Tri-City Mental Health Center

Mental Health Services Act

FY 2013-14 Annual Update

April 2013

TABLE OF CONTENTS

MHSA COUNTY COMPLIANCE CERTIFICATION

County: TRI-CITY MENTAL HEALTH CENTER

Local Mental Health Director	Program Lead
Name: JESSE H. DUFF	Name: RIMMI HUNDAL
Telephone Number: (909) 623-6131	Telephone Number: (909) 784-3016
E-mail: jduff@tricitymhs.org	E-mail: rhundal@tricitymhs.org
County Mental Health Mailing Address: 1717 N. Indian Hill Boulevard, Suite B Claremont, CA 91711	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the County has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this annual update, including stakeholder participation and nonsupplantation requirements.

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

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.

JESSE H. DUFF		
Local Mental Health Director/Designee (PRINT)	Signature	Date

County: TRI-CITY MENTAL HEALTH CENTER

Date:_____

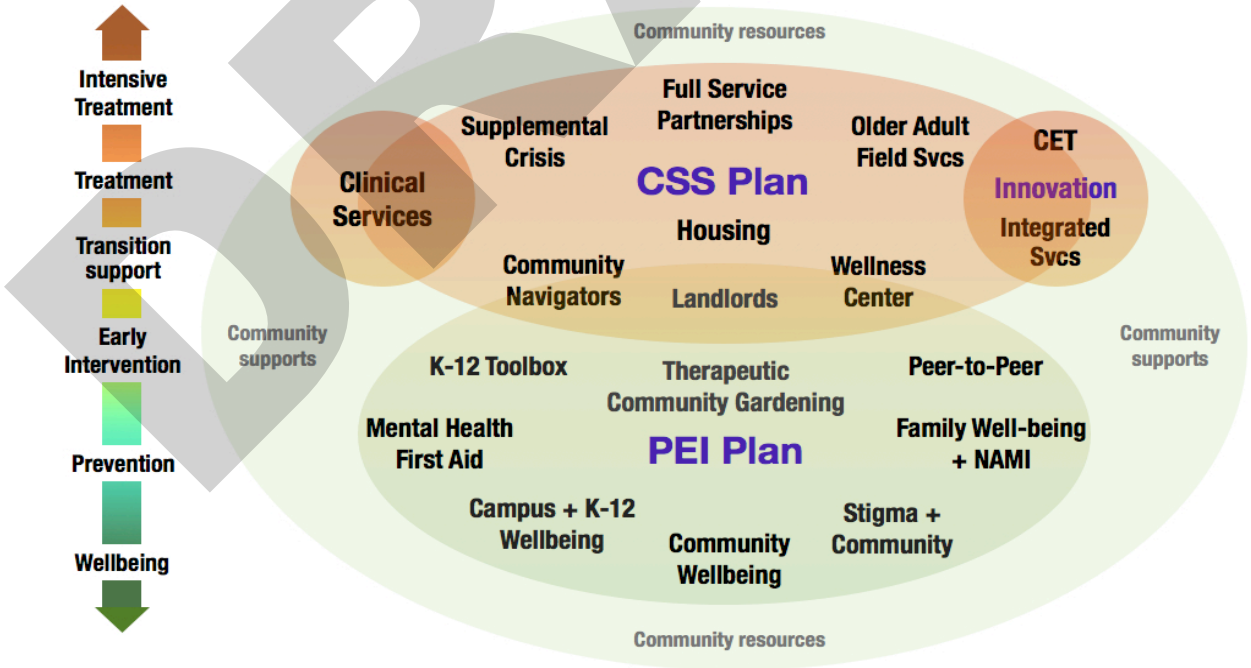
Introduction to Tri-City Mental Health Center

Tri-City Mental Health Center (TCMHC) was created in 1960 as a result of the Joint Powers Authority adopted by the cities of Claremont, La Verne and Pomona. By understanding the needs of consumers and families, it provides high quality, culturally competent behavioral health care treatment, prevention and education in the diverse cities of Pomona, Claremont and La Verne.

TCMHC used the MHSA planning effort to create a unique and transformative approach to mental health service delivery. Guided by a vision of a system of care that is aimed at creating wellbeing in the three cities of Pomona, Claremont and La Verne, TCMHC plays a critical but not exclusive role in providing mental health supports and services. Rather, the system of care is made possible by the community's own capacity to care for its members without relying exclusively on expanded services provided by TCMHC. The role of TCMHC in this system of care is to provide services when necessary and to support the community's capacity to care for its members.

This orientation toward building a community's capacity for wellbeing is the foundation of TCMHC's MHSA programming. The approach can be visualized using the following map of the emerging system of care and the MHSA investments that have been made to date:

Map of Tri-City's System of Care -- Programs and Services



Along the left side are the types of supports and services available, ranging from intensive treatments such as Full Service Partnerships to programs aimed at prevention and wellbeing such as the Community Wellbeing grants. The programs are listed in the center of the diagram and are clustered around the MHSA funds that made them possible. All of these programs are bolstered by formal and informal community supports.

Demographic Profile of TCMHC's Service Area

TCMHC serves the three city population of Pomona, Claremont and La Verne of approximately 215,000 persons with Pomona being the larger of the three. According to the U.S. Census (2010), 57% of the population is Latino, 26% is White, 9% is Asian Pacific Islander, 6% is African American, 2% is multiracial and less that one percent is American Indian. Forty-three percent of the population has an income that is less than 200% of the federal poverty threshold.[1] Roughly 48% of the Tri City population speaks monolingual English, while 42% speaks Spanish as the primary language at home. Another 6.7% speak an Asian Pacific Islander language as the primary language, and 3.5% of the population speaks a language other than the ones already named.

TCMHC has a current client base of 928 persons. In FY 2011-12, TCMHC served more than 1,400 unduplicated clients who are enrolled in formal services. It has 127 full-time and 19 part-time employees and an annual operating budget of $15 million dollars. TCMHC strives to reflect the diversity of its communities through its hiring, languages spoken and cultural competencies.

Description of Stakeholder Process

Tri-City Mental Health Center engaged in expansive community engagement and stakeholder processes throughout its MHSA planning and implementation efforts by including more than 6,000 people for its Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) plans. As a demonstration of its commitment to engaging community stakeholders, TCMHC created a permanent Delegates structure in July 2011. This sixty-member TCMHC Delegates Group is intended to ensure that broad stakeholder and community engagement takes a deep hold in our transformed mental health system.

[1] 200% of poverty is $45,622 for a family of four and is often used as a definition for the "working poor." This measure will soon be the threshold for eligibility for certain health programs.

Delegates and their alternates represent stakeholder perspectives including individuals who receive services; family members; community providers; leaders of community groups in unserved and underserved communities; representatives from the three cities of Claremont, La Verne and Pomona; representatives from the local school districts; primary health care providers; law enforcement representatives; faith-based community representatives; representatives from the LGBTQ community; representatives from LACDMH and other county agencies; and many others.

In preparation for this Annual Update, the Delegates convened on April 11, 2013 to hear updates and recommendations from staff on CSS, PEI and INN programs. The Delegates agreed to all of the recommendations made and indicated in this Annual Update.

The dates of the 30-day review process are April 22, 2013 through May 22, 2013. Staff will circulate a draft of the annual update by making electronic copies available on TCMHC's website and providing printed copies at various public locations (such as at the Wellness Center, libraries, etc.). Several methods of collecting feedback will be available such as phone, fax, email, mail and comments at the public hearing.

Community Services and Supports (CSS) Programs

TC-01: Full Service Partnerships

Full Service Partnerships are funded under the MHSA Community Services and Supports plan. Reserved for people who are most severely ill and who are at risk of homelessness or other devastating consequences, the program uses a "whatever it takes approach" to helping people in their recovery. The starting place for a Full Service Partnership is a recovery plan that the person creates with a clinician.

Numbers Served by Age Group and Average Annual Cost per Client, FY 2011-12

Age Group	# of Individuals FSP	Average Annual Cost per Client FSP only
Child and Youth	92	$23,009
TAY	92	$19,960
Adults	137	$20,621
Older Adults	15	$22,923
Total	336	

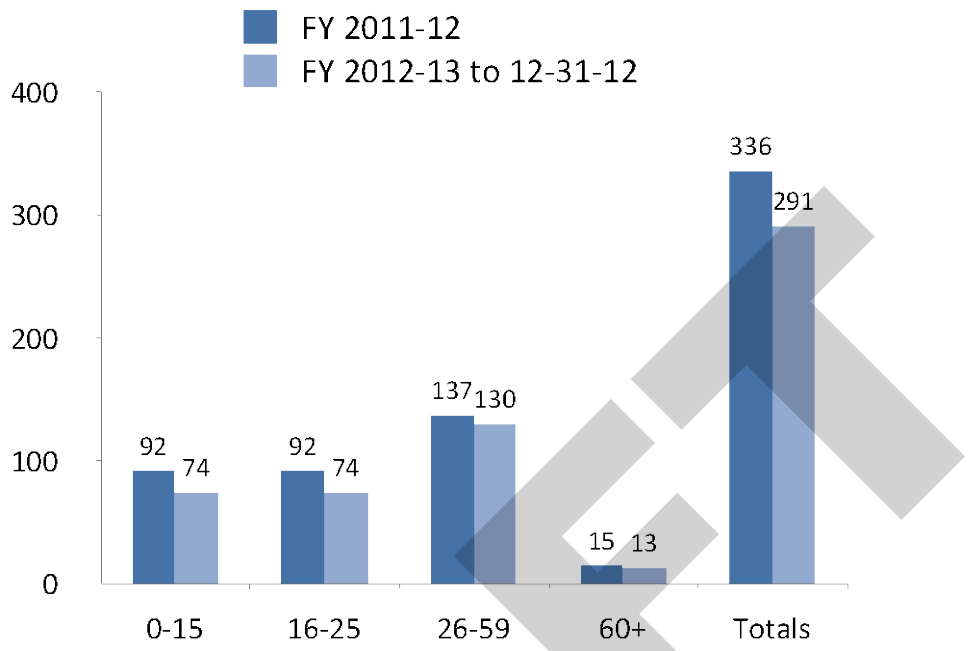
Demographic Distributions of People Served, FY 2011-12

	White	African American	Asian/Pacific Islander	Native American	Hispanic	Other
Child and Youth	17%	21%	0%	0%	58%	4%
TAY	7%	26%	4%	0%	60%	3%
Adults	26%	27%	3%	0%	42%	2%
Older Adults	54%	15%	0%	0%	31%	0%

Primary language data were not available to report, nor were any numbers regarding people served from the LGBTQ or veterans groups.

