Mental Health Services Act (Prop 63)
Review of California's Innovation Work Plans

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The MHSA provides funding to counties to address a broad range of prevention and intervention services. There are five components of MHSA: Community Services and Supports (CSS); Workforce Education and Training (WET); Capital Facilities and Technological Needs; Prevention and Early Intervention (PEI), and Innovation (INN). Five percent (5.0%) of the total MHSA funding to counties is set aside for INN projects. This report summarizes the INN work plans approved by CalMHSA, the independent oversight body, for fiscal years 2008-2009 and 2009-2010. This report is divided into three sections: 1) *Overview of all Innovative Work Plans*; 2) *Comparison of Plans with an Integration Component to those with no Integration Component*; and 3) *Taking a Closer Look at Work Plans with an Integration Component*.

Overview of all Innovative Work Plans

Thirty-three (33) of 58 counties (56.9%) submitted work plans[1]. A total of 91 work plans were submitted, as some counties submitted multiple work plans. Collectively, more than $57 million dollars were requested for the first year of INN work plans implementation, and at least $135 million is projected to be requested to fund the full duration of each project. The 91 INN plans are designed to serve nearly 50,000 consumers each year. Table 1 shows counties with submitted work plans, the number of work plans submitted by each county, and counties as yet to submit work plans.

Table 1: INN Work Plans by County

Counties with Submitted Work Plans (N=33)			Counties that have not Submit Work Plans (N=25)		
Alameda (1)	Mariposa (1)	San Luis Obispo (8)	Alpine	Lake	San Joaquin
Amador (1)	Merced (1)	San Mateo (1)	Colusa	Lassen	Sierra
Butte (5)	Modoc (1)	Santa Barbara (1)	Del Norte	Mendocino	Siskiyou
Calaveras (2)	Mono (1)	Santa Clara (7)[2]	El Dorado	Napa	Sutter
Contra Costa (2)	Monterey (6)	Santa Cruz (1)	Fresno	Nevada	Tehama
Humboldt (1)	Orange (10)	Shasta (2)	Glenn	Plumas	Tulare
Kern (1)	Placer (1)	Solano (1)	Imperial	Sacramento	Ventura
Kings (1)	Riverside (2)	Sonoma (3)	Inyo	San Benito	Yolo
Los Angeles (4)	San Bernardino (5)	Stanislaus (1)			Yuba
Madera (3)	San Diego (5)	Trinity (1)			
Marin (1)	San Francisco (9)	Tuolumne (1)			

[1] The California Mental Health Services Oversight and Accountability Commission website, which lists all county work plans for Innovation, was last updated on March 2011. Counties that submitted and had their work plans approved after March 2011 do not appear in this report.

[2] Santa Clara County has 7 approved work plans, and one additional work plan that has not been approved (as of March 2011).

Five percent (5.0%) of the total MHSA funding for each county is allocated for Innovation work plans. At the time of this report, not all counties had submitted INN work plans to claim their allocation of funds. Table 2 presents the total INN funds available to each county for **fiscal year 2011-2012**[3]. Counties that do not have approved work plans are highlighted in yellow[4]. Counties are reported by the amount of funds available from largest to smallest. Additionally, the ranking of each county by population size is presented.

Table 2: INN Funds by County

County	INN Allocation[5]	County Ranking by Population Size (1-58)	County	INN Allocation	County Ranking by Population Size (1-58)	County	INN Allocation	County Ranking by Population Size (1-58)
Los Angeles	$210,077,200	1	Solano	$7,527,700	21	San Benito	$1,589,000	42
San Diego	60,240,700	2	Merced	5,547,300	26	Tehama	1,588,500	41
Orange	59,752,100	3	Santa Cruz	5,483,900	24	Tuolumne	1,540,300	43
San Bernardino	39,143,000	5	Placer	5,145,300	22	Calaveras	1,444,400	45
Riverside	38,793,200	4	San Luis Obispo	5,101,800	23	Siskiyou	1,419,700	44
Santa Clara	33,536,100	6	Butte	4,396,600	27	Amador	1,357,100	46
Alameda	26,276,200	7	Marin	4,219,100	25	Glenn	1,304,600	49
Sacramento	23,754,100	8	Yolo	4,096,100	28	Lassen	1,299,300	47
Fresno	18,292,000	10	Imperial	3,768,400	30	Del Norte	1,296,400	48
Contra Costa	16,752,600	9	Shasta	3,676,000	29	Colusa	1,242,900	50
Kern	15,817,000	13	Madera	3,324,400	33	Plumas	1,200,400	51
Ventura	15,417,800	12	Kings	3,186,900	32	Mariposa	858,500	52
San Francisco	13,557,900	11	El Dorado	3,083,200	31	Inyo	851,000	53
San Joaquin	12,591,000	15	Humboldt	2,750,400	35	Mono	831,500	55
San Mateo	11,976,500	14	Napa	2,558,500	34	Trinity	827,900	54
Stanislaus	9,620,600	16	Nevada	2,139,300	37	Modoc	792,100	56
Tulare	9,126,900	18	Sutter	1,959,200	36	Sierra	736,700	57
Monterey	8,708,200	19	Mendocino	1,943,800	38	Alpine	718,400	58
Santa Barbara	8,624,200	20	Yuba	1,754,800	39	Berkeley City	2,212,400	
Sonoma	8,426,900	17	Lake	1,634,300	40	Tri-City	4,107,700	

[3] The total INN funds available for fiscal year 2011-2012 is $741,000,000.

[4] The California Mental Health Services Oversight and Accountability Commission website, which includes county work plans for INN, was last updated on March 2011. Counties that submitted work plans after March 2011 are highlighted in yellow.

[5] The total funds that have been claimed by counties with approved INN work plans is $625,633,700; Funds for counties that have not submitted their INN work plan(s) totals $115,366,300.

