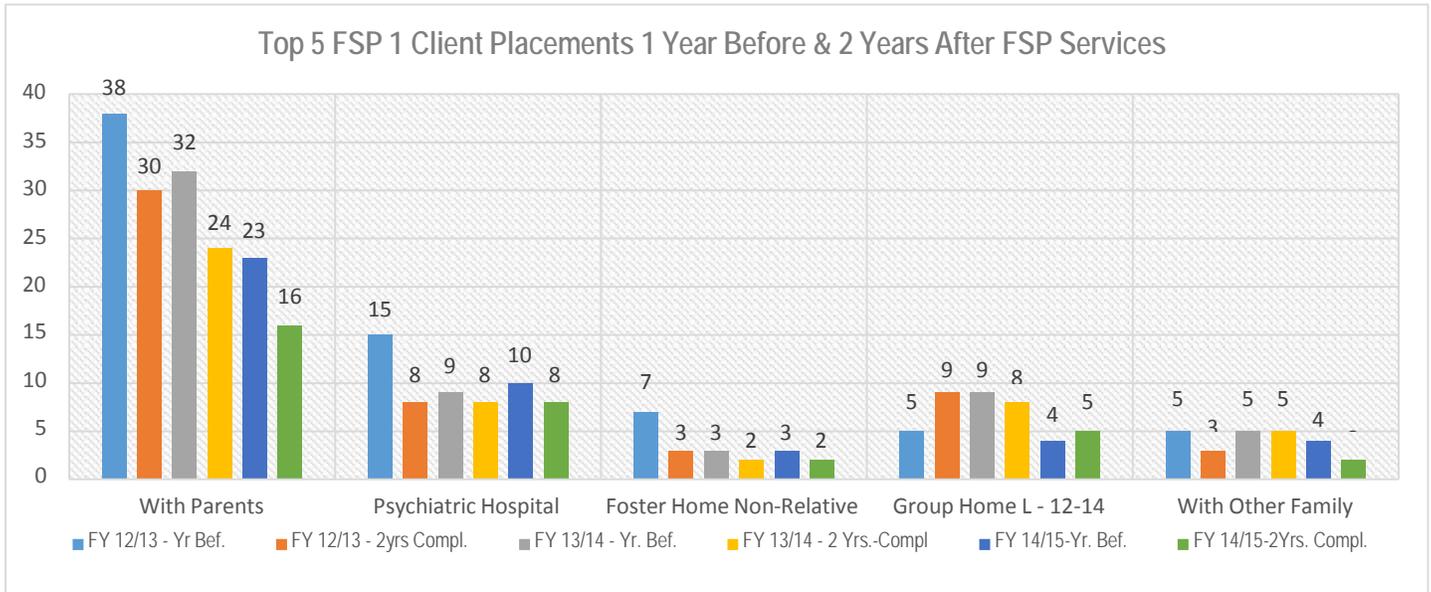


The frequency of the reasons clients were discharge from FSP 1 for FY 12/13, FY 13/14 and FY 14/15 are listed below.

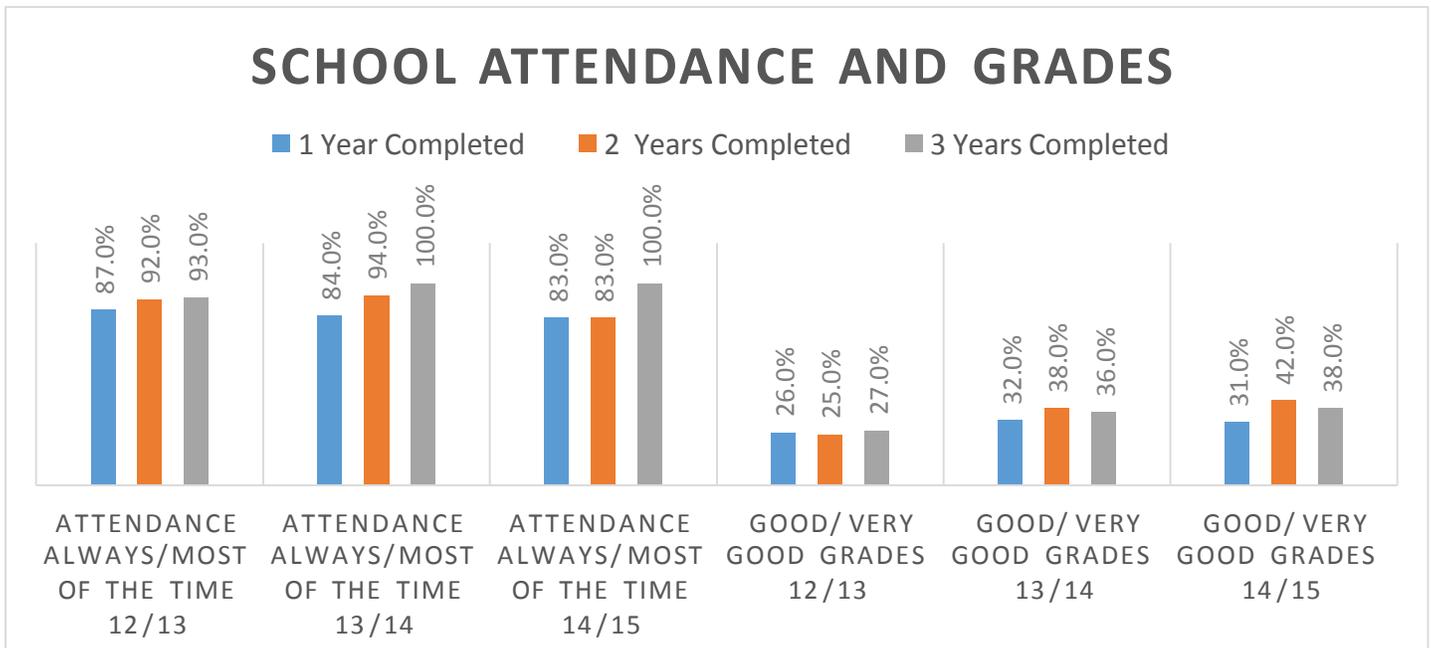


The charts below represents the five most frequency types of residential settings for clients of this FSP for the year before entering the FSP, and after attending two years of FSP services. During these fiscal years FY 12/13, FY 13/14 and FY 14/15 there was a significant increase in the number of referrals to the FSP for children and youth that were already placed in group homes. Less than half of the clients enrolled during the fiscal

years completed 2 years of FSP services. The rates of completion were FY 12/13 (47%), FY 13/14 (43%) and FY 14/15 (31%)



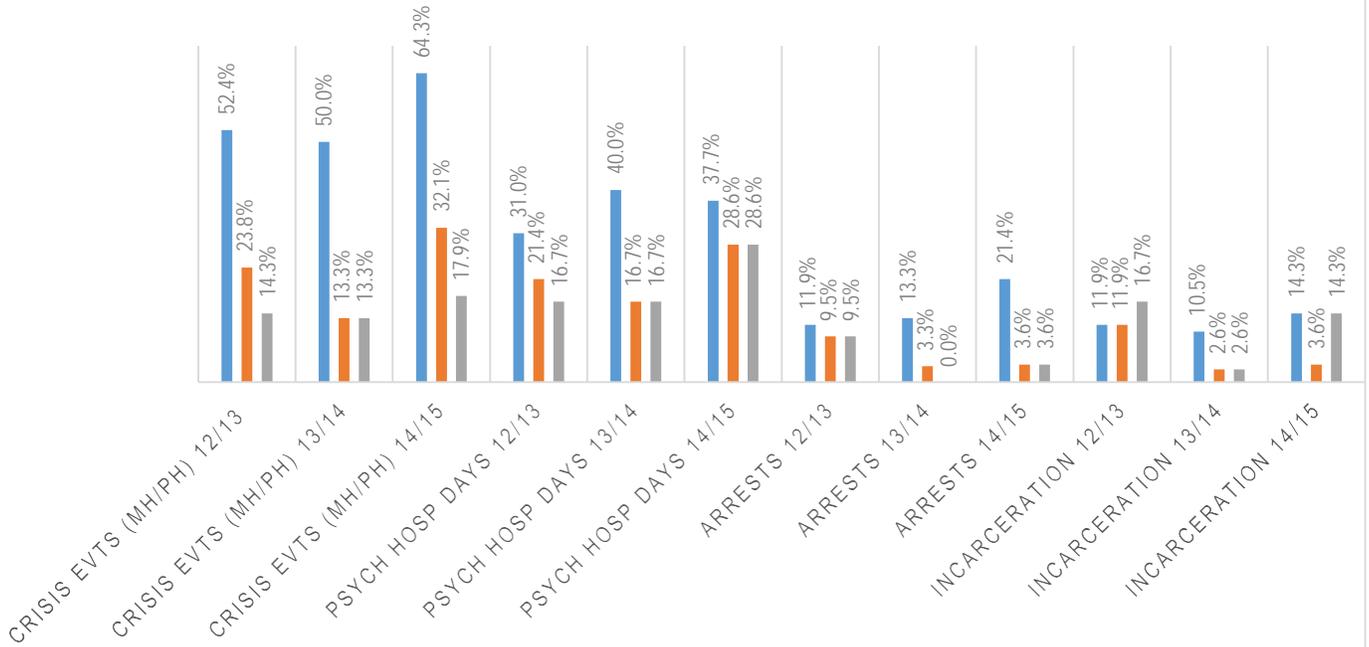
Children and youth that completed one to two years of FSP services increased their school attendance rate and grades.