The FSP program served a record number of clients in FY 2011-12 and is on track towards exceeding these numbers in FY 2012-13. The chart below demonstrates the number of clients served by age group for both fiscal years.

FSP Clients Served by Age Group



In all of the FSP programs, the main challenge has been the severity of the clients' needs because it is difficult to address all of them at an adequate level. This is particularly true for the Adult FSPs as a significant number of them also face chronic drug or alcohol use. TAY FSPs also face co-occurring disorders similar to adults, but with less severity. Child FSPs also experience an intense level of need among the larger family unit, as many parents have difficulty maintaining employment. Due to the multiple needs of each client, TCMHC has spent more per client than originally anticipated. The additional costs are now reflected in the coming year's budget.

TCMHC has experienced some difficulty in reaching out to and engaging the older adult population for the Older Adult FSP program. This may be because those with severe mental illness, as the FSP program is designed for, may not live as long as other adults. Many of the older adults that do come to TCMHC don't qualify for the FSP program, but are assisted through other TCMHC programming.

To mitigate these challenges, TCMHC increased its training of staff members to identify and address each of the compounding issues as appropriate. For our staff, we are working to set reasonable expectations of the progress that can be seen in FSP clients within a given time period and finding ways to improve our clinicians' feelings of efficacy and accomplishment. We are building partnerships with substance abuse providers and working with these providers to improve the integration of mental health and substance abuse services through the Integration Services Project, one of the MHSA Innovation programs.

For the Child FSPs, TCMHC staff will participate in more family therapy training and refer families to the Wellness Center and other community partners as appropriate. For the Older Adult FSPs, TCMHC will use our Community Navigators to help with outreach and identify potential participants.

In FY 2011-12, the Adult and Older Adult FSP programs experienced a shortage of bilingual (Spanish/English) clinical therapists, which has since been remedied in FY 2012-13.

No significant changes were made to this program during the 2011-12 year.

TC-02: Community Navigators

Community Navigators are funded through the CSS plan to help people in the Tri-City area connect to local resources, including informal community supports and formal services where available. Navigators also provide education and stigma reduction services to local communities and organizations. All of our Community Navigators are bilingual and bicultural, and they regularly visit community organizations, emerging and well-established health and mental health programs, law enforcement agencies, schools, courts, residential facilities, nominee chapters, self-help groups, client advocacy groups, homeless shelters and others.

Demographic Distributions of People Served

Age Group	# of individuals OE
Child and Youth	357
TAY	225
Adults	847
Older Adults	205
Age Unknown	87
Total	1,721

Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
White	325	English	1,355	LGBTQ	n/a
African American	237	Spanish	237	Veteran	n/a
Asian & Pacific Islander	34	Vietnamese	0	Other	
Native American	1	Chinese	3		
Hispanic	880	Tagalog	0		
Multi	16	Cambodian	0		
Middle Eastern	10	Hmong	0		
Unknown	218	Russian	0		
		Farsi	2		
		Arabic	0		
		Unknown	124		
Totals	1,721		1,721		

Starting in FY 2011-12, TCMHC's Community Navigators were stationed both at the clinic and at offices imbedded in the community. As a result, they have increased the number of consumers they serve with resources and linkages needed. They have increased the number of organizations they attend, and have a frequent presence at health fairs and other community-organized events. Community Navigators also provide critical follow up to the Supplemental Crisis services and FSP teams, such that all of our programs utilize the resources provided by the Community Navigators at some point in time.

The main challenge for the Community Navigators has been helping those consumers who are homeless or in dire financial straits. The Tri-City area lacks resources for the homeless, and shelter facilities are not available.

There were no staff shortages nor significant changes to the program in FY 2011-12, however a Community Navigator was added in FY 2012-13 to address the increased need for linkages and resources related to housing issues. More information about this Community Navigator can be found under the Building Bridges with Landlords, Mental Health Providers and Clients program.

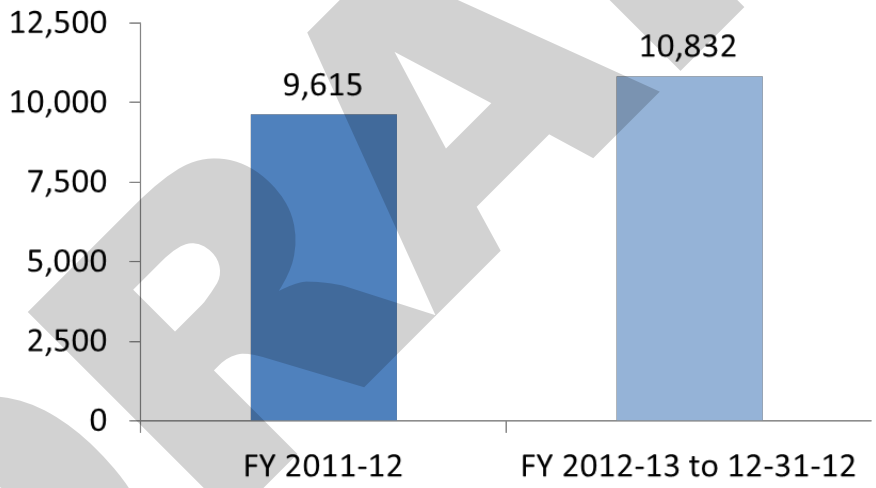
TC-03: Wellness Center

The Wellness Center is a community hub of activities that promote recovery, resiliency, and wellness for residents of the Tri-City area. The Center is open to people of all ages, focusing especially on people in recovery and their families. The Center sponsors support groups and provides an array of holistic services through collaboration with other community partners.

The Wellness Center opened in November 2011 in a state-of-the-art, community-accessible, comprehensive site that allows us to offer numerous support groups, informational workshops and seminars, and educational vocational training to increase each consumer's levels of independence and stability. The space allows TCMHC to expand our offerings and support.

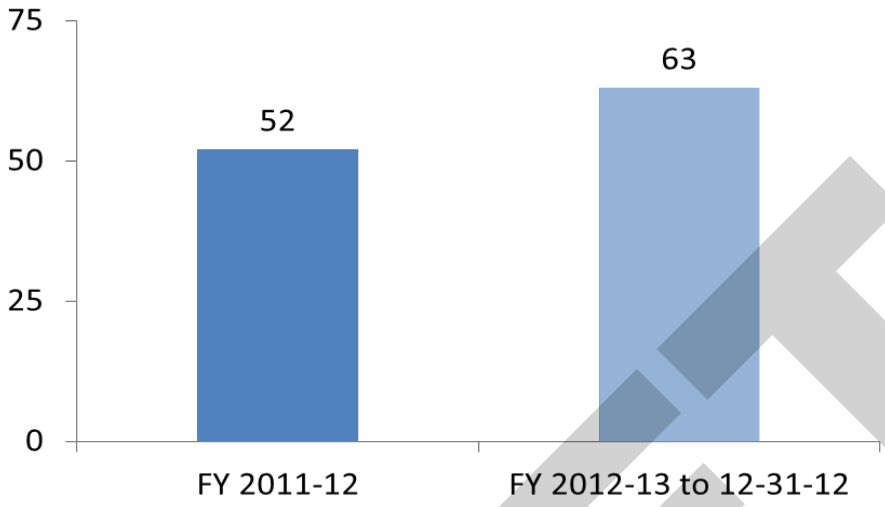
The Wellness Center has seen a massive increase in foot traffic since its opening; the number of visits for the first half of FY 2012-13 already exceeds the number of visits in the FY 2011-12.

Number of Wellness Center Visits



The Wellness Center also has become a critical community hub as it serves as the host of many support groups, 64% of which are led by peers.

Average Number of Groups Hosted by Wellness Center per Month



In addition, the Wellness Center has seen success in its employment placements. TCMHC placed an Employment Outreach Coordinator at the Wellness Center and in FY 2011-12, 53 consumers were placed in jobs. In the first half of FY 2012-13, we have placed 94 consumers in jobs.

It has been a challenge to capture the number of unduplicated visits and other demographic data on visitors. We expect to have the technology systems in place by May 2013 to track this data in the future.

We also have been challenged with the high turnover rate for peer employees at the Wellness Center. We are trying to provide them more training, but their training needs are intensive as the Wellness Center is often their first employer in a long time.

Another challenge has been that TAY consumers have been difficult to engage and get to come consistently. To address this issue, TCMHC hired a full-time clinician and two other part-time workers to conduct outreach.

In FY 2011-12, TCMHC lost all of our TAY clinical social workers and hired new staff. In addition, the Wellness Center had a shortage of Spanish-speaking staff and high turnover among the peer employees.

To address the need for training the peer employees and to reduce turnover, TCMHC required peer employees to go through the same rigorous training as other volunteers. This has served to set a high standard for the quality of service we can provide to visitors and has narrowed the field to a smaller, but more dedicated, group of people.

There were no significant changes made to the program this year, however the trend toward increased demand leads us to budget for additional staff in FY 2013-14.

TC-04: Supplemental Crisis Services

Supplemental Crisis Services provides coverage after-hours and on weekends to individuals who are not currently receiving TCMHC services but are suffering a crisis. Local area clinicians respond to police calls, meet police officers at the crisis location, and offer support as needed to police personnel, the person in crisis, and others as appropriate.

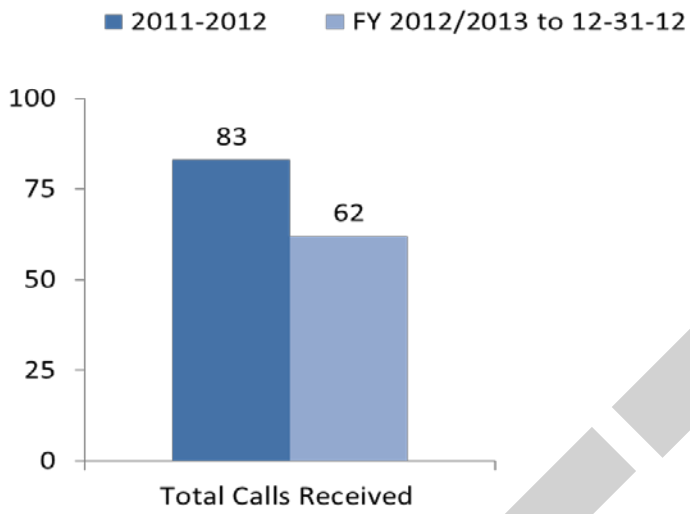
Demographic Distributions of People Served

Age Group	# of individuals OE
Child and Youth	1
TAY	11
Adults	25
Older Adults	9
Unknown	37
Total	83

Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals	City of Call Origin	# of Individuals
White	12	English	80	LGBTQ	0	Pomona	49
African American	2	Spanish	2	Veteran	0	Claremont	0
Asian	2	Vietnamese	0	Other		La Verne	5
Pacific Islander	0	Cantonese	0			Other	11
Native American	0	Mandarin	0			Unknown	18
Hispanic	31	Tagalog	0				
Multi	0	Cambodian	0				
Unknown	34	Hmong	0				
Other	2	Russian	0				
		Farsi	0				
		Arabic	0				
		Other	1				
		Unknown	0				
Totals	83		83				83

Paired with follow-up by the Community Navigators, the Supplemental Crisis Services program helps to fill gaps in service and helps consumers prevent hospitalization and receive more appropriate care. The number of calls we received indicates that we will be receiving more in future years, especially as the community becomes more aware of the services available.