Table 3 shows the names of the INN work plans for each county and the total projected total cost of each project, if available. There are twenty-two (22) work plans (24.2% of total) that include a component that integrates physical and mental health. These projects are highlighted in blue. Totals in may exceed the sum of work plan budgets because the total funds may also include county administration costs and/or optional operating reserve

Table 3: INN Work Plan Names and Budgets by County

County	Total Budget	First Year Budget	Duration	Name of Innovation Work Plan (N=91)
Alameda	$2,543,800	$2,543,800	3	Innovative Grant Program
Amador	$483,430	$85,023	4	Community-Driven Delivery of Self-Management Practices
Butte	$408,538	$173,437	3	Effectiveness of Services for People Experiencing a Mental Health Crisis
	$418,530	$180,787	3	Homeless Shelter Collaboration
	$315,102	$80,000	3	Early Intervention Systems for Youth Task Force
	$536,540	$230,667	3	Therapeutic Wilderness Experience
	$257,163	$111,701	3	Community-based Tx for Historical Trauma to Help Hmong Elders
Total	$1,935,873	$776,592		
Calaveras	$300,000	$100,000	3	Community Support Groups
	$54,000	$18,000	3	Garden to Families
Total	$354,000	$118,000		
Contra Costa	Unavailable[6]	$1,454,228	3	Social Supports for (LGBTQQI2-S) Youth
	$281,781	$281,781	1	Promoting Wellness, Recovery & Self-Management
Total	Unavailable	$1,736,009		
Humboldt	$818,700	$395,494	2	Adaptation to Peer Transition Age Youth (TAY) Support
Kern	Unavailable	$2,254,600	4	The Freise Hope House Project
Kings	$944,843	$124,580	4	Youth Transitions
Los Angeles	$7,280,000	$3,640,000	2	Integrated Clinic Model
	$8,714,238	$5,220,024	2	Mobile Health Team
	$15,997,800	$7,998,900	2	Community Designed Integrated Service Management (ISM)
	$4,870,000	$2,435,000	2	Integrated Peer-Run Model
Total	$36,862,038	$19,293,924		
Madera	Unavailable	$330,943	3	Increase Access from Crisis Services
	Unavailable	$19,200	3	Linkage to Physical Health by Pharmacist and Integration from MH to Physical…
	Unavailable	$330,079	3	Peer Support and Clinical Services in a Rural County MH System
Total	Unavailable	$680,222		

Table 3: INN Work Plan Names and Budgets by County (continued)

County	Total Budget	First Year Budget	Duration	Name of Innovation Work Plan (N=91)
Marin	$1,481,800	$222,159	3	Client Choice and Hospital Prevention Program
Mariposa	$1,663,400	$714,537	3	MHSA Team Decision Making
Merced	$1,110,101	$44,831	3	Strengthening Families Project
Modoc	$353,900	$85,000	3	Taking Integration Personally
Mono	$24,000	$24,000	1	Peapod Program
Monterey	Unavailable	$290,176	3	Positive Behavioral Intervention Supports
	Unavailable	$327,228	3	Juvenile Sex Offender Response Team
	Unavailable	$233,066	3	Alternative Healing and Promotores de Salud
	Unavailable	$80,000	2	Youth Pro-Social Skill Development: Incubation of Ideas
	Unavailable	$92,976	1	Mental Health Evaluation Model, Outcome Data, and Reporting Plan
	Unavailable	$150,000	2	Transition Age Youth Housing – A New Approach
Total	Unavailable	$1,173,446		
Orange	$4,162,267	$891,733	3	Integrated Community Services
	$1,404,462	$330,172	3	Family-Focused Crisis Management and Community Outreach
	$1,743,869	$398,054	3	Volunteer to Work
	$1,791,542	$407,588	3	OK to Be Me
	$2,168,099	$482,900	3	Vet Connect
	$516,877	$142,655	3	Community Cares Project
	$1,068,839	$226,567	3	Education, Training and Research Institute
	$1,992,837	$447,847	3	Project Life Coach
	$217,457	$60,503	3	Training to Meet the Mental Health Needs of the Deaf Community
	$900,597	$212,599	3	Consumer Early Childhood Mental Health
Total	$15,966,846	$3,600,618		
Placer	$1,340,261	$348,467	3	Innovative Community Collaborative Grants Program
Riverside	$224,949	$224,949	1	Recovery Arts Core Project
	$7,853,534	$2,305,202	3	Recovery Learning Center
Total	$8,078,483	$2,530,151		

Table 3: INN Work Plan Names and Budgets by County (continued)

County	Total Budget	First Year Budget	Duration	Name of Innovation Work Plan (N=91)
San Bernardino	$94,500	$47,250	2	Online Diverse Community Experiences
	$1,791,745	$895,873	3	Coalition Against Sexual Exploitation
	$830,015	$480,708	3	Community Resilience Model
	$1,769,180	$897,014	3	Holistic Campus
	$6,311,400	$1,555,282	5	Interagency Youth Resiliency Team
Total	$10,796,840	$3,876,127		
San Diego	Unavailable	$1,000,000	3	Wellness and Self-Regulation for Children and Youth
	Unavailable	$1,500,000	3	Peer and Family Engagement Project
	Unavailable	$850,000	3	Physical Health Integration
	Unavailable	$200,000	3	Mobility Management in North San Diego County
	Unavailable	$250,000	2	Positive Parenting for Men in Recovery
Total	Unavailable	$3,800,000		
San Francisco	Unavailable	$323,069	2	Adapt the WRAP
	$100,500	$100,500	1	Mindfulness-based Intervention for Youth and their Providers
	Unavailable	$331,775	2	Supported Employment & Cognitive Training
	Unavailable	$224,586	2	Digital Story Telling (DST) for Adults
	$207,763	$207,763	1	Youth-Led Evaluation of Behavioral Health Assessment Tools
	Unavailable	$246,087	2	Peer Education / Advocacy on Self-Help Movement
	Unavailable	$294,688	2	Peer-led Hoarding and Cluttering Support Team
	Unavailable	$338,756	3	Collaboration with the Faith Community
	Unavailable	$1,253,875	3	Community Mini-Grants for Innovation
Total	Unavailable	$3,321,099		
San Luis Obispo	$158,694	$10,276	3	System Empowerment for Consumers, Families, and Providers
	$397,983	$122,377	5	Atascadero Student Wellness Career Project
	$211,310	$100,906	3	Older Adult Family Facilitation
	$186,190	$88,346	3	Nonviolent Communication (NVC) Education Trial
	$327,523	$103,456	4	Wellness Arts 101
	$543,870	$188,921	4	Warm Reception and Family Guidance
	$2,711,189	$130,846	3	Operation Coastal Care
	$314,641	$152,572	3	Multi-Modal Play Therapy Outreach Trial
Total	$4,851,400	$897,700		

Table 3: INN Work Plan Names and Budgets by County (continued)