After two years of FSP services, there were significant reductions in the rate of adverse experiences related to mental illness listed below.

CHILD/TAY FSP ADVERSE EXPERIENCES RATES

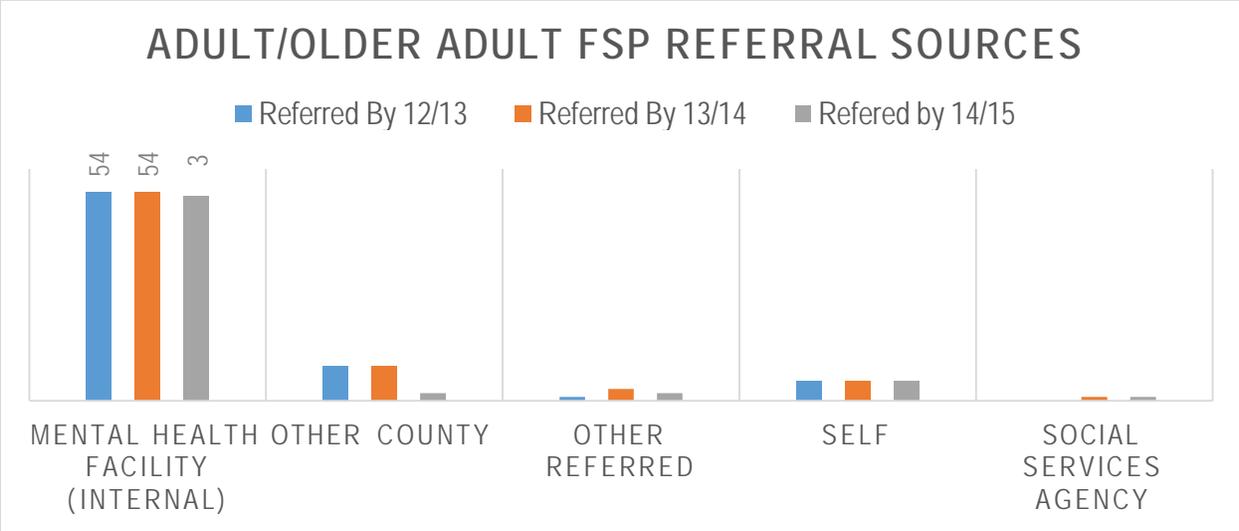
■ 1 Year Before ■ 1 Year Completed ■ 2 Years Completed



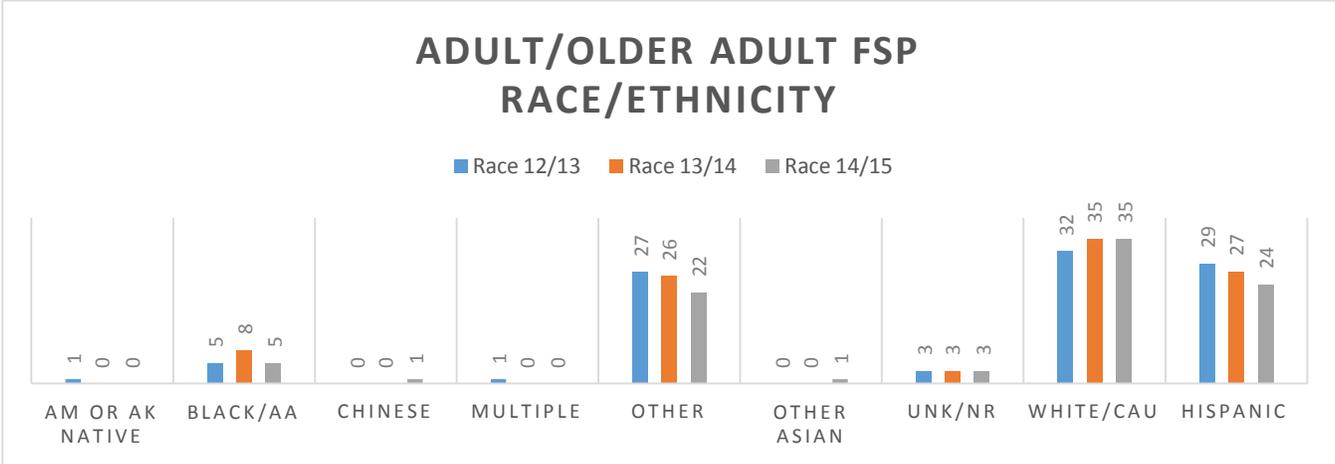
Adult/Older Adult Full Services Partnership

Overall, the majority of FSP participants were male: FY 12/13 (52% Male clients and 48% Female clients), in FY 13/14 (50% Male and 50% Female), and FY 14/15 (50.7% Male and 49.3% Female).

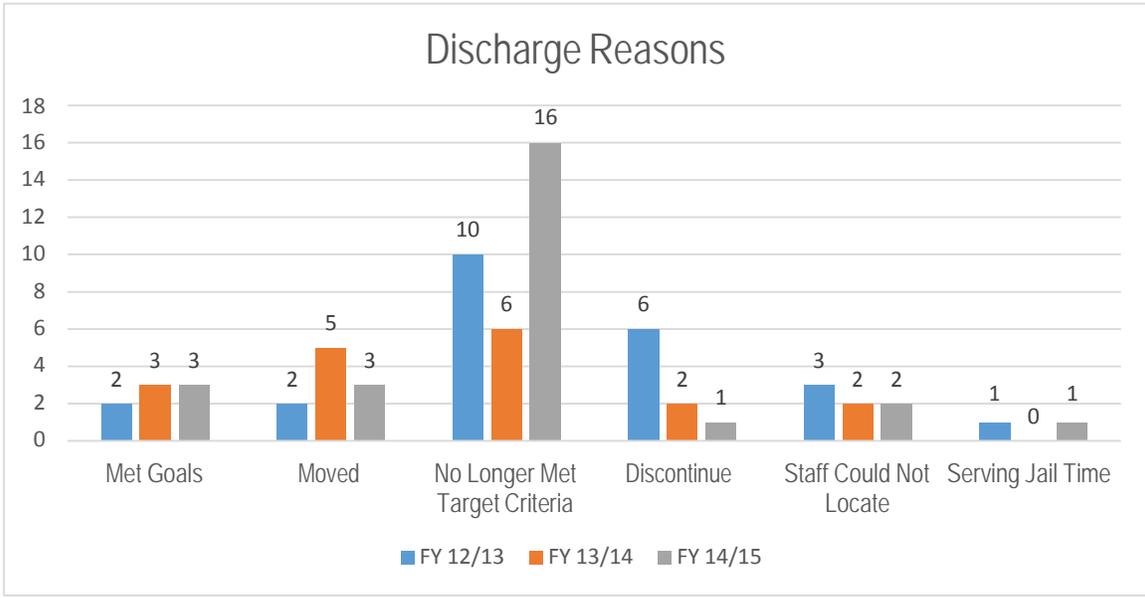
The graph on the following page shows the referral sources for this program. It appears the referrals are largely from the outpatient clinic. However MCBHS staff often complete the referrals forms to expedite service requests from organizations outside of MCBHS.