Number of Calls Received



While the service has been successful, TCMHC also experiences a significant number of non-clients who walk in needing crisis interventions, and the cost of their care (ambulatory and other costs for un-enrolled clients) has gone unplanned. By expanding access to Supplemental Crisis Services to be available 24/7 instead of only after-hours and weekends, we believe we can better serve them and cover the costs more efficiently with CSS funds. The proposed budget for FY 2013-14 reflects the recommended expansion of the hours and ambulatory costs for this program.

No staffing shortages were experienced, nor were there any significant changes made to the program during FY 2011-12.

TC-05: Field Capable Services for Older Adults

Currently at 26-28% of the total population, older adults are the fastest growing population in Claremont and La Verne. Older adults – especially frail elders – often have a difficult time accessing services in traditional venues. TCMHC staff members take mental health services to where seniors are: their homes, senior centers and medical facilities.

TCMHC's Field Capable Services for Older Adults is a popular program that has uncovered a deep need among older adults for mental health services outside of clinician's offices. Many of these clients do not want to exit the program, as this is a service that they are not getting through their medical plans. Because of the isolation clients' experience, older adult consumers need a supplement to their therapy and this service is filling that gap.

One challenge we face is moving clients through this program to be able to provide the service to more seniors, and our current capacity is to serve a maximum of 23 seniors in a month. In addition to needing to reach out to more older adults, TCMHC is working on developing a wider variety and breadth of services available that can address the needs of those currently in the program. For example, there is a Wellness Center seniors group, and we are working to develop more support groups and transportation options. In FY 2012-13, TCMHC hired a TAY/Older Adult programming specialist at the Wellness Center to facilitate program development.

No shortage of personnel was experienced during this fiscal year, nor were there significant changes to the program.

TC-06: MHSA Housing

In July 2011, TCMHC Board approved a Comprehensive Housing Master Plan which outlined a plan to construct or rehabilitate 100 short-term transitional housing units and permanent supportive housing. Permanent supportive housing units are living spaces where the client who is homeless or at risk of homelessness and suffers from one or more mental illness can receive a bundle of services designed to aid in his or her stabilization and recovery.

Number of Housing Units Acquired or in Development

Project Name	Tri-City units	Manager units	General affordable units	Total
Park Avenue	8	0	0	8
Cedar Springs	8	1	27	36
Related Companies	21	1	40	62
Clifford Beers/Garey Ave	22	1	0	23
Clifford Beers/Holt Ave.	16	1	33	50
Totals	75	4	100	179

During the FY 2011-12, TCMHC acquired an eight-unit group home already occupied by five tenants with mental health issues and prevented their eviction. No other additional clients were served through this program during the FY 2011-12 as units were still in development. The 79 units (Tri-City and manager units) will serve up to 85 individuals and their family members and are planned to be developed over the next three to four years. Five of those units are designated for TAY and three are for TAY and their families. The other 71 units can serve any of the age groups. Because TCMHC is assisting in the development of units for consumers, our targeted investment will make 100 other affordable units possible.

One of the challenges for the Housing program has been that sources of development funds that we had planned to tap into have been eliminated by downturns in the economy. In addition, the cost of construction per unit has gone up since the original estimates were completed.

To address this challenge, TCMHC is recommending that we allocate $500,000 of unspent CSS funds to current projects already in development and listed above. These funds would come out of CSS funds allocated through 2012-13 that have gone unspent due to TCMHC's initial delays in starting MHSA planning and implementation and that have been accumulating and are not otherwise currently earmarked.

There have not been personnel shortages in FY 2011-12.

Prevention and Early Intervention (PEI) Programs

PEI-01: Community Capacity Building

The Community Capacity Building Program aims to increase the ability of communities to assist each other in achieving wellbeing. *Community* is defined as a group of individuals who rely on each other for support and can act together. Three projects fall into this program: Community Wellbeing Grants, Mental Health First Aid, and Stigma Reduction within Cultural Groups.

Community Wellbeing Program

Open to any community in the Tri-City area, the Community Wellbeing program provides small grants and technical assistance to help communities build their capacity to strengthen the wellbeing of their members. In FY 2011-12, 16 community groups received a grant through the Community Wellbeing program. Thirty-five groups attended the bidders conference, and 31 submitted applications. Although these groups were funded in June 2011, their projects were implemented in the FY 2011-12 and served the following people:

Demographic Distribution of Numbers Served in Cohort 1, FY 2011-12

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	745	White	374	English	2,845	LGBTQ	12
Transition Age Youth (16-25)	339	African American	131	Spanish	168	Veteran	34
Adult (18-59)	1,375	Asian	35	Vietnamese	0	Other	
Older Adult (60+)	592	Pacific Islander	5	Cantonese	0		
		Native American	2,000	Mandarin	3		
		Hispanic	465	Tagalog	1		
		Multi	16	Cambodian	0		
		Unknown	23	Hmong	0		
		Other	2	Russian	0		
				Farsi	0		
				Arabic	0		
				Unknown	34		
Total	3,051		3,051		3,051		

As an example of notable impact, here is a story from a grantee, the Costanoan Carmel Rumsen Tribe:

> *A 16-year old tribal member who was diagnosed with ADD, severe depression and suicidal tendencies was being kept on many medications that caused him not to feel anything. His mother feared for his safety, and she thought the only way to keep him safe would be to commit him. After she was told about the Costanoan Carmel Rumsen Tribe's program by several of her family members, she brought him in. The sweat leader and the young man's family knew his story and began to work on him. After attending a couple ceremonies he began to open up to the Tribe's traditional way of healing and has begun to understand some of the things he was going through. His medications were reduced and he is thinking and feeling more clearly. He is doing well in school and is ambitious about his life and looking forward to a bright future.*

One of the challenges of the first year of this program was that some communities did not spend down their grants consistently throughout the year and required a great deal of assistance from TCMHC staff for their administration. Another challenge was that while grantees were accepted based on the strength of their application, not all of them could demonstrate the characteristics of "community" as defined by this program.

To mitigate these challenges, TCMHC instituted new quarterly reporting procedures to help communities more regularly evaluate their progress and encourage them to plan for the next quarter. We also incorporated an interview process for all potential grantees to allow the selection team to get a better sense of the community. We think that this helped level the playing field for those communities with less grant writing experience by giving them an opportunity to demonstrate their strengths in person. In FY 2013-14, we plan to reduce the number of communities selected to better support the ones chosen. Savings from the fewer number of the communities chosen will be re-directed to other community capacity-building efforts.

There were no personnel needs, nor significant changes made during the 2011-12 year.

Mental Health First Aid Program

Mental Health First Aid (MHFA) is a nationally recognized program that trains individual community members (Mental Health First Aiders) to recognize the early warning signs of someone who may be experiencing mental and emotional distress. Similar to CPR training, these Mental Health First Aiders are taught how to intervene quickly and effectively to offer support and encourage connections to appropriate and professional help.

During FY 2011-12, TCMHC trained 868 people in Mental Health First Aid. Many participants responded with enthusiasm to the material. One gave this feedback: "I really enjoyed the course. I learned a lot about mental illness. I did not know what to expect, but I'm glad I took the course. I would recommend this training to anyone, [because] you learn so much that will help you in your everyday life. This training helped me realize that everyone can be affected by mental illness."

Demographic Distribution of Mental Health First Aid Trainees

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	0	White	212	English	650	LGBTQ	15
Transition Age Youth (16-25)	126	African American	126	Spanish	0	Veteran	6
Adult (18-59)	546	Asian	54	Vietnamese	0	Other	85
Older Adult (60+)	85	Pacific Islander	8	Cantonese	0		
Unknown	111	Native American	7	Mandarin	0		
		Hispanic	310	Tagalog	0		
		Multi	24	Cambodian	0		
		Unknown	36	Hmong	0		
		Other	91	Russian	0		
				Farsi	0		
				Arabic	0		
				Unknown	218		
Total	868		868		868		

The main challenge has been getting participants and instructors to commit to the large blocks of time required to meet national certification standards for MHFA. Of the 49 certified MHFA instructors, only 24 maintained certification for a second year. Many of the instructors reported that it was difficult to schedule, arrange, and find participants for their trainings because of the time commitment required. To mitigate this challenge, TCMHC provided training on how to organize and set up an MHFA training. We also offered instructors the opportunity to co-train with a Tri-City instructor who could arrange the MHFA training. Because of instructors' limited schedules, some trainings were conducted by Tri-City instructors instead of community ones.

Despite these adjustments, we continue to see a drop off in the numbers of nationally certified MHFA instructors. We will explore a variety of options through discussions with key stakeholders in the near future, but for now there are no significant changes being made to the program.

Stigma Reduction within Cultural Groups

The Stigma Reduction within Cultural Groups project is a one-time project that began in March 2012 to engage leaders and members of underserved cultural groups in conversations about mental illness. One goal was to gather information to make services more relevant and culturally sensitive to every cultural group and community. The other was to increase mental health awareness, have groups recognize (in their own time and on their own terms) cultural beliefs that prevent members of their communities from accessing help for mental illness when in need, and ultimately eradicate this stigma.