County	Total Budget	First Year Budget	Duration	Name of Innovation Work Plan (N=91)
San Mateo	$3,322,920	$1,107,640	3	Total Wellness[7]
Santa Barbara	$2,948,000	$916,000	3	Benefit Acquisition for High-Risk Indigent Individuals
Santa Clara	$503,255	$170,158	2	Early Childhood Universal Screening
	$3,504,222	$703,529	3	Peer-Run TAY Inn
	$1,084,302	$252,060	3	Older Adults Project
	$2,135,998	$481,791	3	Multi-Cultural Center
	$1,316,700	$256,025	3	Transitional MH Services to Newly Released County Inmates
	$911,075	$285,209	2	Mental Health / Law Enforcement Post-Crisis Intervention
	$335,500	$214,500	3	Interactive Video Simulator Training
	N/A	N/A	N/A	MH Disorders in Adults with Autism / Developmental Disabilities[8]
Total	$9,791,052	$2,363,272		
Santa Cruz	Unavailable	$776,710	5	Avenues: Work First for Individuals with Co-Occurring Disorders
Shasta	Unavailable	$583,907	3	Community Intervention Pre-Crisis Team[9]
	Unavailable	$592,200	5	Non-Revocable Parolee Intervention Team[10]
Total	Unavailable	$1,176,107		
Solano	Unavailable	$1,078,300	3	Community Access to Resources and Education (CARE)
Sonoma	$877,367	$200,000	3	Interdisciplinary Mobile Intervention Team
	$1,861,315	$300,000	3	Three-Pronged Integrated Community Health Model
	$350,000	$100,000	3	Reducing Disparities Community Fund Initiative
Total	$3,088,682	$600,000		
Stanislaus	$712,200	$166,872	3	Evolving a Community-Owned Behavioral Health System of Supports
Trinity	Unavailable	$70,000	2	Respite Support Project
Tuolumne	$1,049,346	$324,942	3	Building a Life at Home Innovation Project

[7] Approval pending
[8] Approval pending. Limited information was provided for this plan; it has been excluded from all analyses in this report.
[9] Approval pending
[10] Approval pending

Stakeholder Planning Process

Counties were asked to describe the community planning process for the development of their INN work plan(s), including the method for obtaining stakeholder input[11]. Depending on the planning method(s) that each county chose to use, planning processes for INN ranged from one or two months to more than one year. Planning for INN often incorporated information gathered from other MHSA planning activities:

- Community Services and Support (CSS)
- Prevention and Early Intervention (PEI)
- Workforce Education and Training (WET)

Some counties reported hundreds of stakeholders participating in the various MHSA planning processes/groups. At minimum, all INN plans included stakeholder representation from:

- Consumers and family members
- Community-based and partner organization
- County agencies
- Ethnic/diverse populations
- Interested community members (All Innovation work plans were subjected to a 30-day comment period by the public)

Counties used a variety of methods to gather stakeholder input, including but not limited to:

- Community meetings
- Forums
- Convening of a variety of committees/workgroups (planning, review, ranking, etc)
- interviews with key informants
- review of previously gathered input
- focus groups
- surveys/questionnaires
- presentations
- individual and group meetings

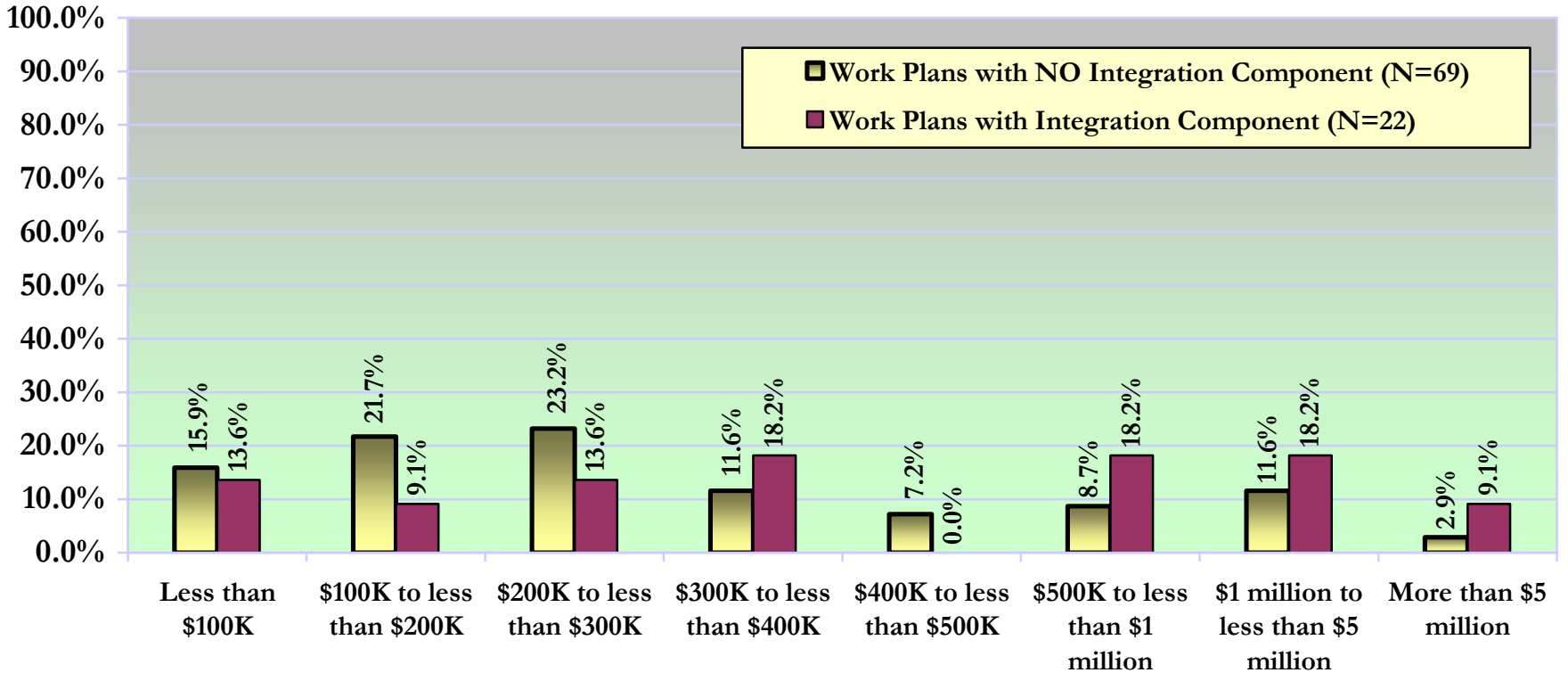
For plans that include an integration component, the development of INN work plan ideas were derived primarily by members of planning groups (52.6%) or through solicitation of ideas from the community/public (47.4%) (N=19). For plans that did NOT include an integration component, the development of INN work plan ideas were derived primarily by members of planning groups (36.7%) or through solicitation of ideas from the community/public (63.3%) (N=60).