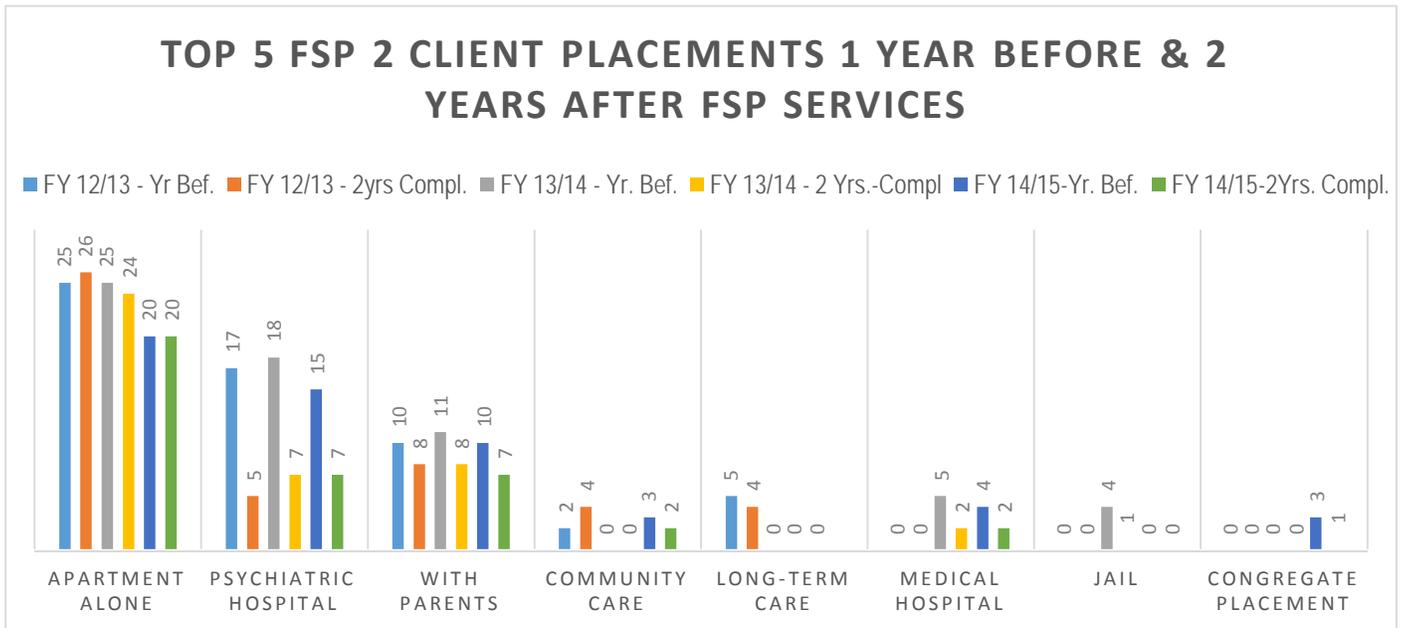
The three largest race/ethnicity groups in FSP 2 identified as White, Hispanic and Other. For FY 12/13, 46% identified as White, 42% as Hispanic and 39% as Other. In FY 13/14 49% identified as White, 38% as Hispanic, and 36% as Other. In FY 14/15 50.7% identified as White, 34.8% identified as Hispanic, and 31.9% identified as other. Clients are required to choose a Race category before choosing an Ethnicity category. Therefore the total amount of Race and Hispanic exceed 100% of the total FSP participants.



The chart below presents the reasons for discharge from the Adult/Older adult FSP for FY 12/13 – FY 14/15.



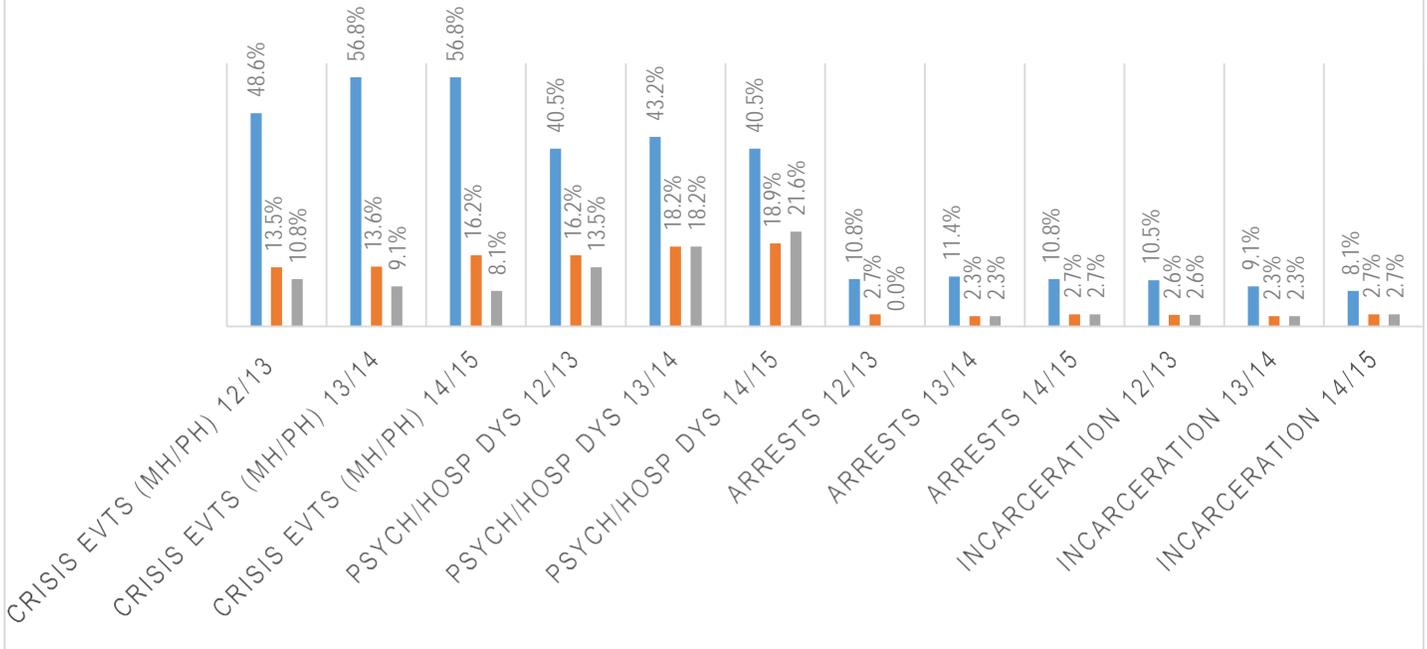
The charts below represents the five most frequent types of residential settings for clients served by this FSP for the year before entering the FSP, and after attending two years of FSP services during FY 12/13 - FY 14/15.



After two years of FSP services, there were significant reductions in the rate of adverse experiences related to mental illness listed below. Most adults are in FSP services for one to two years. The number of adults that attended FSP services for two years is lower than the number that attend for one year. The adults that attend for longer periods of time have higher needs than the adults that attend for shorter time periods.

ADULT/OLDER ADULT FSP ADVERSE EXPERIENCES RATES

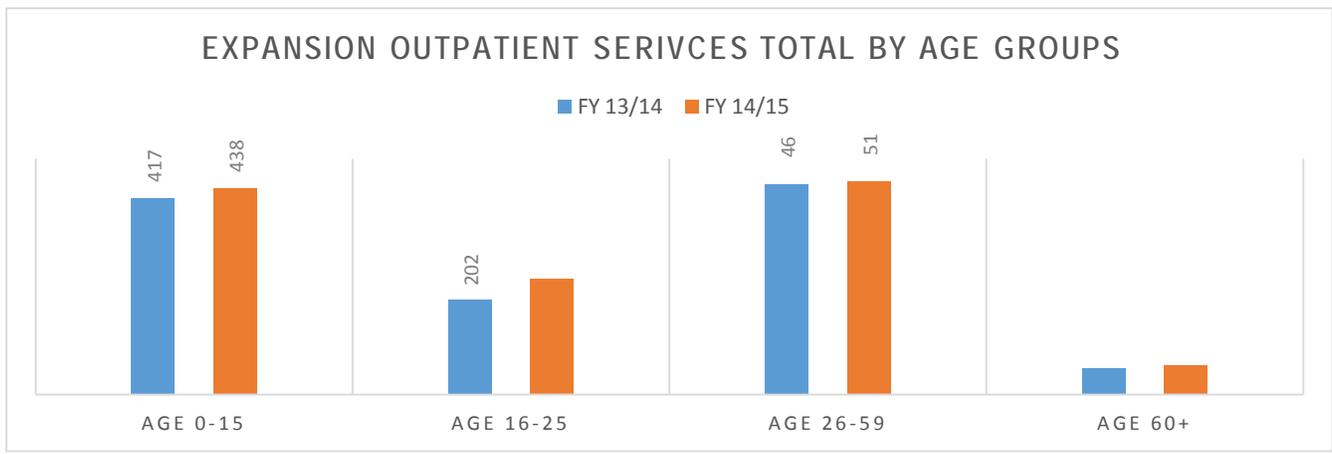
■ 1 Year Before ■ 1 Year Completed ■ 2 Years Completed



Expansion

EXPANSION OUTPATIENT SERVICES TOTAL BY AGE GROUPS

■ FY 13/14 ■ FY 14/15



During Fiscal Year (FY) 2013-14, Expansion provided outpatient services to 1672 people, which was an increase from FY 2012-13, and 1,195 people in FY 2014-15.

The following table is for FY 14-15 through FY 16-17.