Demographic Distribution of Numbers Served, FY 2011-12

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	0	White	32	English	114	LGBTQ	2
Transition Age Youth (16-25)	11	African American	24	Spanish	81	Veteran	6
Adult (18-59)	166	Asian	2	Vietnamese	0	Other	
Older Adult (60+)	18	Pacific Islander	1	Cantonese	0		
		Native American	2	Mandarin	0		
		Hispanic	116	Tagalog	0		
		Multi	7	Cambodian	0		
		Unknown	4	Hmong	0		
		Other	7	Russian	0		
				Farsi	0		
				Arabic	0		
				Other	0		
Totals	195		195		195		

This project reached nearly 200 people representing Latino, African American, Asian, Islamic, Homeless and Native American communities. Outreach was also conducted to law enforcement departments in the Tri-City area, who responded eagerly to the opportunity to learn tools to respond to mental illness. The project used a survey to help stimulate discussion and gauge participants' levels of awareness. The project's success led to the decision to continue the project for an additional three years.

So far in FY 2012-13, more than 500 people have been reached in this effort, and the program is gaining in breadth and depth. However, the workload is greater than the current infrastructure, so we are exploring potential shifts in the implementation of this project while maintaining the original budget and scope.

PEI-02: Older Adult Wellbeing

The Older Adult Wellbeing Program consists of peer-to-peer counseling and peer support groups for older adults who are struggling with issues of mental and emotional wellbeing. Peer to Peer Counseling trains volunteers from the Tri-City area who want to learn how to provide support to peers who are in emotional distress. Once trained, peer counselors can offer both individual and group counseling, and additional support through linkages to age- and culturally-appropriate resources. Included among the volunteer counselors are Mental Health First Aiders.

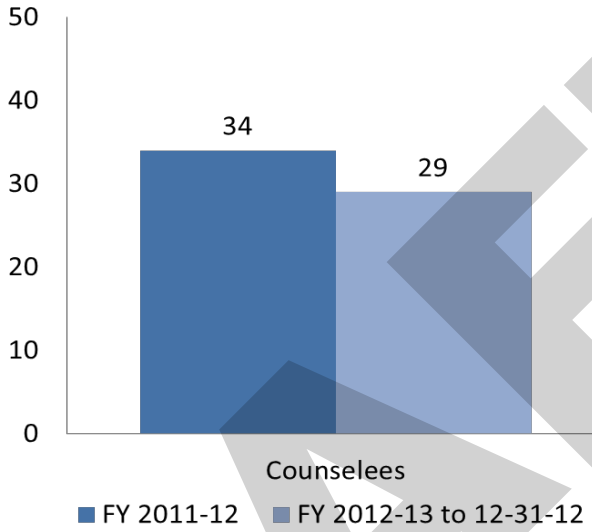
Demographic Distribution of Older Adult Referrals, FY 2011-12

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	0	White	25	English	45	LGBTQ	n/a
Transition Age Youth (16-25)	0	African American	10	Spanish	8	Veteran	n/a
Adult (18-59)	0	Asian	0	Vietnamese	0	Other	
Older Adult (60+)	53	Pacific Islander	0	Cantonese	0		
		Native American	0	Mandarin	0		
		Hispanic	18	Tagalog	0		
		Multi	0	Cambodian	0		
		Unknown		Hmong	0		
		Other	0	Russian	0		
				Farsi	0		
				Arabic	0		
				Other	0		
Total	53		53		53		

During FY 2011-12, TCMHC had few older adults interested in becoming counselors in the Peer Support Program but many adults who did not meet the age requirement who were interested. During FY 2012-13, we lowered the age requirement to become a Peer Support Counselor for older adults in order to include some of the younger adult volunteers. TCMHC also conducted significant outreach to several senior housing sites throughout the Tri-City area.

One challenge we experienced was that many other parts of TCMHC's system of care were still under development, so during FY 2011-12 there were few options for older adults with mental health needs. To address this challenge in FY 2012-13, we expanded our offerings and have more support groups for this age group. Our mid-year numbers for counselees appear to have us on track to exceed our numbers from last year.

Senior Counselees Receiving Counseling Services



Another challenge has been to find Spanish-speaking senior counselors, which we will address by focusing our recruitment strategy on them.

There were no significant changes made to the program beyond the changes to the age requirement described earlier.

PEI-03: Transition-Aged Youth Wellbeing

The Transition-Aged Youth Wellbeing Project consists of peer-to-peer counseling and support groups aimed at the particular needs of transition-aged youth. The Peer-to-Peer Program recruits and trains TAY volunteers as peer counselors who can assess the mental health and wellbeing of TAY clients, provide one-to-one peer counseling, and lead age-based peer support groups. Groups organized under this program focus on providing support and creating opportunities for members to engage in projects that serve their communities and other wellness activities.

Demographic Distribution of TAY Referrals, FY 2011-12

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	0	White	3	English	11	LGBTQ	n/a
Transition Age Youth (16-25)	11	African American	1	Spanish	0	Veteran	n/a
Adult (18-59)	0	Asian	0	Vietnamese	0	Other	
Older Adult (60+)	0	Pacific Islander	0	Cantonese	0		
		Native American	0	Mandarin	0		
		Hispanic	7	Tagalog	0		
		Multi	0	Cambodian	0		
		Unknown		Hmong	0		
		Other	0	Russian	0		
				Farsi	0		
				Arabic	0		
				Other	0		
Totals	11		11		11		

Notable impact for this program has come in the form of anecdotal feedback from participants. One counselee reported that her peer counselor helped her find direction in her life. Another counselee who has been in the program for over a year reported that it has been nice to have someone to speak with consistently. Our TAY Wellbeing program received an enthusiastic response from students from our local college communities. Sixteen became TAY counselors, however, we were challenged to find sufficient numbers of counselees.

With the opening of the Wellness Center, TCMHC gradually increased the number of support groups dedicated for the TAY population; this programming had not previously been available to them. To address this challenge, TCMHC hired a TAY Wellbeing Specialist in FY 2012-13 to operate the programs and conduct more extensive outreach into the TAY communities.

PEI-04: Family Wellbeing

Staff and volunteers in the Family Wellbeing Program will build trusting relationships and provide supports to family members and caregivers of people who participate in the Mental Health First Aid Program, the Peer Support Programs, the Community Wellbeing Program and the Student Wellbeing Program, focusing particularly on family members from unserved and underserved communities.

The Family Wellbeing Program provides supports such as culturally-appropriate programming focused on wellness interests such as exercise, cooking and other interests that can attract family members and other caregivers from vulnerable communities. Many support groups for parents and caregivers meet in the Wellness Center, including several new support groups led by the Pomona Valley chapter of the National Alliance on Mental Illness (NAMI PV) and based on their NAMI Basics, Family to Family and NAMI Helpline programs.

TCMHC also operated a summer camp for the second year. The camp ran for one month for three hours, Monday through Friday. Some of the participants were returning from the first year's camp. The camp allows for children to receive treatment during the day, as many of the participants are not able to attend other summer camps less equipped to handle their needs. Our staff received training on working with autistic and ADHD children and met with them prior to camp to get to know the children and their strengths and preferences.

One significant challenge for this program was the volume of work for the one staff person to do. We delegated some of her responsibilities and added intern and clinician support. The internal restructuring resolved this challenge. There were no other significant changes to the program this year.

PEI-05: Student Wellbeing

The Student Wellbeing Program includes K-12 Student Wellbeing and College Student Wellbeing. The K-12 Student Wellbeing Program provides support for the three school districts to expand and better integrate their efforts to promote the mental and emotional wellbeing of their students. The College Student Wellbeing Program provides support for area public and private colleges to expand and better integrate their efforts to promote the mental and emotional wellbeing of their students.

K-12 Student Wellbeing

In the K-12 Student Wellbeing Program, TCMHC successfully reached out to the three unified school districts and began implementing their planned projects. Information was distributed, committees formed and counseling services were provided at some locations. Below is a chart that summarizes the demographic distribution of the participants:

Demographic Distribution of K-12 Program Participants

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	2,688	White	1,049	English	2,619	LGBTQ	1
Transition Age Youth (16-25)	98	African American	241	Spanish	218	Veteran	1
Adult (18-59)	218	Asian	277	Vietnamese	35	Other	
Older Adult (60+)	8	Pacific Islander	12	Cantonese	3		
		Native American	5	Mandarin	7		
		Hispanic	1,069	Tagalog	4		
		Multi	1	Cambodian	0		
		Unknown	356	Hmong	0		
		Other	2	Russian	0		
				Farsi	3		
				Arabic	32		
				Other	62		
				Unknown	29		
Total	3,012		3,012		3,012		

The K-12 Student Wellbeing Program experienced some challenges with the loss of time and momentum over the summer months in part due to the break in schedule and in other part due to losing coordinators who were the link between TCMHC and the schools. New coordinators are now in place for FY 2012-13 and minor adjustments have been made to the program based on parent and teacher feedback.
The Student Wellbeing Programs will conclude as planned with two exceptions. We will extend the project with the Bonita Unified School District to be funded one more year because there were unavoidable delays in implementation (at no additional cost). Also, in FY 2011-12, a technology project was incorporated into the Student Wellbeing Project. We will end that project earlier than anticipated because the schools do not have the capacity to implement the project as it was designed. TCMHC will use the Delegates process to revisit that project as part of developing the Integrated Plan.

College Wellbeing

In FY 2011-12, the colleges began implementation on 10 out of 24 of the mini-grants/campus proposals, and five additional groups planned their first events. We started a parent resource guide, and hired a consultant to develop a campus-wide campaign for student resiliency. No demographic distribution data is available for these projects.

Just as with the K-12 Student Wellbeing Program, the projects lost momentum and coordinators during the summer months, but were able to get back on track in the fall.

PEI-06: NAMI Community Capacity Building

The NAMI Community Capacity Building Program is a collaboration with the National Alliance on Mental Illness – Pomona Valley (NAMI PV) that is designed to build the capacity within the three cities to promote and sustain the mental wellbeing of community members. This program consists of two projects: Parents and Teachers as Allies and the Inter-Faith Collaborative on Mental Illness. Parents and Teachers as Allies provides in-service trainings for school professionals and families to better understand the early warning signs of mental illnesses in children and adolescents and how best to intervene so that youth with mental health treatment needs are linked with services. The Inter-Faith Collaborative on Mental Illness provides outreach, education and training opportunities to faith organizations, which are often a first point of contact when individuals and families seek assistance. The Collaborative conducts seminars and conferences twice a year.

Parents and Teachers as Allies

NAMI PV visited and presented at a total of 22 sites during FY 2011-12 and reached more than 1,000 parents, teachers and school staff from across the area. These presentations were made in both English and Spanish and were well received. Evaluations indicated consistently high marks from attendees on items such as helping to increase their understanding of the symptoms of childhood and adolescent mental illness and providing them with new and useful resources for working with families. No demographic distribution data are available for this program for FY 2011-12.