[11] It is difficult to quantify/qualify the planning process(es) for INN because the process(es) were not necessarily separated from other MHSA planning processes.

Comparison of Plans with an Integration Component to those with no Integration Component

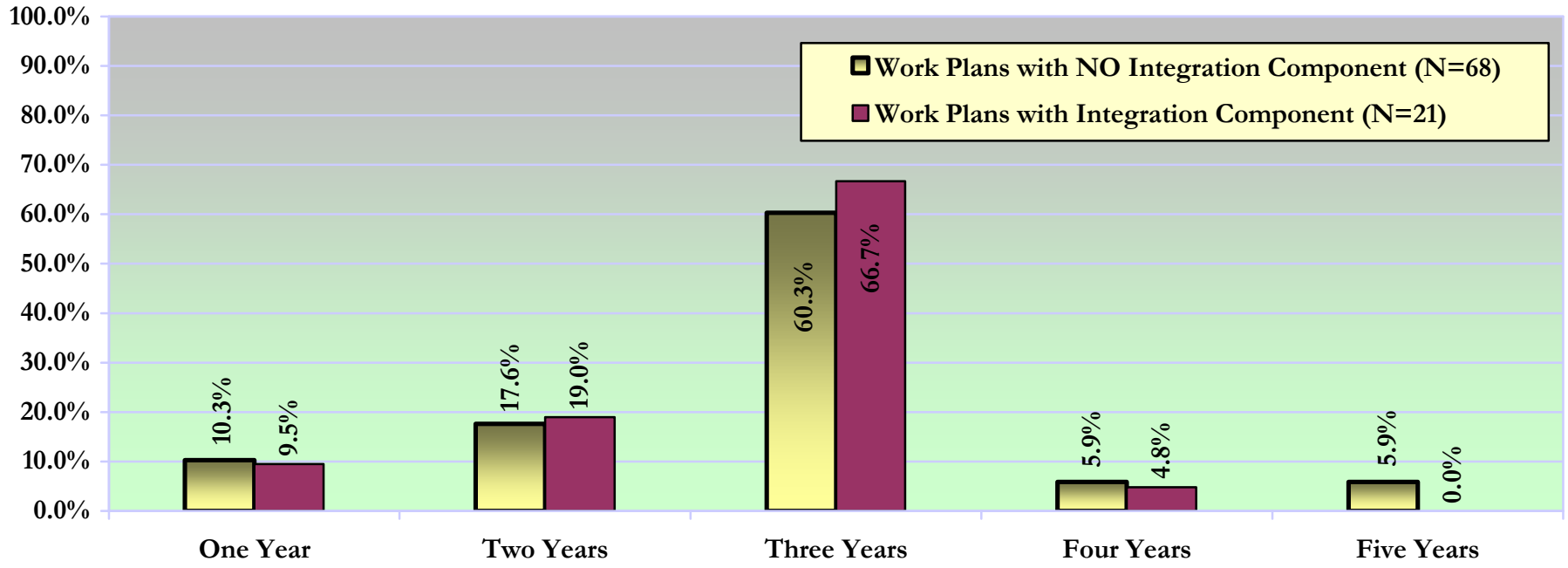
For the first year that INN projects were implemented, counties requested amounts ranging from $10,276 (San Luis Obispo, "*System Empowerment for Consumers, Families, and Providers*") to $7,998,900 (Los Angeles County, "*Community Designed Integrated Service Management*"). Figure 1 presents the percentages by dollar range that the counties requested for the first year of integration and non-integration initiatives based on budgets posted as of March 2011.

Figure 1: Dollar Ranges of INN Work Plan Budgets



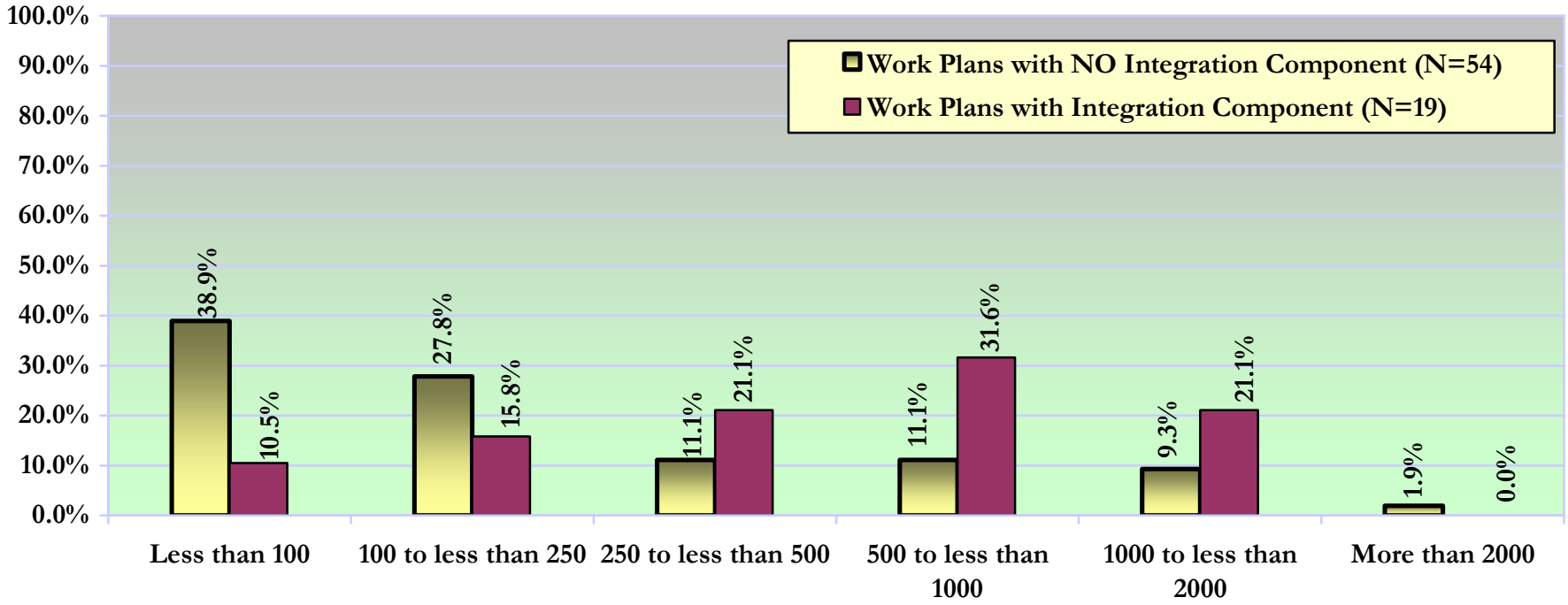
INN work plans ranged in duration from one to five years. Figure 2 presents the percentages of the duration of the INN work plans for integration and non-integration initiatives.