Community Services & Support (CSS)	# Serve	FY 2014 -15	FY 2015 - 16	FY 2016 -17	Total Three Year Plan
Full Services Partnership FSP					
#1 FSP Children/TAY	68	1,246,390	1,333,638	1,426,993	4,007,021
#2 FSP Adult/Older Adult	85	1,557,426	1,666,446	1,783,097	5,006,969
System Development					
#3 SD Expansion	500	1,880,985	2,012,653	2,153,539	6,047,177
#4 SD Supportive Services & Structure	N/A	309,768	331,451	354,653	995,872
CSS Administration	N/A	553,352	592,086	633,532	1,778,970
Total CSS		5,547,920	5,936,274	6,351,814	17,836,008

Cost per Person

Based on the information above, the cost per person would be:

1FSP FY 14-15: \$18,329, FY 15-16: \$19,612, FY 16-17: \$20,985

#2 FSP FY 14-15: \$18,323, FY 15-16: \$19,605, FY 16-17: \$ 58,906

#3 SD FY 14-15: \$3,762, FY 15-16: \$ 4,025, FY 16-17: \$ 4,307

Prevention and Early Intervention (PEI)

Prevention and Early Intervention (PEI) programs designed to prevent mental illnesses from becoming severe and disabling. The standards for these programs are defined in WIC § 5840. The description below describes PEI programs and program components/activities including;

- The number of children, adults, and seniors to be served in each PEI program that provides direct services to individuals/groups.
- The cost per person for PEI (separated out by Prevention versus Early Intervention programming) that provides direct services to individuals/groups.

Madera County's PEI services provide education and outreach services to the community to;

- Assist community members in identifying people that may be in danger of developing serious mental illness that can lead to disability or
- Are in the early stages of experiencing mental illness.

The general approach is to build protective factors to promote mental health and reduce risk factors that contribute to developing mental illness. Madera County originally developed two programs with this goal in mind.

The first program is the **Community Outreach & Wellness Centers**, which has two “drop-in-centers” with the primary goal of providing outreach and education services for community members prevent the risk factors that contribute to the development of and disability related to mental health illness. This was accomplished by providing environments that purposefully reduce factors that compromise a person’s mental health and can lead to or exacerbate a person’s mental illness. In addition, it provides individuals with services to build mental health protective factors, such as access to resources that promote their independent living skills and social skills.

The second goal is the **Community and Family Education program** which builds community protective social factors. It does this through educating the community on how to recognize someone that is at risk of or is experiencing mental illness and how to support them to access behavioral health services if needed. This program offers training in specific educational curriculums to any member of the public including clients, client family members, and staff, such as Mental Health First Aid, ASIST, SafeTALK and evidenced based and culturally based parenting classes.

In FY 2013-14 Madera County Department of Behavioral Health Services initiated the development of outcomes for its MHSA funded prevention services, based on the models developed for substance use prevention services in the California Outcome Measurement System (CalOMS). These services do not include clinical treatment services such as therapy and medication services.

Using the Institute of Medicine’s model of interventions as a reference, these include services that fall in the areas of Promotion and Prevention including the categories of Universal, Selective and Indicated Prevention. Categories of services were created that could be counted across all prevention programs. These categories are listed below were:

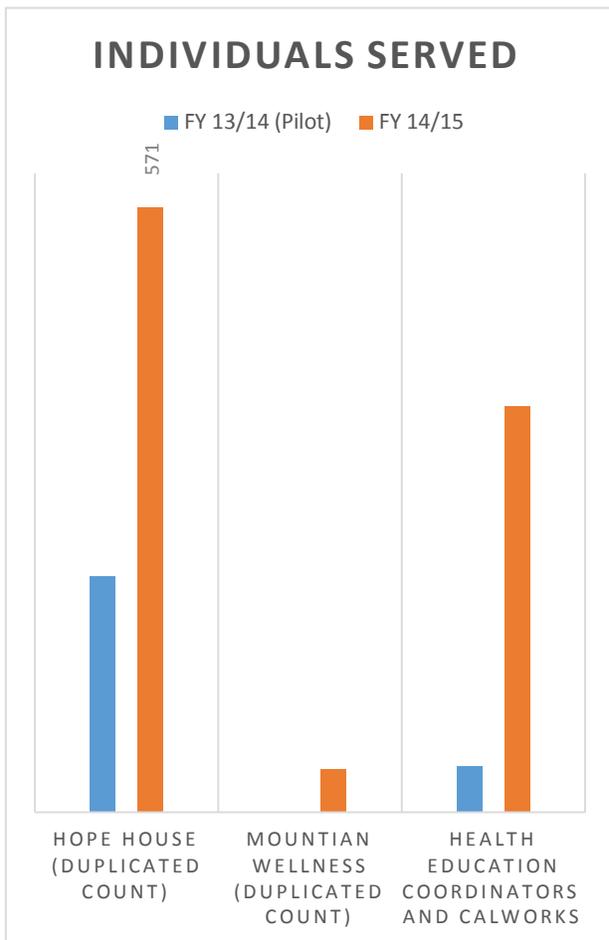
- Information Dissemination,
- Education,
- Problem Identification and Referral,
- Community Based Process,
- Alternatives, and
- Environmental.

The first two categories have to do with exchanging information to promote people’s mental health. Problem Identification and Referral services occur when staff encounter a person that may have serious mental illness symptoms and who staff refer for a clinical assessment for treatment. Community Based Process and Environment services attempt to change the social environment in communities to promote mental health and reduce risk of mental illness development or exacerbation. Alternative interventions have to do with purposefully creating a particular activity or venue that has reduced mental illness risk factors and promote mental health protective factors. This service model is still in development.

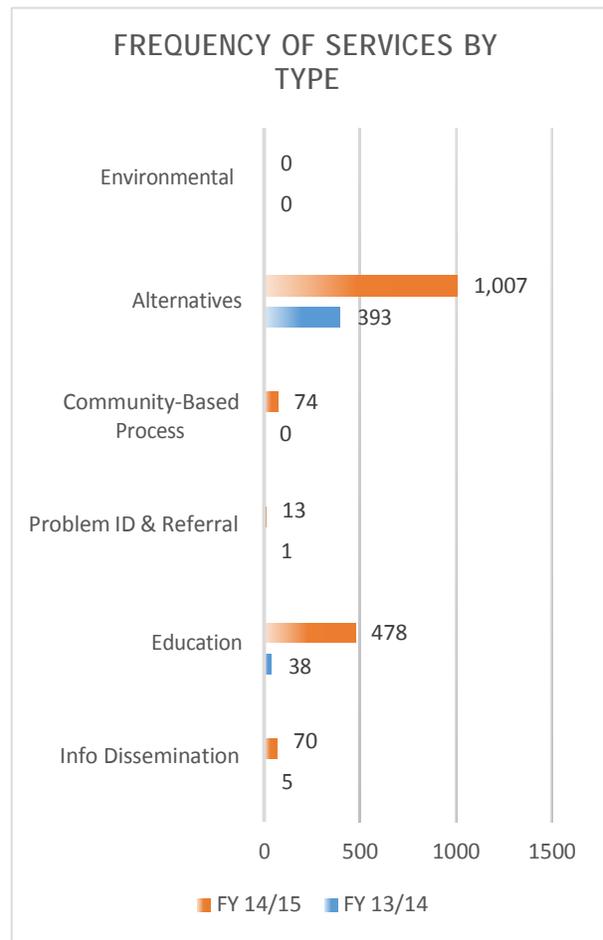
For FY 2013-14 and FY 2014-15, the Hope House, Mountain Wellness Center, the Health Education Coordinators and CalWORKs staff generated data for the fiscal year. While the preliminary information and data collection methodology are still being refined, the overall data patterns reveal important information. For example, the data identified that the percentage of Hispanic/Latino participants attending PEI services is more than double the White/Caucasian participants. Below are the initial services outcomes.

In addition, to what was reported last year, the report will report the programs activities using the new PEI regulation categories

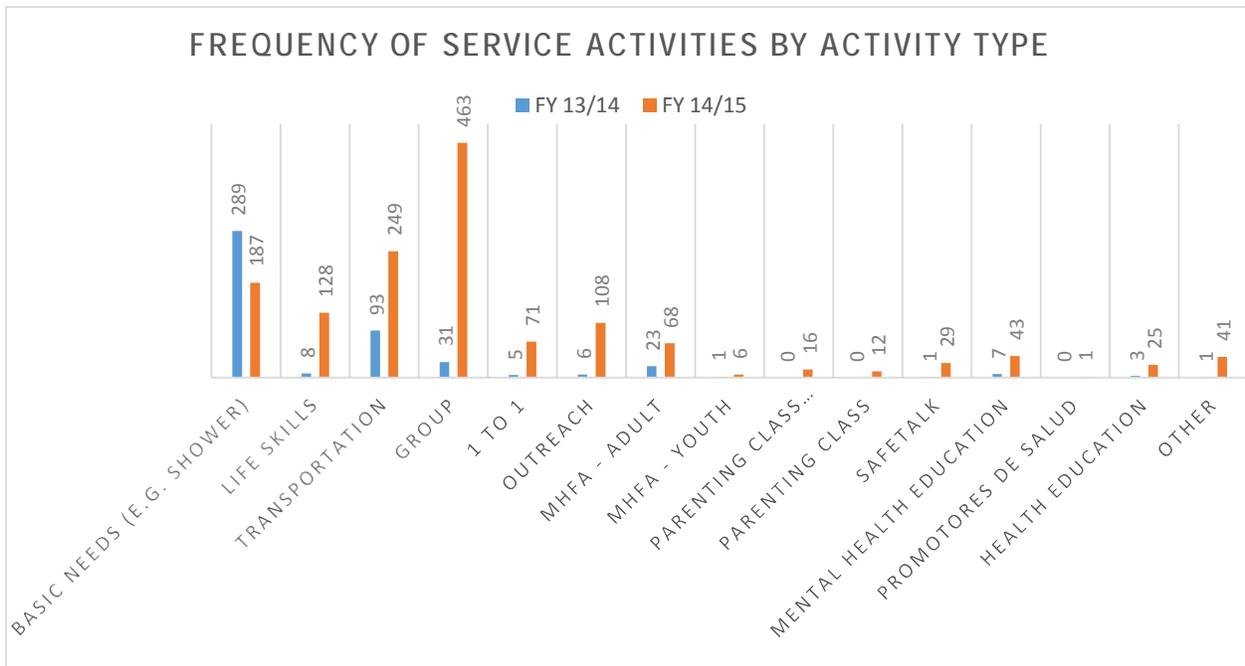
Performance Outcomes: WIC § 5848 states that Plans shall include reports on the achievement of performance outcomes for MHSa services. Below are some of the outcomes (evaluations or performance) for the PEI programs separated out by Prevention versus Early Intervention (when possible) for FY 2013-14 and FY 2014-15. This is a duplicated count, as MCBHS is still working on developing an unduplicated count.