One challenge in the program was that it was difficult to get teachers to attend without a stipend to pay for their in-service time. In FY 2011-12, one-time funds were allocated for stipends that were not previously included in the FY 2011-12 budget. In order to enable more teachers to attend these in-service trainings, TCMHC has included a recommended increase in the FY 2013-14 budget for stipends.

No personnel shortages were experienced, nor were there any significant changes made to the program during the year.

Interfaith Collaborative on Mental Illness

In February of 2012, NAMI PV hosted its second conference for faith communities entitled: “Widening the Welcome and Deepening the Support: Faith Communities Responding to Mental Illness.” This conference was convened in a town hall format to allow for more listening and interaction, which ultimately helped diverse faith communities become more responsive to the mental and emotional needs of people within their communities. The event reached 695 people representing those from the Church of God in Christ, From the Heart Ministries, New Directions, Antioch Missionary Baptist Church, Macedonia Baptist Church, Primm AME Church, Emmanuel Church, Mt. Zion Baptist Church, Total Restoration Ministries, and Juniper Avenue Seventh Day Adventist Church.

Demographic Distribution of Participants, FY 2011-12

Age Group	# of Individuals	Race and Ethnicity	# of Individuals	Primary Language	# of Individuals	Culture	# of Individuals
Child and Youth (0-17)	0	White	272	English	477	LGBTQ	21
Transition Age Youth (16-25)	19	African American	205	Spanish	8	Veteran	12
Adult (18-59)	387	Asian	4	Vietnamese	0	Other	
Older Adult (60+)	78	Pacific Islander	0	Cantonese	0		
Unknown	211	Native American	0	Mandarin	0		
		Hispanic	101	Tagalog	0		
		Multi	13	Cambodian	0		
		Unknown	4	Hmong	0		
		Other	96	Russian	0		
				Farsi	0		
				Arabic	0		
				Other	0		
				Unknown	210		
Totals	695		695		695		

The main challenge we discovered was that our levels of support were not sufficient to achieve the impact for which we had hoped, and we see an opportunity to expand the impact of this program by redirecting some of the Community Wellbeing Program funds here to add another staff member.

The summary report for the Interfaith Collaborative highlighted the positive attitudes, feelings and behaviors that people had in seeking professional help outside of their congregations; the uncertainty of many participants in how to respond appropriately; and the need for mental health professionals to be more culturally responsive to people's spirituality as a factor in creating mental health.

No significant changes were made to the program in FY 2011-12.

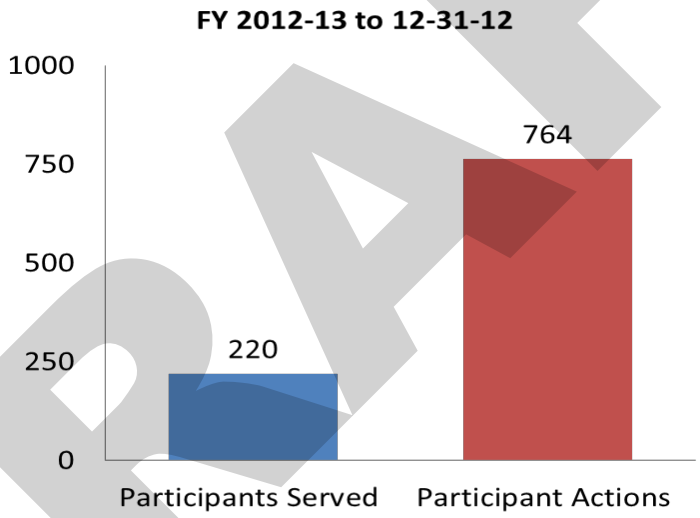
PEI-07: Building Bridges between Landlords, Mental Health Providers and Clients

TCMHC began a Landlords Outreach Program in January 2012 to better understand and meet the needs of landlords, property managers, clients and mental health service providers in order to maintain current housing arrangements for people with mental health needs or to find more appropriate housing.

No data is available for the FY 2011-12 as the program was in the early development stages. During that time, the "Landlords" program reached out to landlords and began working with the Apartment Association of the Greater Inland Empire to develop training on mental health issues for their annual conference. A "Good Tenant" training to help consumers become ready for housing is also in development.

The initial numbers for the FY 2012 year demonstrate the need for housing assistance:

Total Participants Served and Actions



The demand for housing and landlord linkage, advocacy and landlord/tenant education, and staff referrals and consultations was so great that TCMHC hired a Community Navigator in FY 2012-13 to specialize in housing resources. So far in FY 2012-13, TCMHC has placed 40 people in housing.

One of the challenges has been to find sources of funding for rental deposits. TCMHC will continue to investigate possible options.

There were no significant changes in this program in FY 2011-12.

PEI-08: Therapeutic Community Gardening

The Therapeutic Community Gardening project helps participants experience mental health benefits by decreasing their isolation through participation in gardening and horticultural group therapy programs. The focal populations for this project are veterans, school-aged children and their families, and youth transitioning out of foster care.

The project was approved in April 2012 as the Urban Farming project. In line with the original plan, a site was identified to use as the basis for the therapeutic gardening classes. This land was required to be cultivated and prepared for farming. As implementation continued, changes needed to be made to the original plans as we found that it was more efficient to work directly with landowners with already developed sites rather than trying to develop them through a third party. In addition, we found that there was confusion about the use of the term “urban farm,” and that the intent for mental health benefit was more clear when we used the term “therapeutic community gardening.” Therefore, the program name is now changed to Therapeutic Community Gardening to better reflect the purpose of the program.

In FY 2012-13, in addition to the site originally selected, we identified a site next door to TCMHC offices that would also provide land to be used for therapeutic community gardening. As a result, the project is operating at this site, and we are continuing to look for additional locations. We started the program with one group of school-aged children and their families and one group of youth transitioning out of foster care.

The biggest challenge in FY 2011-12 was identifying sites for the project, and the current challenge is engaging veterans to participate. Our strategy to overcome this challenge is to open up the project to all age groups.

Innovation Programs

INN-01: Modified Cognitive Enhancement Therapy (CET)

Cognitive Enhancement Therapy (CET) is a Recovery-oriented Evidence Based Practice that assists individuals in developing and enhancing their mental capacities where self-awareness encourages self-directed social interactions that leads to greater psychosocial functioning and wellbeing. Clients diagnosed with Schizophrenia and Schizoaffective disorders can improve their mental stamina, active information processing, while learning to function better with and around other people. Originally, CET was developed to support individuals with psychotic disorders and was only utilized with persons who were fluent in English. During the span of our Innovations learning project, TCMHC will expand CET to include those with bi-polar disorder and those who are monolingual Spanish speakers.

Modified CET was approved in January of FY 2011-12 and began operations immediately with the hiring of the coordinator. The Center for Cognition and Recovery began helping TCMHC hire four coaches, train the coaches, and recruit enough clients to create two cohorts for the CET treatment. Sessions began in FY 2012-13.

No significant challenges or barriers were experienced during this start-up phase. There were also no personnel needs, nor significant changes to the program.

INN-02: Integrated Services

The Integrated Services project aims to create a model of truly integrated care with high levels of communication and coordination among providers and a shared commitment to the consumer's wellness. By testing a variety of activities with a pilot cohort of physical health, mental health and substance abuse practitioners, our hope is to build relationships, understanding and knowledge among providers of physical health, substance abuse and mental health services, and changing policies and procedures in ways that result in truly integrated care.

Approved in January of FY 2011-12, the Integrated Services project began implementation in July 2012. TCMHC hired a coordinator, and she began contacting organizations who were involved in the planning of the project to help form the Integration Committee. The Integration Committee met for 13 sessions, developed a mission statement and secured commitments from participating organizations and individuals. This committee includes service providers from all levels of administration and management in the participating organizations.

For FY 2012-13, the Integration Committee recommended the formation of an advisory panel that will include consumers and family members of consumers who have service experiences with at least two of the participating organizations. A survey was administered and feedback was provided to committee members.

No significant challenges or barriers were experienced during this start-up phase. There were also no personnel needs, nor significant changes to the program.

Identified Technical Assistance Needs

TCMHC's review of FY 2011-12 reveals a handful of technical assistance needs, namely:

- More statewide training on geriatric and older adult issues (such as quality of life issues) to assist in delivering Field Capable Services to older adults and our Older Adult Wellbeing programs;
- More statewide training on play therapy, incorporating recovery and strength-based models with kids (how to approach treatment from a strengths-based perspective and still manage challenging behaviors) to assist our Family Wellbeing programs; and,
- More financial access to CiMH trainings on Cognitive Enhancement Therapy.

Description of Performance Measures and Outcomes

To measure the effectiveness of all its programs, including MHSA programs, TCMHC uses Results-Based Accountability (RBA) methods to create a comprehensive, data-driven evaluation system. Each program must go through five stages to develop this evaluation system:

1. Develop priority performance measures for each program;
2. Agree on data sources;
3. Develop a workflow for how that data is collected and reported;
4. Collect data; and,
5. Engage in learning conversations.

Our MHSA programs are in various stages within the above five mentioned and have made significant progress towards learning how to implement the RBA process, systematizing the process, and developing meaningful performance measures for the outcomes we seek. Included as Appendix A are more detailed documents of the performance measures and their data sources for the MHSA programs that have gone through those stages. We anticipate being able to report data on many of these programs in the next Annual Update.