Figure 2: Duration of INN Work Plans



The number of clients served each year[12] by the INN work plans range from 12 consumers (Humboldt County, *Adaptation to Peer Transition Age Youth (TAY) Support*) to 21,000 consumers (Contra Costa County, *Social Supports for Lesbian, Gay, Bi-Sexual, Transgender, Queer, Questioning, Intersex, 2-Spirit (LGBTQQI2-S) Youth*). Besides Contra Costa County's work plan to serve 21,000 consumers each year, all work plans serve 2,000 or less consumers in a 12-month period. Across California, the INN work plans will annually serve nearly 50,000 consumers. Figure 3 presents the percentages of the ranges of clients served each year by the INN work plans for integration and non-integration initiatives. Across the 22 integration work plans, a total of 11,655 services per year to individuals are projected.

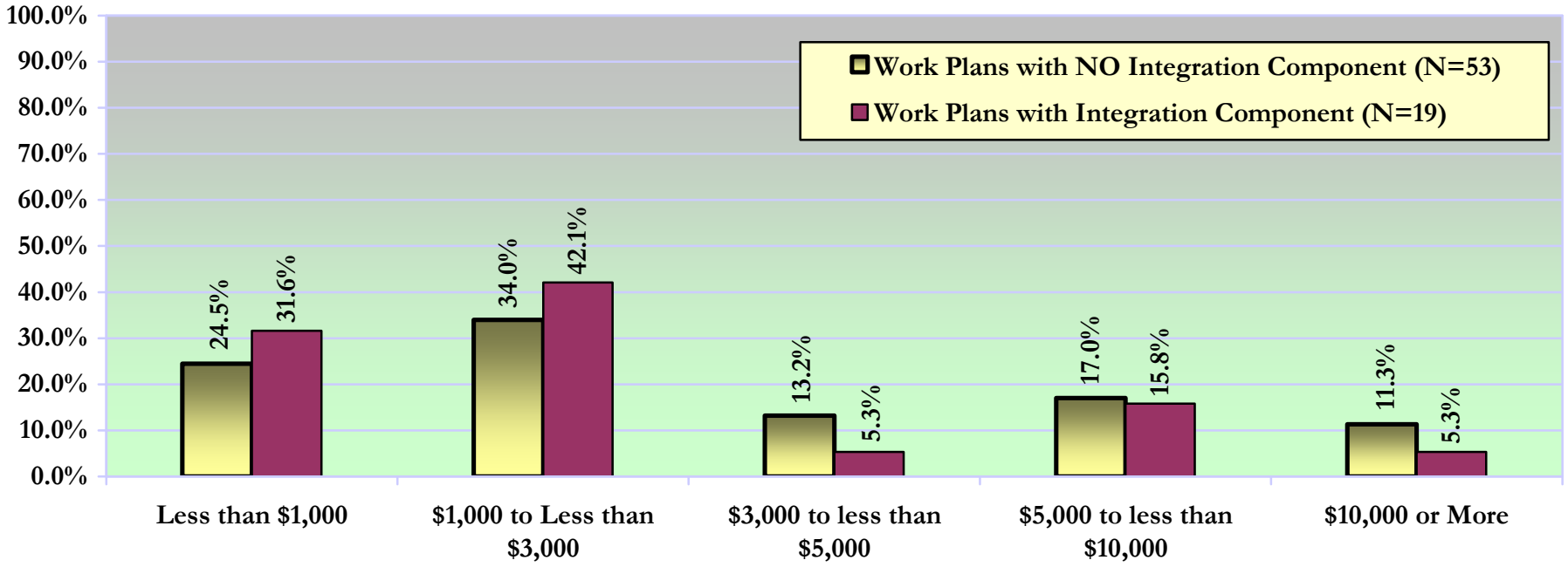
Figure 3: Number of Clients Served Annually by INN Work Plans



[12] Some work plans did not specify the number of clients that will be served each year; and other work plans were not designed to provide direct services to consumers.

During the first year of the work plan[13], more than half (58.5%) of work plans without an integration component will serve each client per year for less than $3,000 (N=53).[14] Nearly three-quarters (73.7%) of work plans with an integration component will serve each client during the first year for less than $3,000 (N=19). Figure 4 presents the percentages of dollar ranges of the cost per consumer per year for the INN work plans for integration and non-integration initiatives, for the first year of the each plan.

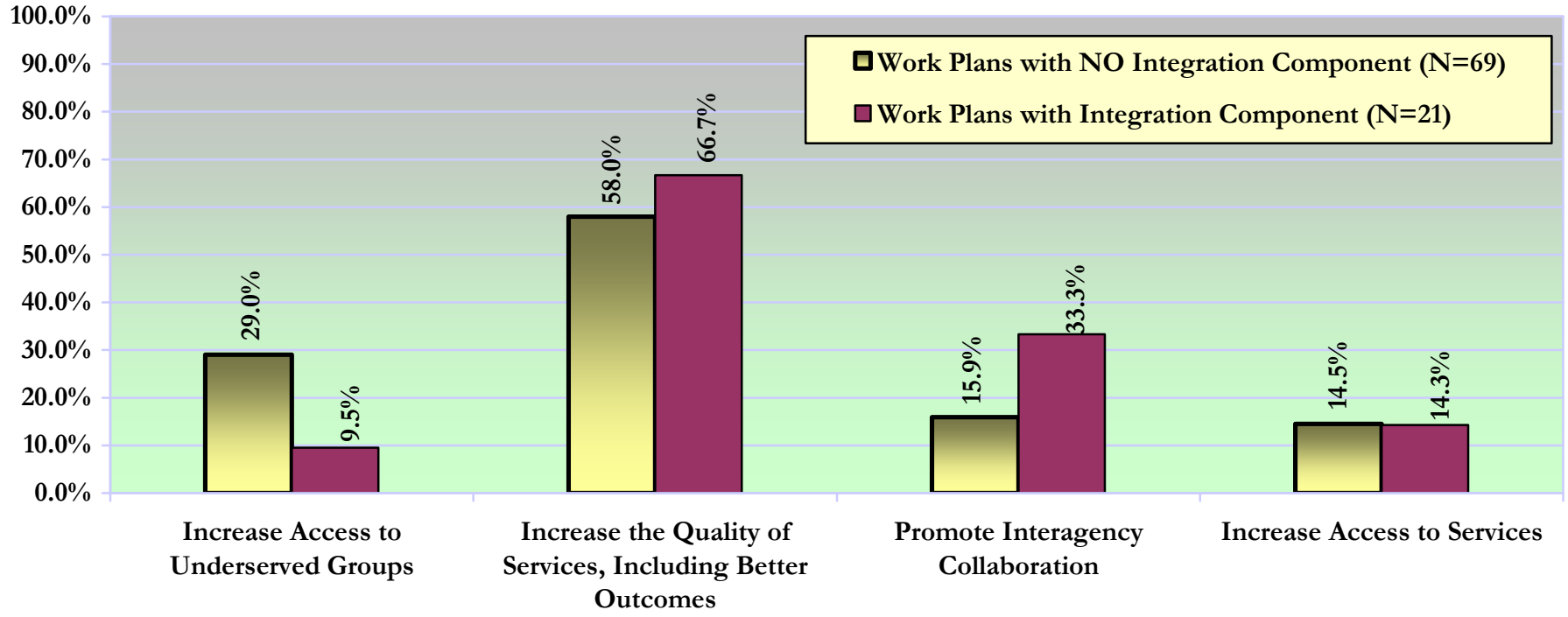
Figure 4: Cost of INN Work Plans per Consumer per Year for the First Year