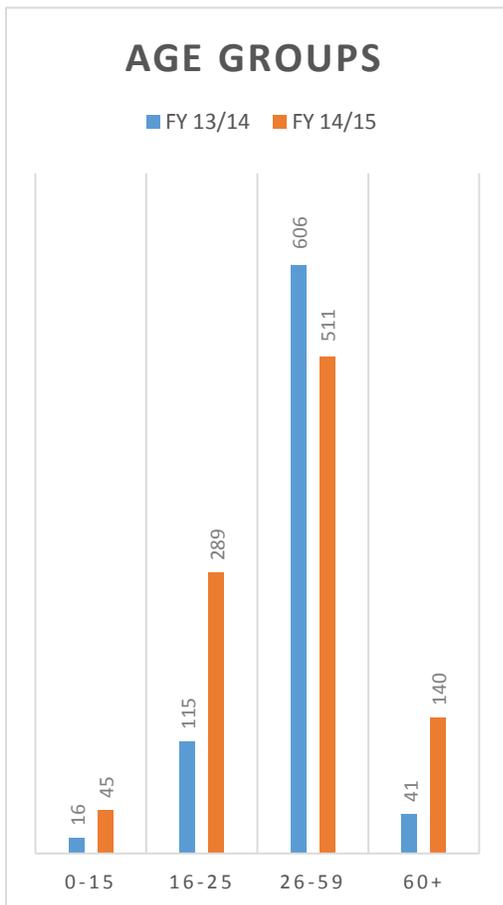
Total People: FY 13/14 = 3,530 and FY 14/15 = 13,194



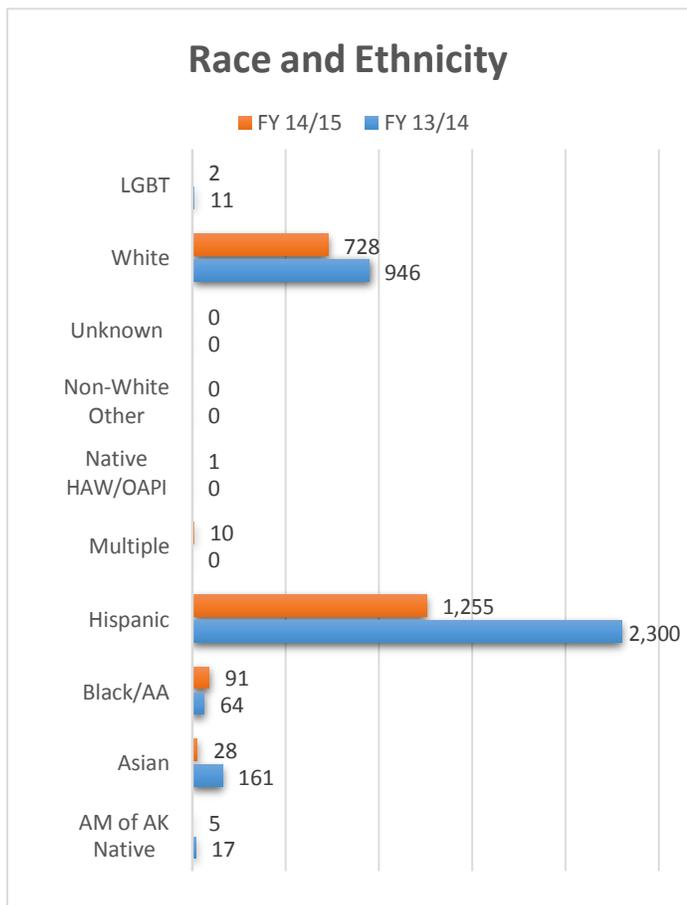
Total People: FY 13/14 = 431 and FY 14/15 = 1,642



Total Services: FY 13/14 = 468 & FY 14/15 = 1,447



FY 13/14 = 778 and FY 14/15 = 985



FY 13/14 = 3,499 and FY 14/15 = 2,120

Hope House had 2,946 visits in FY 13/14, which included 2,733 members, 64 county employees and 149 public visitors. Their average daily attendance was 33. In FY 14/15 Hope House had 9,777 visits, which included 9,258 member visits, 176 county employees, and 343 public visitors. The average monthly attendance was 815. These numbers include duplicated counts because participants can attend more than one service in a day and more than once a month. Members of Hope House are all clients.

Mountain Wellness Center had 1,633 visits in FY 13/14 and their average *monthly* attendance was 136 visits. In FY 14/15 in had 339 monthly visits with 29 people. Members of Mountain Wellness Center are all clients.

Mental Health Educator conducted Outreach for Increasing Recognition of Early Signs of Mental Illness, which is listed in the table below. The following tables will present services for Stigma Reduction, Suicide Prevention, Access and Linkage to Treatment, and Improving Access for Underserved Groups and Access.

Outreach for Increasing Recognition of Early Signs of Mental Illness (Potential Responders)			
FY 13/14		FY 14/15	
Total Individuals Served = 982		Total Individuals Served = 1,641	
Individuals	Event	Individuals	Event
120	Camarena Health – Health Fair	52	Parenting Class
30	Community Unity Fair	3	CalWORKs
35	Farmers Market	24	Community Agencies
15	Farmworker Housing	127	Camarena FOHC Health Fairs
34	Health Education	155	Court House Park Event
30	Mental Health Care	77	First 5
9	Community Hospital	200	Griffin Hall (Homeless)
300	High School Health Fair	78	Hope House Wellness Center
16	Pioneer Tech School	60	Lincoln Elementary School
21	Shunammite Supportive Housing	25	Lowe’s Employee Health Fair
24	Workforce Connection	130	Madera Community College
6	CalWORKs	30	Madera Community Hospital
17	Community Agency	9	After School Program Staff
15	First 5	9	Tribal TANF
100	Sierra Vista Elementary School	47	Community Wellness Groups
50	Tribal TANF	200	County Office of Ed. Parenting Youth
100	Trinity Lutheran Church	23	Public Health – Parenting Class
20	Veterans Health Fair	145	Pioneer Tech School
10	Homeless in the Park	90	Welfare to Work - DSS
25	CalVIVA Promotoras	6	Trinity Church Youth Group
		100	Trinity Church Health Fair
		50	Veterans Events

The current Suicide and Stigma Reduction services consist of the evidence based training and education lasted below. All of this occurred outside of the MCBHS.

Suicide and Stigma Reduction Activities (Potential Responders)			
FY 13/14		FY 14/15	
Total Individuals Served = 142		Total Individuals Served = 278	
safeTALK	50	safeTALK	85
ASIST	15	ASIST	21
Mental Health First Aid	77	Mental Health First Aid	149
Mental Health 5150	0	Mental Health 5150	23