FY 2013/14
MHSA FUNDING SUMMARY

County: Tri-City Mental Health Center **Date:** 5/16/2013

	MHSA Funding					
	CSS	**WET**	**CFTN**	**PEI**	**INN**	**Local Prudent Reserve**
A. Estimated FY 2013/14 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	$4,948,910	$799,980	$2,716,634	$2,040,656	$1,386,057	
2. Estimated New FY 2013/14 Funding	$5,422,164			$1,393,656	$358,380	
3. Transfer in FY 2013/14[a/]	($665,000)			($25,000)		$690,000
4. Access Local Prudent Reserve in FY 2013/14						
5. Estimated Available Funding for FY 2013/14	$9,706,074	$799,980	$2,716,634	$3,409,312	$1,744,437	
B. Estimated FY 2013/14 Expenditures	$6,156,495	$226,350	$0	$1,719,433	$730,241	
C. Estimated FY 2013/14 Contingency Funding	$3,549,579	$573,630	$2,716,634	$1,689,879	$1,014,196	

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

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2013	$2,771,200
2. Contributions to the Local Prudent Reserve in FY 2013/14	$690,000
3. Distributions from Local Prudent Reserve in FY 2013/14	$0
4. Estimated Local Prudent Reserve Balance on June 30, 2014	$3,461,200

CSS PROJECTED FY 2013/14 MHSA EXPENDITURES

County: Tri-City Mental Health Center

Date: 4/19/13

CSS Programs			FY 13/14 Projected MHSA Expenditures	Estimated MHSA Funds by Service Category				Estimated MHSA Funds by Age Group			
	No.	Name		Full Service Partnerships (FSP)	General System Development	Outreach and Engagemen	MHSA Housing	Children and Youth	Transition Age Youth	Adult	Older Adult
Previously Approved Programs											
1.		Full Service Partnerships	$2,560,20	$2,560,20				$467,38	$626,35	$1,112,46	$353,99
2.		Community Navigators	$388,29		$194,14	$194,14		$108,72	$54,36	$174,73	$50,47
3.		Wellness Center	$1,155,52		$1,155,52			$192,97	$192,97	$577,76	$191,81
4.		Supplemental Crisis Services	$175,52		$175,52			$17,55	$52,65	$96,54	$8,77
5.		Field Capable Services For Older Adults	$203,07		$203,07						$203,07
6.		CSS Housing	$716,44				$716,44	$107,46	$214,93	$358,22	$35,82
7.											
8.			$0								
9.			$0								
10.			$0								
11.			$0								
12.			$0								
13.			$0								
14.			$0								
15.			$0								
16.		Subtotal: Programs [a/]	$5,199,06	$2,560,20	$1,728,27	$194,14	$716,44	$894,09	$1,141,28	$2,319,72	$843,96
17.		Plus up to 15% Indirect Administrative Costs	$777,42								
18.		Plus up to 10% Operating Reserve-for Planning	$180,00								
19.		Subtotal: Programs/Indirect Admin./Operating Reserve	$6,156,49								
New Programs/Revised Previously Approved Programs											
1.											
2.			$0								
3.			$0								
4.			$0								
5.			$0								
6.		Subtotal: Programs[a/]	$0	$0	$0	$0	$0	$0	$0	$0	$0
7.		Plus up to 15% Indirect Administrative Costs									
8.		Plus up to 10% Operating Reserve									
9.		Subtotal: Programs/Indirect Admin./Operating Reserve	$0								
10.		**Total MHSA Funds Requested for CSS**	$6,156,49								

a/ Majority of funds must be directed towards FSPs (Cal. Code Regs., tit. 9, § 3620, subd. (c)). Percent of Funds directed towards FSPs= 57.10%

Additional funding sources for FSP requirement:

County must provide the majority of MHSA funding toward Full Service Partnerships (FSPs). If not, the county must list what additional funding sources and amount to be used for FSPs. [In addition, the funding amounts must match the Annual Cost Report.] Refer to DMH FAQs at http://www.dmh.ca.gov/Prop_63/ MHSA/Community_Services_and_Supports/docs/FSP_FAQs_04-17-09.pdf

CSS Majority of Funding to FSPs

Other Funding Sources

	CSS	State General Fund	Other State Funds	Medi-Cal FFP	Medicare	Other Federal Funds	Re-alignment	County Funds	Other Funds	Total	Total %
Total Mental Health Expenditures:	$2,560,203	$452,028	$0	$1,623,381	$0	$0	$0	$0	$0	$4,635,612	89 %

FY 2013/14 ANNUAL UPDATE **EXHIBIT E2**

WET PROJECTED FY 2013/14 MHSA EXPENDITURES

County: Tri-City Mental Health Center **Date:** 4/19/2013

	Workforce Education and Training		FY 11/12 Requested MHSA Funding	Estimated MHSA Funds by Service Category					
	No.	Name		Workforce Staffing Support	Training and Technical Assistance	Mental Health Career Pathway	Residency and Internship	Financial Incentive	
Previously Approved Programs									
1.	WET 01	Learning and Improvement	$150,458	$150,458					
2.	WET 02	Volunteers and Future Employees	$45,008			$45,008			
3.									
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.	Subtotal: Programs [a/]		$195,466	$150,458	$0	$45,008	$0	$0	Percentage
17.	Plus up to 15% Indirect Administrative Costs		$25,884						13%
18.	Plus up to 10% Operating Reserve-for Planning		$5,000						2.3%
19.	Subtotal: Programs/Indirect Admin./Operating Reserve		$226,350						
New Programs									
1.									
2.			$0						
3.			$0						
4.			$0						
5.			$0						
6.	Subtotal: WET New Programs [a/]		$0	$0		$0	$0	$0	Percentage
7.	Plus up to 15% Indirect Administrative Costs								#VALUE!
8.	Plus up to 10% Operating Reserve								#VALUE!
9.	Subtotal: New Programs/Indirect Admin./Operating Reserve		$0						
10.	**Total MHSA Funds Requested**		$226,350						

Note: Previously Approved programs to be expanded, reduced, eliminated and consolidated are considered New.

PEI PROJECTED FY 2013/14 MHSA EXPENDITURES

County: Tri-City Mental Health Center **Date:** 4/19/13

	PEI Programs		FY 12/13 Projected MHSA Expenditures	Estimated MHSA Funds by Type of Intervention		Estimated MHSA Funds by Age Group			
	No.	Name		Prevention	Early Intervention	Children and Youth	Transition Age Youth	Adult	Older Adult
		Previously Approved Programs							
1.	PEI 01	Community Capacity Building	$770,304	$631,649	$138,655	$115,546	$269,606	$231,091	$154,061
2.	PEI 02	Older Adult Wellbeing	$94,686	$60,599	$34,087				$94,686
3.	PEI 03	Transition-Aged Younger Adult Wellbeing	$96,924	$66,878	$30,046		$96,924		
4.	PEI 04	Family Wellbeing	$96,155	$72,116	$24,039	$47,116	$24,039	$13,462	$11,539
5.	PEI 05	Student Wellbeing	$58,900	$42,997	$15,903	$50,065	$8,835		
1.	PEI 06	NAMI Community Capacity Building	$101,123	$82,921	$18,202	$15,168	$35,393	$30,337	$20,225
7.	PEI 07	Building Bridges Between Landlords, Mental Health Providers and Clients	$121,273	$99,444	$21,829	$12,127	$30,318	$78,827	
8.	PEI 08	Therapuetic Community Gardening	$149,240	$122,377	$26,863	$14,924	$37,310	$97,006	
9.									
10.			$0						
11.			$0						
12.			$0						
13.			$0						
14.			$0						
15.			$0						
16.	Subtotal: Programs*		$1,488,605	$1,178,981	$309,624	$254,946	$502,425	$450,723	$280,510
17.	Plus up to 15% Indirect Administrative Costs		$210,828						
18.	Plus up to 10% Operating Reserve-for Planning		$20,000						
19.	Subtotal: Programs/Indirect Admin./Operating Reserve		$1,719,433						
	New/Revised Previously Approved Programs								
1.			$0						
2.			$0						
3.			$0						
4.			$0						
5.			$0						
6.	Subtotal: Programs*		$0	$0	$0	$0	$0	$0	$0
7.	Plus up to 15% Indirect Administrative Costs		$0						
8.	Plus up to 10% Operating Reserve		$0						
9.	Subtotal: Programs/Indirect Admin./Operating Reserve		$0						
10.	**Total MHSA Funds Requested for PEI**		$1,719,433						

*Majority of funds must be directed towards individuals under age 25. Percent of funds directed towards those under 25 years = 51%

Note: Previously Approved Programs that propose changes to Key Community Health Needs, Priority Populations, Activities, and/or funding as described in the Information Notice are considered New.

INN PROJECTED FY 2013/14 MHSA EXPENDITURES

County: Tri-City Mental Health Center **Date:** 4/19/13

	INN Programs		Projected FY 13/14 MHSA Expenditures
	No.	**Name**	
	Previously Approved Programs		
1.	INN 01	Modified Cognitive Enhancement Therapy	$277,422
2.	INN 02	Integrated Services	$331,594
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.	Subtotal: Programs		$609,016
17.	Plus up to 15% Indirect Administrative Costs		$91,225
18.	Plus up to 10% Operating Reserve-for Planning		$30,000
19.	Subtotal: Previously Approved Programs/Indirect Admin./Operating Reserve		$730,241
	New Programs		
1.			
2.			
3.			
4.			
5.			
6.	Subtotal: Programs		$0
7.	Plus up to 15% Indirect Administrative Costs		
8.	Plus up to 10% Operating Reserve		
9.	Subtotal: New Programs/Indirect Admin./Operating Reserve		$0
10.	**Total MHSA Funds Requested for INN**		$730,241

Note: Previously Approved Programs that propose changes to the primary purpose and/or learning goal are considered New.

COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

County: Tri-City Mental Health Center

County Mental Health Director	**County Auditor Controller**
Name: Jesse H. Duff	Name: Margaret Harris
Telephone Number: (909) 623-6131	Telephone Number: (909) 784-2308
E-mail: jduff@tricitymhs.org	Email: mharris@tricitymhs.org
Mailing Address: 1717 N. Indian Hill Boulevard, Suite B Claremont, CA 91711	

I hereby certify that said County has complied with all fiscal accountability requirements as directed by the State Department of Health Care Services, and that all expenditures are consistent with the requirements of the Mental Health Services Act, including Welfare and Institutions Code sections 5891, 5892 and 5893 and Title 9 of the California Code of Regulations sections 3400 and 3410. Additionally, expenditures for Prevention and Early Intervention and Innovative Programs are consistent with the guidelines issued by the Mental Health Services Oversight and Accountability Commission (W&I 5846(a)).

JESSE H. DUFF	_____	_____
Mental Health Director/Designee (PRINT)	Signature	Date
MARGARET A. HARRIS	_____	_____
County Auditor Controller (PRINT)	Signature	Date

County: _____

Date: _____

Mental Health Services Act (MHSA)
Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) FY 2012/13 Prudent Reserve Funding Request

County: **Tri-City Mental Health Center** **Date:** **4/19/13**

Instructions: Utilizing the following format please provide a plan for achieving and maintaining a local Prudent Reserve.