[13] This analysis presents budget data for the first year of the INN work plans only because not all plans provided projections for subsequent years or project totals.
[14] Not all work plans are designed to provide direct services to clients.

The guidelines for proposed INN plans, as set forth by CalMSHA, required applicants to establish the purpose for their work plan. Applicants were given four (4) purposes from which to choose. Figure 5 presents the percentages[15] for each purpose chosen by applicants requesting INN funds for integration and non-integration initiatives.

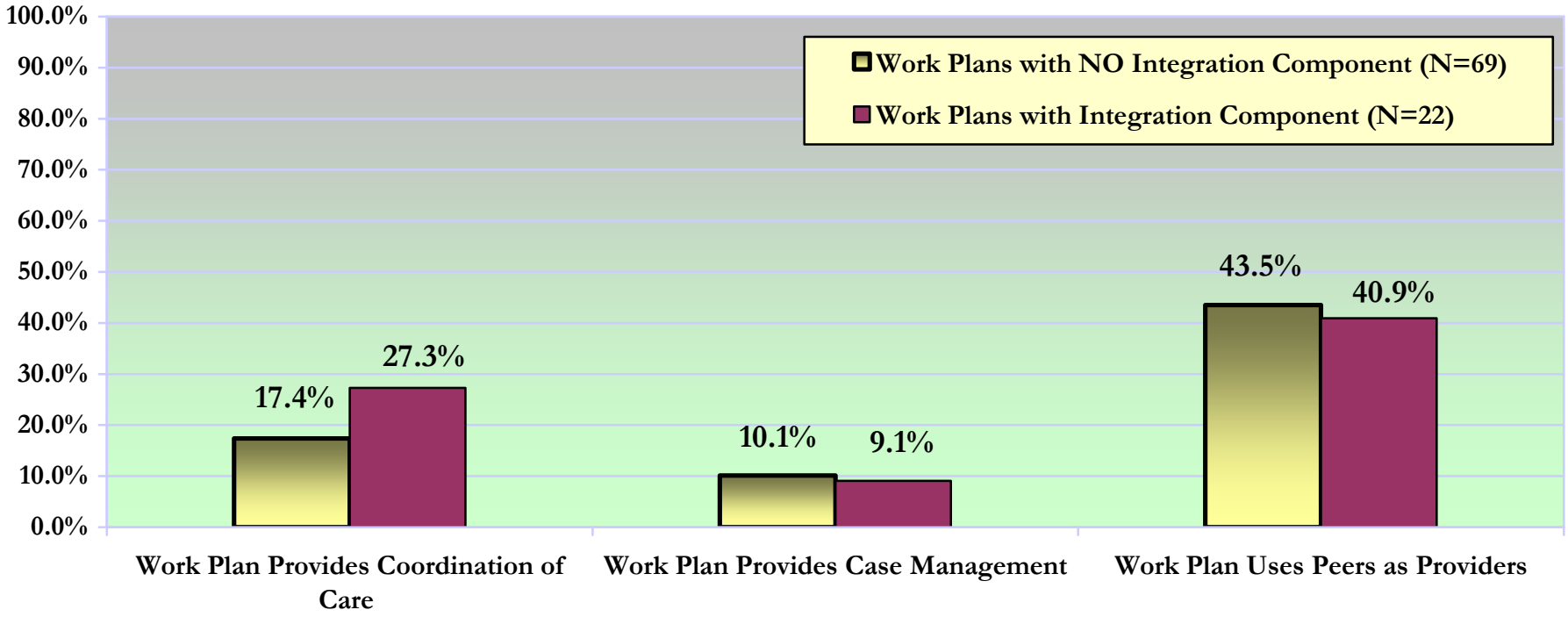
Figure 5: Purpose of INN Work Plans



[15] Percentages total more than 100.0% because applicants were asked to check all that apply.

Figure 6 presents the percentages of three services that are provided by INN plans for integration and non-integration initiatives: coordination of care, case management, and using peers as providers. There was no statistical significance for these services between plans with an integration component and plans without an integration component. [Coordination of care (p=.36), case management (p=1.0), and using peers as providers (p=.832)].

Figure 6: Care Coordination, Case Management, and Peers as Providers



The percentages and frequencies of each population targeted[16] to be served for each INN work plan is presented in Table 4 for for integration and non-integration initiatives.

Table 4: Target Population of Innovative Work Plans

Target Population	Percentage[17] of Plans with NO Integration (N=64)	Percentage of Plans with Integration (N=21)
Individuals (all ages, or age not specified)	20.3%	57.1%
Adults	39.1%	33.3%
Families	21.9%	19.0%
Transition age youth (TAY)	28.1%	14.3%
Older adults	21.9%	14.3%
Youth (not including TAY)	31.3%	9.5%
Ethnic groups	15.6%	9.5%
Un-served or underserved individuals	9.4%	9.5%
Individuals with homelessness issues	4.7%	9.5%
Uninsured or underinsured individuals	1.6%	4.8%
Individuals with substance abuse issues	9.4%	4.8%
Individuals involved with law /justice systems	10.9%	0.0%
LGBTQ individuals	6.3%	0.0%
Military or veterans	4.7%	0.0%
Individuals with disabilities	4.7%	0.0%

[16] Some work plans were not designed to provide direct services to consumers, and therefore do not have a target population
[17] Percentages total more than 100.0% because some work plans targeted more than one population

The approach(es) for each work plan were reviewed and divided into twelve (12) themes. The percentages of each theme are presented below in Table 5 for integration and non-integration initiatives.