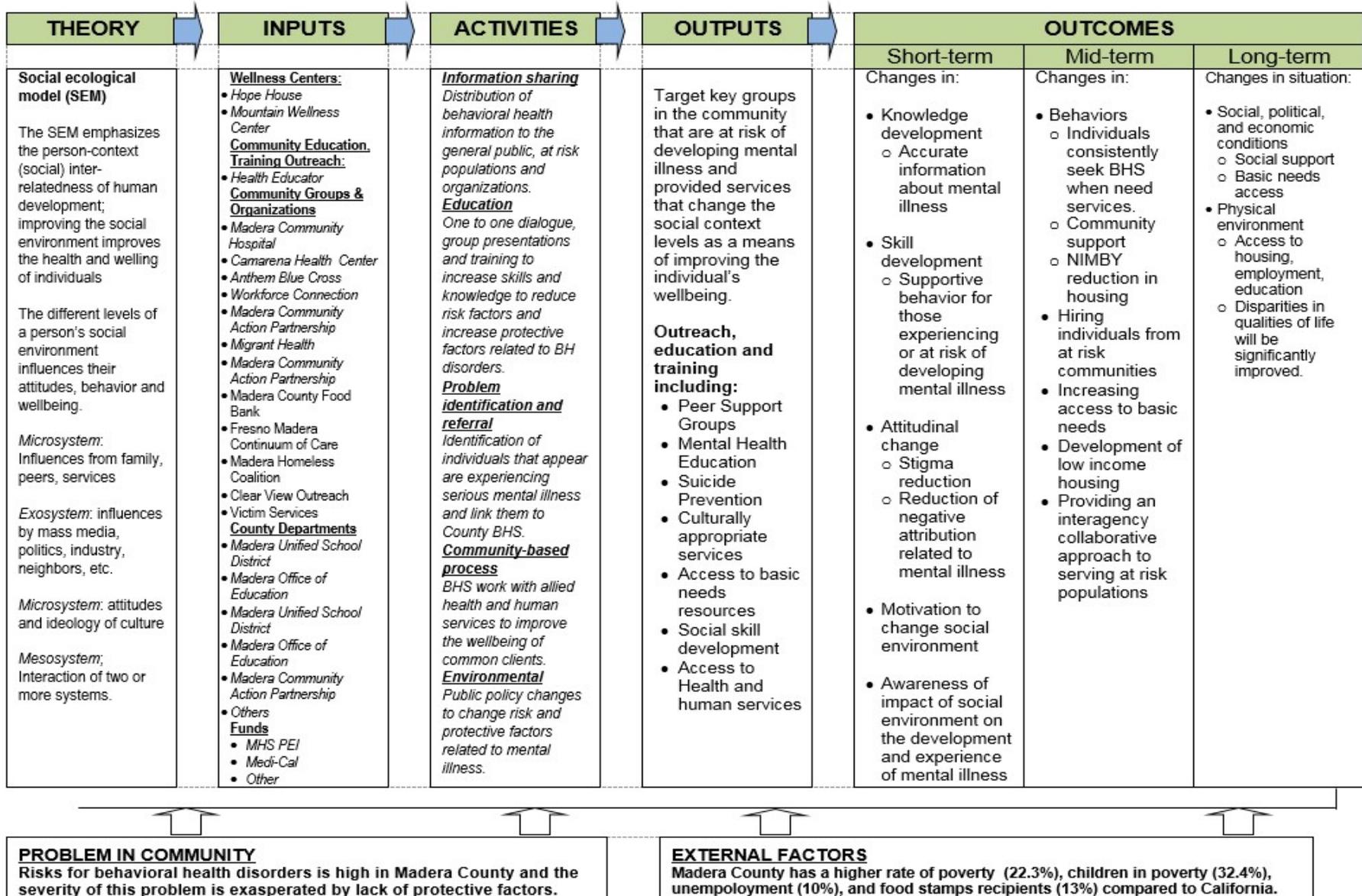
Access and Linkage and Brokerage to Treatment (ALT) services is initiated at community settings/organizations, and county departments. The system of tracking ALT, including the linked to services confirming first attended appointment and measuring average duration of untreated mental illness and average time between and treat are being developed.

Access and Linkage to Treatment (Outpatient Mental Health Services)			
FY 13/14		FY 14/15	
Individuals	30	Individuals	48

MCBHS' outreach and education services in community setting are the primary way of improving timely access to treatment by underserved populations.

Improving Timely Access to Mental Health Services for Individuals and/or Families from Underserved Populations			
FY 13/14		FY 14/15	
Total Individuals Served =		Total Individuals Served = 1,641	
Individuals	Event	Individuals	Event
120	Camarena Health – Health Fair	3	CalWORKs
15	First 5	127	Camarena FQHC Health Fairs
35	Farmers Market	155	Court House Park Event
15	Farmworker Housing	77	First 5
300	High School Health Fair	200	Griffin Hall (Homeless)
16	Pioneer Tech School	60	Lincoln Elementary School
21	Shunammite Supportive Housing	25	Lowe's Employee Health Fair
6	CalWORKs	30	Madera Community Hospital
17	Community Agency	9	After School Program Staff
15	First 5	9	Tribal TANF
50	Tribal TANF	200	County Office of Ed. Parenting Youth
20	Veterans Health Fair	23	Public Health – Parenting Class
10	Homeless in the Park	145	Pioneer Tech School
25	CalVIVA Promotoras	90	Welfare to Work - DSS
		6	Trinity Church Youth Group
		50	Veterans Events

Madera County Behavioral Health Prevention and Early intervention LOGIC MODEL



Funding Estimate and Request

	# Serve	FY 2014 - 15	FY 2015 - 16	FY 2016 - 17	Total Three Year Plan
Prevention & Early Intervention (PEI)					
#1 PEI Community Outreach & Wellness Center	155	585,431	602,994	621,084	1,809,509
#2 PEI Community and Family Education	100	421,083	450,559	482,098	1,353,740
PEI Administration		44,890	48,032	51,394	144,316
Total Prevention & Early Intervention (PEI)		1,051,404	1,101,585	1,154,576	3,307,565

Cost Per Person

The estimated cost person would be

#1 PEI: FY 14-15 \$3,777, FY 15-16 \$ 3,890 FY 16-17

#2 PEI: FY 14-15 \$4,211, FY 15-16 \$4,506, FY 16-17 \$4,821

Innovation (INN)

In accordance with WIC § 5830 Counties may expend Innovation (INN) funds for time limited projects upon approval by the Mental Health Services Oversight and Accountability Commission (MHSOAC). These funds are for new or changed services. The MHSOAC determines if these projects meet statutory requirements for this category of service. If INN projects prove to be successful, the county may choose to continue it by transitioning the project to another category of funding as appropriate. The main goal of an INN project is to improve mental health services delivery by increasing staff knowledge and learning rather than simply providing new services. The INN program does not fund ongoing services, but are used to pilot or test new service approaches.

The primary purpose of this project is to **Promote Interagency and Community Collaboration Related to Mental Health Services, Supports or Outcomes**. Madera County Behavioral Health Services (MCBHS) INN project is named the Perinatal Mental Health Integration Project (PMHIP), which was named Nurture2Nurture Madera. This project was contracted with the California Health Collaborative to implement this service and evaluation. Within the first year, the stakeholders named the coalition group the Maternal Wellness Coalition. The services that will operationalize the interagency collaboration process is a perinatal program focusing on mother's that are at risk of developing a serious mental illness or in the early stages of developing a mental illness, especially Perinatal Mood and Anxiety Disorder (PMAD), which is specific to pregnancy. The following statistics were generate by contracted organization. PMAD is the most frequent health complication of pregnancy and thought to effect as many as 70% of childbearing women. Madera County's PMAD prevalence is as high as 20%, which is three times the national rate among low-income women. The US Census indicates the

following significant risk factors in Madera County: high teen births rates by Latinas 51.8% in Madera, as compared to 34.9% in California, and by Whites 17.2% in Madera, as compared to 9.2% in California. Madera has a high county poverty rate (19.5%), and the county need for mental health services ranks third among California counties. Therefore, the collaborative approach to providing services for this population was chosen to facilitate access to services from multiple resources. The evidence based model of measuring and improving service integration and access is the Pathways Model. This model is promoted by the federal Agency of Healthcare Research and Quality. The model has been implemented in multiple states, rural to urban areas, and for many underserved or inappropriately serviced populations with success.

Performance Outcomes: WIC § 5848 states that Plans shall include reports on the achievement of performance outcomes for MHSA services. Please include the results of any evaluations or performance outcomes the county has for INN programs. Please specify the time period these performance outcomes cover.

During FY 14-15 the Nurture2Nutrue Madera (N2N-M) (information provided by contractor)

Engaging the Community

- Conducted 16 outreach events, in addition to informal meetings
- County-wide providers were identified and contacted
- Conducted an awareness and promotion campaign for the project
- Initial coalition leaders were convened
- Baseline collaborative strength of the coalition was assessed, using a standardized instrument
- Primary care and behavioral health linkages were initiated

Training and Education

- A total of 9 medical provider trainings and workshops were provided, in addition to other trainings, workshops and informal training sessions
- Approximately 26 trainings and workshops were provided to non-medical personnel
- 90 Pre and 85 Post-training participants demonstrated an overall 23.4% net gain in PMAD understanding following the training
- 97% of trainees report to “Agree” or “Strongly Agree” that they had a better understanding of PMAD following the training.

PMAD Awareness (Key Informant Interviews)

- Information campaign consisted of billboards, bilingual radio and television advertisements, and pamphlet distribution

- 304 Awareness Survey responses for benchmark Madera County data that indicated that PMAD understanding was relatively weak
- Post-information campaign showed increase in awareness of PMAD and a significant increase in awareness of the INN project N2N-M.

System-Level Change

Key Informant Interviews indicated that the system of care for PMAD was weak. Indicators that system change was occurring were leadership and providers behavior changes, growing PMAD awareness, increased capacity of services, and the strengthening coalition.