Most Recent Annual Approved Funding Level-MHSA 2012/13 Annual Update

A. CSS Annual Funding Level for Services	**$** $4,779,540	
B. PEI Annual Funding Level for Services	**$** $1,714,391	
Total (A + B):		**$** $6,493,931
C. Less: Total Non-Recurring Expenditures CSS and PEI Subtract any identified non-recurring expenditures for CSS and/or PEI, included in A and B above.		**-** $1,435,929
D. Plus: Total Administration CSS and PEI Enter the total administration funds requested for CSS and/or PEI.		**+** $887,685
E. Sub-total		$5,945,687
F. Maximum Prudent Reserve (50%) Enter 50%, or one-half, of the line item E sub-total. This is the estimated amount the County must achieve and maintain as a local Prudent Reserve by June 30, 2011.		$2,972,844
G. Prudent Reserve Balance from Prior Approvals Enter the total amounts previously approved through Plan Updates for the local Prudent Reserve.		$2,271,200

Amounts Requested to Dedicate to Local Prudent Reserve

H. Plus: CSS Component
Enter the Sub-total amount of funding requested for CSS in H.

*FY 2010/11	Unapproved Funds	**$** $0	
	Unspent Funds	**$** $100,000	
	Sub-total:		**+** $100,000

I. Plus: PEI Component
Enter the Sub-total amount of funding requested for PEI in I.

*FY 2010/11	Unapproved Funds	**$** $0	
	Unspent Funds	**$** $400,000	
	Sub-total:		**+** $400,000

J. Total Amount Requested to Dedicate to Local Prudent Reserve Enter the sum of lines H and I.	$500,000
K. Prudent Reserve Balance Enter the sum of G and J.	$2,771,200
L. Prudent Reserve Shortfall to Achieving 50% (Describe below)	$201,644

Note: Tri-City anticipates that it will dedicate the increase in CSS and PEI funds received in fiscal 2012-13 to the prudent reserve before funding any new or expanded programs.

Signature _____

Name and Title _____

**Per WIC Section 5892 (b), Counties shall not exceed 20% of the average amount of funds allocated to the County for the previous five years.*

Mental Health Services Act (MHSA)
Community Services and Supports (CSS) and Prevention and Early Intervention (PEI)
FY 2013/14 Prudent Reserve Funding Request

County: **Tri-City Mental Health Center** **Date:** **4/19/2013**

Instructions: Utilizing the following format please provide a plan for achieving and maintaining a local Prudent Reserve.

Most Recent Annual Approved Funding Level-MHSA 2013/14 Annual Update

A. CSS Annual Funding Level for Services	**$** $5,358,619			
B. PEI Annual Funding Level for Services	**$** $1,488,605			
	Total (A + B):		**$**	$6,847,224
C. Less: Total Non-Recurring Expenditures CSS and PEI Subtract any identified non-recurring expenditures for CSS and/or PEI, included in A and B above.			**-**	$775,341
D. Plus: Total Administration CSS and PEI Enter the total administration funds requested for CSS and/or PEI.			**+**	$828,704
E. Sub-total				$6,900,587
F. Maximum Prudent Reserve (50%) Enter 50%, or one-half, of the line item E sub-total. This is the estimated amount the County must achieve and maintain as a local Prudent Reserve by June 30, 2011.				$3,450,293
G. Prudent Reserve Balance from Prior Approvals Enter the total amounts previously approved through Plan Updates for the local Prudent Reserve.				$2,771,200

Amounts Requested to Dedicate to Local Prudent Reserve

H. Plus: CSS Component
Enter the Sub-total amount of funding requested for CSS in H.

*FY 2011/12 Unapproved Funds	**$** $0			
Unspent Funds	**$** $665,000			
	Sub-total:		**+**	$665,000

I. Plus: PEI Component
Enter the Sub-total amount of funding requested for PEI in I.

*FY 2011/12 Unapproved Funds	**$** $0			
Unspent Funds	**$** $25,000			
	Sub-total:		**+**	$25,000

J. Total Amount Requested to Dedicate to Local Prudent Reserve Enter the sum of lines H and I.		$690,000
K. Prudent Reserve Balance Enter the sum of G and J.		$3,461,200
L. Prudent Reserve Shortfall to Achieving 50% (Describe below)		-$10,907

Signature _____

Name and Title _____

**Per WIC Section 5892 (b), Counties shall not exceed 20% of the average amount of funds allocated to the County for the previous five years.*

PERFORMANCE MEASURES: COMMUNITY NAVIGATORS

	Performance Measure	Data Source	Notes
How much did we do?	1. # of individuals engaged by city (a) By phone (b) In person (c) Other	Available?	Possible data for Outreach
	2. # of meetings attended in the community (month/Quarter) by location		Possible data for Outreach
	3. # of referrals made to Navigators (a) By phone (b) In person (c) Other	Available?	
	4. # of referrals made by Navigators to resources (a) By phone (b) In person (c) Other By type of resource	Available?	
	5. # of requests by type of resource		(a) PM#5 is a derivative of PM#3 (b) Type ex: Shoes; food; housing; M.H services; other.
How well did we do it?	6. Demographics of individuals served	Available?	Poss. Data for Outreach.
	7. % of referrals made to Navigators that resulted in successful inquiry of needs.	Available?	
	8. % of referrals made by Navigators that resulted in successful "linkage" to resources.	Available	Their goal is to "link" individuals to resources to meet their needs.(whether they go or not is a different PM)
	9. % of individuals who access resources to which they are referred a) By follow-up to participant b) By follow-up to provider	DD	Create anecdotal log sheet
Is anybody better off?	10. % of individuals whose needs were met	DD	Is this possible to get?
	11. % of participants making connections to others	DD	How to get this data? Can Navigators see increased interactions?
	12. Increased awareness in the community of Community Navigators		(a)Possible random survey (b) Possible data for Outreach
	13. % of partnerships developed between Tri-City and community resource providers	DD	(a) Used one time vs multiple times for resources. (b) Possible (survey) & data for Outreach

Other Questions:

1. #6: Trying to reflect demographic of some population?
2. #9: Challenges in follow-up to participant?
3. #13: Is there a subset of community resource providers whom there is a connection with that can be surveyed?
4. Use Community Navigators as data source for Community Outreach?

PERFORMANCE MEASURES MAPS
WELLNESS CENTER AND RELATED PROGRAMS

Wellness Center Groups/Workshops Map

	Performance Measures	Data Source	Notes
How much did we do?	**Participants**		
	1. # of participants by type of experience (e.g., groups, 1:1, workshops, outside events)	a. I.T database b. Sign-in sheets	Survey Q3 (a-o)
	2. # of participants by age (TAY, Adult, Older Adult)	DD	Survey Q6
	Staff		
	3. # of community presentations per quarter	DD	Gamaliel's Outlook Calendar
	4. # of groups/workshops/events run by community partners	DD	Space reservation form
How well did we do it?	**Participants**		
	5. % of participants who come to Wellness Center from: a. They've been coming for awhile b. Tri-City staff member told them c. A community presentation by a Wellness Center staff d. A friend or relative e. Tri-City website f. A formal referral g. Other (media, newspapers, etc.)	DD	Survey Q1 (a-g)
	6. % of participants who have attended the Wellness Center for: a. Less than 1 month b. 1-6 months c. 7 months to 1 year d. More than 1 year	DD	Survey Q2
	7. % of participants satisfied with experience	DD	Survey Q4 (a-e)
	8. % of groups: a. Led by group leads b. Led by other staff c. Self-led	DD	Gamaliel's tracking sheet
	9. % of groups that average 8 or more participants for the month	DD	
	10. % of months at full capacity for Wellness Ctr run groups (XX)	DD	Total number of groups TBD
	Staff		
	11. Community awareness of Wellness Center and programs	DD	Survey Q1c
Is anyone better off?	**Participants**		
	12. % reporting feeling improved relationship with self.	DD	Survey Q5a
	13. % reporting feeling improved relationship with others.	DD	Survey Q5b
	14. % reporting improved relationship with own family.	DD	Survey Q5c
	15. % reporting improved wellbeing.	DD	Survey Q5d
	16. % of participants transitioning into lower levels of care	DD	Exit calls + tracking form
	17. % of participants transitioning into higher levels of care	DD	a. Follow-up b. Exit calls+ tracking form c. (conversation to be had in Q3 February)
	Staff		
	18. % reporting improved wellbeing	DD	Staff Survey (Adaptation of CWB Survey and POQI Survey)

PERFORMANCE MEASURES MAPS
WELLNESS CENTER AND RELATED PROGRAMS

Family Wellbeing Program Map

	Performance Measures	Data Source	Notes
How much did we do?	**Participants**		
	1. # of participants by type of experience (e.g., groups, 1:1 support, referrals)	DD	a. Sign in sheets b. Survey Q3 (a-o)
How well did we do it?	**Participants**		
	2. % of participants who come to the Family Wellbeing Program from: a. They've been coming for awhile b. Tri-City staff member told them. c. A community presentation by a Wellness Center staff d. A friend or relative e. Tri-City website f. A formal referral g. Other (media, newspapers, etc.)	DD	Survey Q1 (a-g)
	3. % of participants who have participated in the Family Wellbeing Program for: a. Less than 1 month b. 1-6 months c. 7 months to 1 year d. More than 1 year	DD	Survey Q2
	4. % of participants satisfied with experience	DD	Survey Q4 (a-e)
	5. % of referred individuals who receive follow-up	DD	Participant log
	Staff		
	6. Community awareness of Family Wellbeing Program	DD	Survey Q1c
Is anybody better off?	**Participants**		
	7. % reporting feeling improved relationship with self.	DD	Survey Q5a
	8. % reporting feeling improved relationship with others.	DD	Survey Q5b
	9. % reporting improved relationship with own family.	DD	Survey Q5c
	10. % reporting improved wellbeing.	DD	Survey Q5d
	Staff		
	11. % reporting improved wellbeing	DD	Staff Survey (Adaptation of CWB Survey and POQI Survey)

Employment Program Map

	Performance Measures	Data Source	Notes
How much did we do?	**Participants**		
	1. # of participants	DD	a. Sign in sheets b. Survey Q3 (e, f, g, n)
How well did we do it?	**Participants**		
	2. % of participants who come to the Employment Program from: a. They've been coming for awhile b. Tri-City staff member told them. c. A community presentation by a Wellness Center staff d. A friend or relative e. Tri-City website f. A formal referral g. Other (media, newspaper etc)	DD	Survey Q1 (a-g)
	3. % of participants who have participated in the Employment Program for: a. Less than 1 month b. 1-6 months c. 7 months to 1 year d. More than 1 year	DD	DD
	4. % of participants satisfied with experience	DD	Survey Q4 (a-e)
	5. % of referred individuals who receive follow-up	DD	Participant log
	Staff		
	6. Community awareness of Employment Program	DD	Survey Q1c
Is anybody better off?	**Participants**		
	7. % reporting feeling improved relationship with self.	DD	Survey Q5a
	8. % reporting feeling improved relationship with others.	DD	Survey Q5b
	9. % reporting improved relationship with own family.	DD	Survey Q5c
	10. % reporting improved wellbeing.	DD	Survey Q5d
	11. % of participants who maintain employment at 30 days • 90 days • more than 90 days	DD	Sonny's tracking sheet
	12. % of participants who enroll in education	DD	Sonny's tracking sheet
	13. % of participants who enroll in vocational education	DD	Sonny's tracking sheet
	Staff		
	14. % reporting improved wellbeing	DD	Staff Survey (Adaptation of CWB Survey and POQI Survey)