Table 5: Approach of INN Work Plans

Approach	Percentage[18] of Plans with NO Integration (N=69)	Percentage of Plans with Integration (N=22)
Work plan co-locates services (e.g. integration with primary care, 'one-stop' services)	1.4%	50.0%
Work plan uses peers, consumers, or family members (either paid or volunteer) to deliver support/services, etc	31.9%	36.4%
Work plan establishes intervention team to provide services	18.8%	22.7%
Work plan establishes system changes (e.g. collaboration, networking, coordination of services)	15.9%	22.7%
Work plan implements new modality (e.g. new therapeutic intervention, new program, adaptation of an intervention)	42.0%	13.6%
Work plan establishes mobile team (e.g. response team, intervention team)	2.9%	13.6%
Work plan provides training, education or outreach (to providers or consumers)	17.4%	9.1%
Work plan provides consumer support (e.g. links to resources, referrals, system navigation assistance)	14.5%	9.1%
Work plan convenes group for oversight or programmatic review and input, including allocation of funds (e.g. task force, work group Board, council, decision-making body)	14.5%	4.5%
Work plan establishes a new physical location for services (e.g. center, house, unit)	8.7%	4.5%
Work plan is designed to serve those currently in or recovering from a crisis	7.2%	4.5%
Work plan establishes community grant-making process	7.2%	0.0%

[18] Percentages total more than 100.0% because some work plans utilized more than one approach

The personnel involved in the implementation of each work plan were reviewed and divided into thirteen (13) groupings[19]. The percentages of each grouping are presented in Table 6 for integration and non-integration initiatives.

Table 6: Personnel Involved in Innovation Work Plans (N=91)

Personnel Involved in Work Plan	Percentage[20] of Plans with NO Integration (N=69)	Percentage of Plans with Integration (N=22)
Medical providers (traditional, non-traditional healers, public health, PCPs, trained peer wellness coaches or promoters, etc.)	21.7%	100.0%
Peers providing services or input (paid or volunteer)	55.1%	72.7%
Licensed or advanced mental health providers/interns (LCSW, Psychiatrist, MFT, etc.)	36.2%	68.2%
Substance abuse counselors	4.3%	22.7%
Mental health providers (non-licensed or unspecified)	24.6%	22.7%
Community agency or program staff members	53.6%	18.2%
Family members providing services or input	17.4%	13.6%
Social service providers (APS, CPS, financial services, etc.)	10.1%	9.1%
General community (non-service providers such as business owners, professional trainers, college students, evaluators)	21.7%	4.5%
School personnel (teachers, educators, school counselors, etc.)	20.3%	4.5%
Professionals within the Law /Justice systems (probation, parole, police, judges)	13.0%	4.5%
Faith-based leaders	7.2%	4.5%
Leaders of ethnic/diverse communities	4.3%	4.5%

[19] There are limitations in this analysis. For example, some work plans were specific and provided detailed information, while others did not. Some work plans considered all professionals involved—from those implementing the work plan to those working at referring agencies and providing ancillary services not specifically relevant to the work plan approach. Other work plans only included those professionals who were directly involved in the project. Not all work plans specified the extent of involvement for each professional. Finally, this list is not necessarily exhaustive, as some projects had components to the approach that may not have been included in the work plan, or that are not yet to be determined.

[20] Percentages total more than 100.0% because some work plans have collaboration established with multiple entities.

The collaborating entities involved in the implementation of each work plan were reviewed and organized into eleven (11) groupings[21]. The percentages of each grouping are presented in Table 7 for integration and non-integration initiatives.

Table 7: Collaborating Entities within INN Work Plans

Collaborating Entities Involved in Work Plan	Percentage[22] of Plans with NO Integration (N=69)	Percentage of Plans with Integration (N=21)
Health providers / Public health department	23.2%	100.0%
Community-based / partner agencies (non-mental health)	73.9%	61.9%
Social service/human service providers (including APS, CPS)	21.7%	33.3%
Consumers / family members	36.2%	23.8%
AODS	8.7%	19.0%
Law /justice systems	18.8%	14.3%
Educational institutions (schools, colleges, universities, etc)	33.3%	14.3%
Faith community	10.1%	9.5%
Community advisors (e.g. stakeholders, affected residents)	26.1%	0.0%
Mental-health providers (non-county)	13.0%	0.0%
Ethnic communities (cultural brokers, ethnic service providers, tribal/clan leaders)	7.2%	0.0%

[21] There are limitations with this analysis. For example, some collaborations have been conceptionalized, but not yet established. Some work plans included referring agencies and providers of ancillary services as collaborating entities, while others only included entities directly involved in the work plan. Finally, many work plans are a work in progress and new collaborations will be established after the project has been implemented.

[22] Percentages total more than 100.0% because some work plans have collaboration established with multiple entities.

The training specified within each work plan for agency staff members, peer-providers, and the community varied from project to project[23]. Table 8 presents the percentages of the types of trainings specified within each work plan for integration and non-integration initiatives.

Table 8: Training within INN Work Plans

Training within Work Plans	Percentage[24] of Plans with NO Integration (N=58[25])	Percentage of Plans with Integration (N=20)
Provider or staff training/education	53.4%	85.0%
Peer-provider or family-provider training/education	39.7%	55.0%
Cultural competency training	17.2%	40.0%
Community, stakeholder or consumer training/education/outreach	36.2%	15.0%
Project has a 'train-the-trainer' component	8.6%	0.0%

[23] The overall impression, after review of all work plans, is that most work plans will need to provide training at some level either for implantation of the project, outreach/education about the project, or to ensure cultural competency. Not all work plans detail all the trainings that will likely be provided.
[24] Percentages total more than 100.0% because some work plans have collaboration established with multiple entities.
[25] Some plans had no training specified within the work plan, some work plans required no training component, and other project had training components that were to be determined; these cases have been excluded from the analysis.

Taking a Closer Look at Work Plans with an Integration Component

Table 9 presents the 22 work plans with an integration component, as well as a brief description of the integration.