PMAD Services

- 90 consumers suffering with PMAD were referred to N2N
- 25 participants attended regular weekly support groups, with an average group size of 8 per week
- 144 mothers from Madera community were referred to PMHIP/N2N-M, with 10 mother receiving direct N2N support
- 40 mothers received follow-up calls after giving birth at Madera Community Hospital

Information on Collaborative Development

As presented in the California Health Collaborative first year report, the instruments for measuring change include a Training Assessment, Participant Satisfaction, Stakeholder Satisfaction, Collaborative Strength, PMAD Awareness, Client Satisfaction, and Semi-Structured Key Informant Interview. Because the emphasis is on promoting interagency and community collaboration related to mental illness service and supports and outcomes, this annual update will focus on the Collaborative Strength outcomes. However, the entire report is available upon request.

The Collaborative Assessment tool allows for collaboration strengths and weaknesses to be determined, and it identifies changes that might be needed throughout the project. The assessment instrument used in this evaluation measures collaboration on six dimensions: Environment, Communication, Member Characteristics, Purpose, Resources Available and Collaborative Process. It is a modification of the 40-item Wilder Survey of Collaboration, and is scored on a 1-5 Likert-type scale (1= Strongly Disagree, 5 = Strongly Agree). Our original modification of the Wilder Survey consisted of 33 questions. After the composite scores were calculated within subscales to form reliable and valid measures of the constructs, our final survey consisted of the original six dimensions and 28 items. Cronbach's alpha was used as a reliability measure in this evaluation (California Health Collaborative and Research Evaluation Specialists, Madera County Perinatal Mental Health Integration Project: 2014-2015, 2016, p. 19).

The literature suggests that there are five components of successful partnerships: communication, a shared vision/mission, resources, power sharing, and synergy. These components have been accounted for with the Collaborative Strength Survey, preliminary results of which showed weakness in the dimensions of “Member Characteristics,” “Collaborative Environment” and “Collaborative Process.” Indeed, most respondents (80%) did not support specific statements like: “People involved in this collaboration always trust one another” and “I have a lot of respect for the other people involved in this collaborative work.” Both statements fall under the dimension “Member Characteristics,” and give a sense of coalition members’ attitudes about the group’s constituents. These particular statements are also thought to predict the group’s synergy. PMHIP leaders have taken several, swift measures to strengthen the collaborative group since these preliminary findings.

The first activity was to strengthen group “buy-in” by having members, take ownership of, and rename the group, now known as the “Maternal Wellness Coalition.” Coalition members’ duties were further clarified by a collaborative drafting of the Maternal Wellness Coalition’s by-laws.

The next effort was to have the coalition members develop “Pathways Models” 16 for each respective organization. More specifically, each member defined his/her organization’s “pathway” of action steps to be implemented to connect at-risk mothers to services and to the Nurture2Nurture system of care. To date, maps have been developed for 12 members and respective organizations.

A secondary function of the “Pathways Model” was to facilitate a system change in Madera County so that a general model could be provided for smooth integration of programs and organizations, resulting in increased service efficiency and quality, and reduced duplicated services (California Health Collaborative and Research Evaluation Specialists, Madera County Perinatal Mental Health Integration Project: 2014-2015, 2016, p. 26).

To summarize the overall findings, the year-end Collaborative Strength data did not differ greatly from the preliminary findings, and this was likely due to the inclusion of the preliminary data with the overall data. This should be underscored because some data points are from members who no longer participate in the Maternal Wellness Coalition, and they could not be aware of the significant strides following the initial launch of the project. Nonetheless, the overall picture is that varying degrees of support exist for each dimension, with “Collaborative Process” being most weakly supported.

Many of the participants believe that the members of the collaborative group want this project to succeed; however, they (a) do not have a clear sense of their roles and responsibilities, (b) do not perceive a willingness to discuss different options, (c) do not perceive strong commitment to PMHIP by coalition members, (d) believe

there are insufficient funds and manpower, and I believe PMHIP would benefit by the recruitment of additional, important stakeholders from the community (California Health Collaborative and Research Evaluation Specialists, Madera County Perinatal Mental Health Integration Project: 2014-2015, 2016, p. 33-34).

Awareness of the N2N-M Survey Benchmark Results

A total of 304 respondents answered the survey, with a majority of them being female (89%, n = 264) and 30 male (11%) (10 respondents did not state). Average age of the respondents was 32.8 years (SD = 11.38). Most of the respondents identified themselves as Hispanic/Latino (73%, n = 215), followed by White (19%, n = 56), African American (3%, n = 9), Asian/Pacific Islander (2%, n = 6), Native American (0.7%, n = 2), and other (1.0%, n = 4) (California Health Collaborative and Research Evaluation Specialists, Madera County Perinatal Mental Health Integration Project: 2014-2015, 2016, p. 41).

When asked “Have you heard of the phrase postpartum depression?,” a pattern of responses differed as a function of participants’ (a) race/ethnicity, χ^2 (N = 289, df = 4) = 15.37, p = .004 (Figure 18), (b) language spoken, χ^2 (N = 274, df = 2) = 12.0, p = .002 (Figure 19), and (c) residential area, χ^2 (N = 220, df = 4) = 9.62, p = .047 (Figure 20). Although most of the participants in three race/ethnicity groups responded that they had heard of the phrase “postpartum depression,” there were more Hispanic/Latino participants who responded that they had not heard of the phrase or did not know the phrase (California Health Collaborative and Research Evaluation Specialists, Madera County Perinatal Mental Health Integration Project: 2014-2015, 2016, p. 43).

A pattern of responses to the question “How long do you think the baby blues last after the birth of a baby” differed as a function of participants’ (a) race/ethnicity, χ^2 (N = 280, df = 12) = 35.32, p = .000 (Figure 21), and (b) language spoken, χ^2 (N = 265, df = 6) = 18.84, p = .004 (Figure 22) (California Health Collaborative and Research Evaluation Specialists, Madera County Perinatal Mental Health Integration Project: 2014-2015, 2016, p. 44).

...more Whites and people of the combined other races (i.e., Asian, African American, Native American, and other) answered “5 weeks or longer” than Hispanic/Latino participants, but more Hispanic/Latino participants selected the “do not know” response, compared to Whites and those of other racial/ethnic groups. It should be noted that the correct answer to this question is “about 2 weeks,” thus, many of participants did not answer this item correctly (California Health Collaborative and Research Evaluation Specialists, Madera County Perinatal Mental Health Integration Project: 2014-2015, 2016, p. 45).

Above is the initial information on the INN project development. The project has progressed significantly and one sign of this that all of the member organizations has created a Pathway binder, which provides information regarding the steps to access their

services, the services they provide, and the eligibility information needed when accessing the service.

Funding Estimate and Request

The Madera County MHSA budget includes \$202,105 for Innovation work plans.

Innovation (INN)	# Serve	FY 2014-15	FY 2015-16	FY 2015-17	Total Three Year Plan
#1 INN Perinatal MH Integration Project (PMHIP)		184,904	177,064	177,305	539,273
Operational Reserved		3,949	10,074	10,477	24,500
INN Administration		27,147	29,047	31,080	87,274
Total Innovation (INN)		216,000	216,185	218,862	651,047

Cost per Person

The estimated cost per person for the Perinatal Mental Health Integration Project is \$574 for an estimated 322 people.

Prudent Reserve

Per Information Notice No: 09-16, Madera County has continued to maintain a MHSA prudent reserve at the 50% threshold. The estimated Local Prudent Reserve Balance on June 30, 2014 was 2,761,567 and the estimated Local Prudent Reserve Balance on June 30, 2017 is 2,930,597

ONE TIME FUNDING

Workforce Education and Training (WET)

As of January 16, 2015, the MCDBH had 126 people working for the Department. Race/Ethnicity breakdown is in the table below. For this update we looked at the past three years to see progress on achieving goals related to increasing the number of individuals of Hispanic decent and individuals that are Spanish speaking. See the chart below.

BHS Staffing Race/Ethnicity			
	2015	2014	2013
White	43	50	47
Hispanic	65	55	47
African American	7	10	6
Asian	3	3	3
Other	8	9	6

Staffing Data	
Needs	Improvements (2013 – 2015)
<ul style="list-style-type: none"> • Psychiatrist (especially certified specialties) • Registered Nurses • LCSW/LMFT Therapists • ASW/MFT (Pre-licensed) • Certified AOD Counselor • Hispanic/Spanish Speaking Direct Service Providers 	<ul style="list-style-type: none"> • 10% Increase in Hispanic Clinicians 45% - 55% • 50% Increase in Spanish Speaking Staff 22% - 44% • 23% Increase in Hispanic Peer Support Staff 33% - 56% • 9% Increase in Overall Hispanic Employees • 12% Increase in Overall Spanish Speaking Employees

According to the US Census, persons of Hispanic/Latino descent in Madera County is 55.7% and White (alone) was 36.4%. Given this very general percentage comparison, MCBHS has made some advancement in the number of Hispanic clinicians and peer support. MCBHS' primary workforce diversity needs are staff members that are of Hispanic/Latino descent, especially in the professional level categories of direct services practitioners. Persons of African American, Native American, Mixteco, Farsi descent are also needed.