TAY Program Map

	Performance Measures	Data Source	Notes
How much did we do?	Participants		
	15. # of participants by type of experience (e.g., groups, 1:1 support, workshops/classes, employment/education support)	DD	Sign in sheets Survey Q4 (i-o)
How well did we do it?	Participants		
	16. % of participants who come to the TAY Program from: a. They've been coming for awhile b. Tri-City staff member told them. c. A community presentation by a Wellness Center staff d. A friend or relative e. Tri-City website f. A formal referral g. Other (media, newspaper etc)	DD	Survey Q1 (a-g)
	17. % of participants who have participated in the TAY Program for: a. Less than 1 month b. 1-6 months c. 7 months to 1 year d. More than 1 year	DD	Survey Q2
	18. % of participants satisfied with experience	DD	Survey Q4 (a-e)
	19. % of referred individuals who receive follow-up	DD	Participant log
	Staff		
	20. Community awareness of TAY Program	DD	Survey Q1c
Is anybody better off?	Participants		
	21. % reporting feeling improved relationship with self.	DD	Survey Q5a
	22. % reporting feeling improved relationship with others.	DD	Survey Q5b
	23. % reporting improved relationship with own family.	DD	Survey Q5c
	24. % reporting improved wellbeing.	DD	Survey Q5d
	Staff		
	25. % reporting improved wellbeing	DD	Staff Survey (Adaptation of CWB Survey and POQI Survey)

PERFORMANCE MEASURES: HOUSING

	Performance Measure	Data Source	Notes
How much did we do?	1. # of participants by program type: (a) Shelter + Care (vouchers) (b) Fresh Start (c) Park Ave		List of current participants?
	2. # of individuals participating in Landlord- curriculum (To Be A Better Tenant)		Curriculum is in the process of being developed
	3. # of referrals received (weekly, monthly, quarterly?) (a) Internal (b) External		Housing referral form
	4. # of applications completed (weekly, monthly, quarterly?)		Applications processed
How well did we do it?	5. % of days housed		a) not homeless b) proxy for stigma reduction
	6. % of evictions avoided as a result of "mediation"		) Cases overturned because of Liaison intervention? b) proxy for stigma reduction
	7. % of participants who report increased living skills		a) curriculum participation b) possible survey
	8. % of participants who agree to services		
	9. % of Fresh Start participants who transition to permanent housing		
	10. % of Landlords successfully linked with MHFA		Future program goal
Is anybody better off?	11. % of participants who developed a positive relationship between themselves and: (a) Landlords/property manager (b) Mental Health service providers (c) Community		Possible survey Q (a) Participants (b) Landlords/prop. Mngt.
	12. % of participants who can successfully identify challenges of maintaining permanent housing		Possible survey Q
	13. % of participants who report their needs were met		Possible survey Q
	14. % of participants who understand and can identify what being a good tenant is		(a) Possible survey Q (b) Curriculum participation
	15. % of participants with increased access to services through interagency collaboration		What (total known) services/resources do they receive and where?

Other Questions? (Does Gilbert want to track the following):

1. # of housing units (occupied)
2. Shelter plus care vouchers issued/used?
3. Landlord's curriculum- passed?
4. # of applications disallowed by housing authorities?
5. How will the HEARTH Act affect housing requirements moving forward? (Chronic homelessness def.)
6. Operating costs? (% met by month, quarter, etc)
7. Issues with inter-agency communication? (Clinicians not focusing treatment goals on Housing)

PERFORMANCE MEASURES: COMMUNITY WELLBEING PROGRAM

	Performance Measure	Data Source	Notes
How much did we do?	1. # of individuals outreached to for pre-application process	Tracking sheets; Bidders sign-in sheets, applications Chris	Entered/tracked in Excel Tracked annually
	2. # of communities (met with as a community) outreached to in the pre-application process	tracking sheets Chris	Entered/tracked in Excel Tracked annually
	3. # of communities at bidders conference	Bidders sign-in sheets Chris	feedback re: marketing Tracked annually
	4. # of qualified applications	Applications, score sheets Chris	Entered/tracked in Excel Tracked annually
	5. # of communities chosen each year	Applications Chris	Entered/tracked in Excel Tracked annually
	6. # of intercommunity learning events	Meeting sign-in sheets Chris	Entered/tracked in Excel Tracked annually
	7. # of participants per intercommunity learning event	Meeting sign-in sheets Chris	Entered/tracked in Excel Tracked Annually and Quarterly
	8. # of communities per learning event	Meeting sign-in sheets Chris	Entered/tracked in Excel Tracked Annually and Quarterly
	9. # of individual community support sessions	Staff tracking Chris	Entered/tracked in Excel Tracked Quarterly (w/QI support)
	10. # of community members' lives touched (directly)	CWB Surveys Chris	Tracked Quarterly (w/QI support)
	11. # of lives touched (direct + indirect)	Ask at 1:1 meetings Chris	Tracked Quarterly (w/QI support)
	12. Demographic data	Applications and 1 on 1's Chris	Tracked annually and Quarterly
How well did we do it?	13. % of communities outreached to that submit applications	Outreach sign-in sheets; applications Chris	Entered/tracked in Excel Tracked annually
	14. % of applications submitted that were qualified	Score sheet Chris	Entered/tracked in Excel Tracked annually
	15. % of qualified applications that were selected	Staff Chris	Entered/tracked in Excel
	16. % of communities participating at intercommunity gatherings	Meeting sign-in sheets Chris	Entered/tracked in Excel Tracked Annually and Quarterly
	17. % of communities implementing survey by due date	Surveys QI, Chris	Entered/tracked in Excel Tracked Annually and Quarterly
	18. % of communities reporting that wellbeing data was useful	DD: Add this question to the last wellbeing survey QI, Chris	Tracked Annually and Quarterly
	19. % of leaders satisfied with the support they received	DD: Revise leadership survey QI, Chris	Will revisit after LD framework discussion Tracked annually
Is anybody better off?	20. % of communities reporting improvement in individual members' relationship with others	CWB survey question 8: Aug-Sept; Oct-Dec; Jan-May QI, Chris	Tracked Quarterly (w/QI support)
	21. % of communities reporting improvement in individual members' relationship with self	CWB survey question 9: Aug-Sept; Oct-Dec; Jan-May QI, Chris	Tracked Quarterly (w/QI support)
	22. % of communities reporting improvement in community members supporting each other	CWB survey question 1: Aug-Sept; Oct-Dec; Jan-May QI, Chris	Tracked Quarterly (w/QI support)
	23. % of communities reporting improvement in community members' ability to effectively act together	CWB survey question 5: QI, Chris	Tracked Quarterly (w/QI support)
	24. % of community leaders reporting improved leadership capacity	DD: Revise leadership survey QI, Chris	Will revisit after LD framework discussion Tracked annually

PERFORMANCE MEASURES: MHFA PROGRAM

	Performance Measure	Data Source	Notes
How much did we do?	**Instructors**		
	1. # of free classes taught in the Tri-City area each fiscal year	Available [Google Doc] PEI	
	2. # of instructors maintaining certification each year	Available [Google Doc] PEI	
	3. # of instructors participating in quarterly meetings	Available [Meeting Sign-in] PEI	
	MHFA'ers		
	4. Total # of MHFA'ers trained each fiscal year	Available [Google Doc] PEI	
	5. # of MHFA'ers reporting that they provided support	DD: Ongoing Online Survey QA	
	6. Demographic Data	National Survey & Question 31 PEI/QA	
	People receiving MHFA support		
	7. # of people receiving support each year from MHFA'ers	DD: Ongoing Online Survey QA	
How well did we do it?	**Instructors**		
	8. % current instructors maintaining certification after year 1	Available [Google Doc] PEI	
	9. % instructors maintaining certification for 2 or more years	Available [Google Doc] PEI	
	10. % of trainings conducted each year w/o Tri-City staff instructors	Tracking sheet [Google Doc] PEI	
	MHFA'ers		
	11. YTD comparison to prior year of # of trainings conducted (by qtr)	Available [Google Doc] PEI	FY 2012-13 is baseline year
	12. YTD comparison to prior year of # of MHFA'ers trained (by qtr)	Available [Google Doc] PEI	FY 2012-13 is baseline year
	13. % of MHFA'ers who maintain confidence and ability to apply MHFA: a. 6 months after completing training b. One year after completing training c. More than one year after completing training	DD: Bi Annual Online Survey QA	12.a. Online Survey 12.b. Online Survey 12.c. Online Survey
	14. % who report having the ability to connect individuals to professional help: a. At end of training b. 6 months after completing training c. One year after completing training	[National Survey] PEI/QA DD: Bi Annual Online Survey QI	13.a.: Question 18 of National survey at end of training 13.b. Online survey 13.c. Online survey
	15. % who report having the ability to connect individuals to community supports: a. At end of training b. 6 months after completing training c. One year after completing training	[National Survey] PEI/QA DD: Bi Annual Online Survey QI	14.a.: Question 19 of National survey for at end of training 14.b. Online survey 14.c. Online survey
Is anyone better off?	**Instructors**		
	16. % who demonstrate knowledge of the material taught	Available [National Survey] PEI/QI	Question 10 National survey FY 2012-13 is baseline year
	MHFA'ers report feeling more confident that they can:		
	17. Reach out to someone who may be dealing with a mental health problem or crisis.	Available [National Survey] PEI/QI	Question 14 National survey FY 2012-13 is baseline year
	18. Offer a distressed person basic "first aid" level information and reassurance about mental health problems.	Available [National Survey] PEI/QI	Question 17 National survey FY 2012-13 is baseline year
	19. Recognize and correct misconceptions about mental health and mental illness as they encounter them.	Available [National Survey] PEI/QI	Question 21 National survey FY 2012-13 is baseline year
	People receiving MHFA support		
	20. # of people reporting that they provided MHFA	DD: Ongoing Online Survey QI	

Note: *MHFA'ers will be grouped by training month and 6 months/1 Year out will received an email asking to fill out an Online Survey [Bi Annual]*