The top mental/behavioral health workforce language proficiency needed for MCBHS is Spanish. The department also has significant need for persons that speak Mixteco, Hmong, Farsi or Sign Language.

More financial incentive programs, such as stipends and loan assumptions, for a broader range of staff would encourage individuals to work for county mental health. This would be true for our high need areas listed above.

The Medi-Cal population in Madera County in 2014 was 44,833. Approximately, 8.94% (4,008 people) of the population in the county likely has a serious mental illness. MCBHS served 3,278 in treatment services during FY 2013-14. MCBHS would benefit from a 4% overall increase in staffing (and funding) to meet the demand for services to meet its target population. However, there has not been an increase in funding to meet the demand.

The staff positions mentioned in the chart above continue to be hard to fill. MCBHS has had success with using tele-psychiatry to help meet the needs for psychiatrists. There is a great need for cultural competency training that provides information which can be immediately implemented and is not limited to ethnic and consumer culture. Succession planning is important as "Baby Boomers" retire and there are fewer individuals in the workforce with the specialized training/education to replace them. Leadership, management and organization development training is greatly needed to help the Department adapt to the tremendous scope and rate of change that is presently occurring.

Fiscal year 2012-13 was the last year of operations for WET projects. The programs were **#1 WET Workforce Staffing Support**: this program focused on developing the community's knowledge of mental health issues and helped community members to access appropriate mental health services. WET funds were used to help transform the mental health system through education and training staff and community members through Mental Health First Aid training, parenting training, suicide prevention trainings, etc. Remaining one time funds were depleted in FY 2012-13.

Project **#2 WET Training, Specialty Skill / Practice Development & System Transformation Support** and **#3 WET Workforce Development** were completed during fiscal year 2011-12. The WET program was funded with one time funds for three years, which began in fiscal year 2009-10, therefore the project concluded at the end of fiscal year 2012-2013, however, the community trainings continue.

PEI Statewide Programs

Madera County PEI Statewide dollars have been assigned to the Department of Health Care Services and California Mental Health Authority (CalMHSA). The three programs are CalMHSA Suicide Prevention, CalMHSA Stigma and Discrimination Reduction, and CalMHSA Student Mental Health Initiative. On November 29, 2010, the Madera County BOS approved BHS to assign these funds (FY 08/09, 09/10, 10/11 and 11/12) for each year in an amount of \$162,400 for a total of \$649,600. Since these funds have been delegated, this plan update will not include a request for the previously approved funds. The estimate for PEI statewide programs for FY 14/15 – FY 16/17 is \$40,000 each fiscal year for a total of \$120,000.

Madera County still accessed the information and tools provided by CalMHSA related to Stigma Reduction and Suicide Prevention.

PEI Training, Technical Assistance and Capacity Building

Madera County PEI Training, Technical Assistance and Capacity Building will be requesting funding for training of staff, community stakeholders, and clients/family members in methods that have demonstrated the capacity to increase skills and promote positive outcomes consistent with the MHSA and PEI proposed guidelines. During this stakeholder process a change for the FY14/15 is proposed to purchase additional signature pads for the client data system. The additional signature pads will allow a client signature to acknowledge a delivered service, and provide for a more active role of the client in their wellness and recovery from mental illness. This proposal will replace the original request for smart boards. The proposal for FY 13/14 is to purchase supplies for play therapy, curriculums for adult and adolescent groups, and supplies for clients of all ages to create their own artwork. There will be an art show activity for clients exhibiting their work to the public to help reduce stigma and discrimination toward mental illness. The estimates are FY 14/15 \$40,620, FY 15/16 \$24,600 and \$24,600.

MHSA Housing Program- Supplemental Assignment Agreement (MHSA Housing)

The collaborative effort for housing projects is between Madera County Behavioral Health and the Housing Authority of the City of Madera and Turning Point of Central California has helped to establish three housing projects, which are listed below.

- Four Bedroom House - Supportive/Shared Housing Project – Madera
- Four-plex Supportive/Shared Housing Project – Chowchilla
- Additional Project: Seven Bedroom Apartment Project in Oakhurst Area

Capital Facilities and Technology (CFT)

The Capital Facilities funding is one time funding that has been depleted. Madera County approved Capital Facilities **#1 CF Center for Behavioral Health Services** plan in December 28, 2010, which relocated all Madera-based Behavioral Health Services Programs to one site on September 14, 2012. All Capital and Technology funds were allotted to this single Capital Faculty project.

BOARD OF SUPERVISORS ADOPTION

- **WIC § 5847** states that the County mental health program shall prepare a Plan adopted by the County Board of Supervisors. Please include evidence that the Board of Supervisors adopted the Plan and the date of that adoption.

**FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary**

County: Madera

Date: March 19 2016

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2014/15 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	6,091,536	475,394	183,303	N/A	0	
2. Estimated New FY2014/15 Funding	6,055,592	1,135,423	378,474			
3. Transfer in FY2014/15 ^{a/}	0				0	
4. Access Local Prudent Reserve in FY2014/15						0
5. Estimated Available Funding for FY2014/15	12,147,128	1,610,817	561,777	0	0	
B. Estimated FY2014/15 MHSA Expenditures	5,547,920	1,051,404	216,000	0	0	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	6,599,208	559,413	345,777	0	0	
2. Estimated New FY2015/16 Funding	4,882,301	976,460	650,973			
3. Transfer in FY2015/16 ^{a/}	(2,717,700)				0	2,717,700
4. Access Local Prudent Reserve in FY2015/16						0
5. Estimated Available Funding for FY2015/16	8,763,809	1,535,873	996,750	0	0	
D. Estimated FY2015/16 Expenditures	5,936,274	1,101,585	216,185	0	0	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	2,827,535	434,288	780,565	0	0	
2. Estimated New FY2016/17 Funding	6,151,368	1,230,274	820,182			
3. Transfer in FY2016/17 ^{a/}	0				0	
4. Access Local Prudent Reserve in FY2016/17						0
5. Estimated Available Funding for FY2016/17	8,978,903	1,664,562	1,600,747	0	0	
F. Estimated FY2016/17 Expenditures	6,351,814	1,154,576	218,862	0	0	
G. Estimated FY2016/17 Unspent Fund Balance	2,627,089	509,986	1,381,885	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	2,761,567
2. Contributions to the Local Prudent Reserve in FY 2014/15	55,231
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	2,816,798
5. Contributions to the Local Prudent Reserve in FY 2015/16	2,774,036
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	5,590,834
8. Contributions to the Local Prudent Reserve in FY 2016/17	111,817
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	5,702,651

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 2016/17 Mental Health Services Act Annual Update
Funding Summary**

County: Madera

Date: March 19 2016

	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 2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	8,233,387	859,237	158,535			
2. Estimated New FY 2016/17 Funding	6,151,368	1,230,274	820,182			
3. Transfer in FY 2016/17 ^{a/}	(2,177,700)					2,177,700
4. Access Local Prudent Reserve in FY 2016/17						0
5. Estimated Available Funding for FY 2016/17	12,207,055	2,089,511	978,717	0	0	
B. Estimated FY 2016/17 MHSA Expenditures	6,151,368	1,230,274	820,182	0	0	
G. Estimated FY 2016/17 Unspent Fund Balance	6,055,687	859,237	158,535	0	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2016	2,804,157
2. Contributions to the Local Prudent Reserve in FY 2016/17	2,177,700
3. Distributions from the Local Prudent Reserve in FY 2016/17	0
4. Estimated Local Prudent Reserve Balance on June 30, 2017	4,981,857

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 2016/17 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding**

County: Madera

Date: March 19 2016

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. #1 FSP Children / TAY	1,601,305	1,301,305	300,000			
2. #2 FSP Adult / Older Adult	1,868,359	1,688,359	180,000			
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					
Non-FSP Programs						
1. SD Expansion	2,628,480	2,263,480	365,000			
2. SD Supportive Services & Structure	353,764	353,764				
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					
CSS Administration	619,460	544,460	75,000			
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	7,071,368	6,151,368	920,000	0	0	0
FSP Programs as Percent of Total	56.4%					

**FY 2016/17 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding**

County: Madera

Date: March 19 2016

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. #1 PEI Community Outreach & Family Educa	1,099,733	1,099,733				
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	130,541	130,541				
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	1,230,274	1,230,274	0	0	0	0

**FY 2016/17 Mental Health Services Act Annual Update
Innovations (INN) Funding**

County: Madera

Date: March 19 2016

	Fiscal Year 2016/17					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. #1 NN Perinatal MH Integration Project (PM	646,705	646,705				
2. Operational Reserve	134,430	134,430				
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					
INN Administration	39,047	39,047				
Total INN Program Estimated Expenditures	820,182	820,182	0	0	0	0