Table 9: Work Plans with Integration Component (N=22)

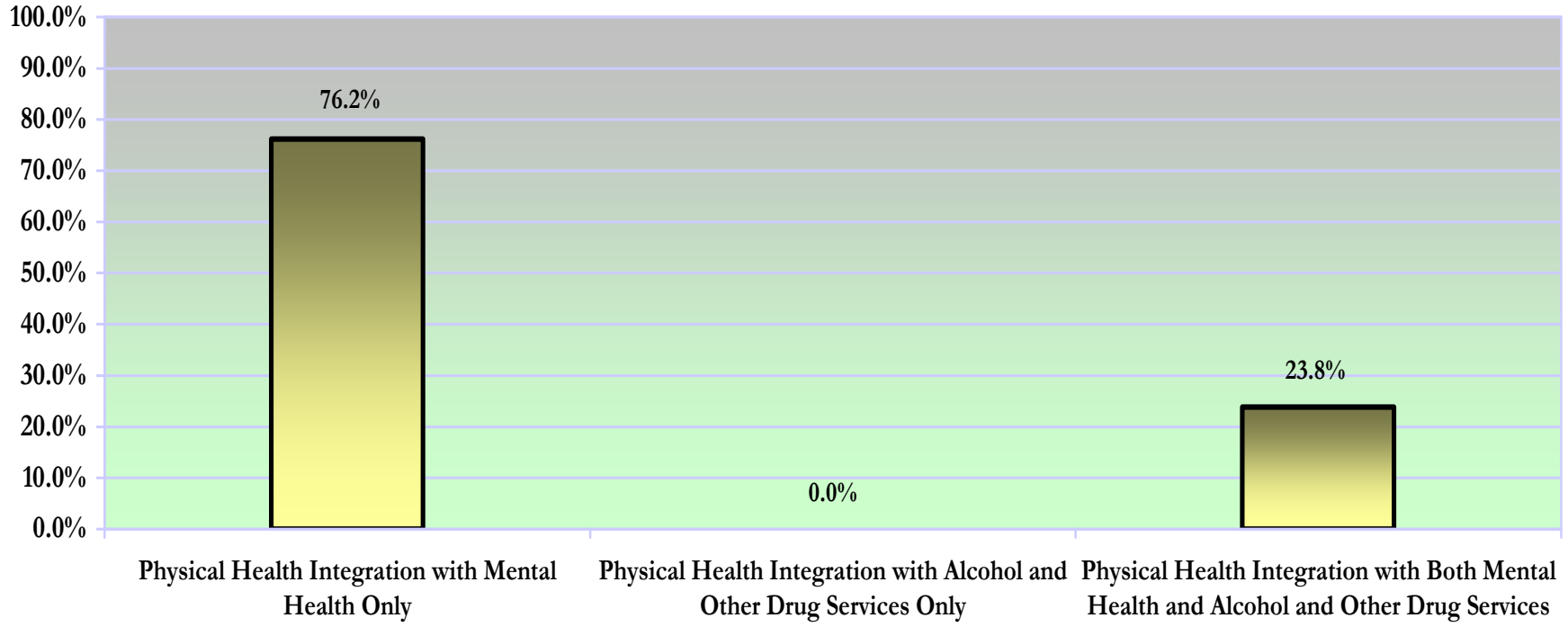
County	Work Plan Name	Description of Integration Component
Butte	Homeless Shelter Collaboration	Public Health Nurse part of intervention team to visit homeless shelter and provide services there. Medical needs will be assessed; if more primary care is needed it will be referred out.
Contra Costa	Promoting Wellness, Recovery and Self-Management in an Integration Pilot Project	Peer Wellness coaches (as part of a service integration team) will be placed in mental health clinics to assist consumers with managing their chronic diseases such as diabetes or heart disease.
Kern	The Freise Hope House Project	RN on staff to provide medical services to residents.
Los Angeles	Integrated Clinic Model	Creates four physical locations/sites to deliver mental health, physical health, and substance abuse services on-site, using a multi-disciplinary team approach.
Los Angeles	Mobile Health Team	Establishes three mobile, multi-disciplinary teams that include physical health, mental health, and substance abuse professionals and specially-trained peers. Plan will leverage multiple funding sources including Federal Qualified Health Center (FQHC) funding
Los Angeles	Community Designed Integrated Service Management (ISM)	Collaboration and partnerships between non-traditional services and formal services (health, mental health, substance abuse) through outreach, education, engagement, linkage, advocacy, and facilitation of inter-provider communication.
Madera	Increase Access from Crisis Services	Team and hospital staff works with consumers experiencing a crisis in the hospital emergency room, or after the consumer has been released.
Madera	Linkage to Physical Health by Pharmacist and Reverse Integration from Mental Health to Physical Health	Pharmacist coordinates client's behavioral health and physical health care.
Madera	Integrated Peer Support and Clinical Services in a Small Rural County Mental Health System	Establish new clinic site that co-locates behavioral health services with the Madera rural health clinic that includes peer/family member staff.
Modoc	Taking Integration Personally	Develop an assessment tool to assure that mental health, substance abuse, and public health issues will be included in a single treatment plan. Will also include a physical health history and basic medical screening. Also identifies models for blending medical records.
Monterey	Alternative Healing and Promotores de Salud	Options for the use of holistic medicines will be integrated into the service options. Psychiatry will include holistic medicine.

Table 9: Work Plans with Integration Component (N=22) (continued)

County	Work Plan Name	Integration Component
Monterey	Mental Health Evaluation Model, Outcome Data, and Reporting Plan	Aims to share information from the Electronic Medical Record. Expand cross-departmental collaboration to create a system-wide approach to Behavioral Health, Public Health, Epidemiology, and eventually Primary Care Clinics.
Monterey	Positive Behavioral Intervention Supports	Increased communication and coordination of services between schools, mental and physical health systems
Orange	Integrated Community Services	Mental health care provided at primary medical care community clinics using trained consumers, and physical health care of behavioral health clients will be monitored by trained peers.
San Bernardino	Holistic Campus[26]	Establish single site for diverse communities and cultures to provide culture specific healing and to address other needs
San Diego	Physical Health Integration	Integrates an existing mental health clinic and local primary care clinic to create a medical home for people w/ serious mental illness. Services provided in clinic.
San Mateo	Total Wellness	Integration of primary and behavioral care services at behavioral care clinics. Includes regular screening and tracking of health status, nurse care managers who assure preventive clinical screening and engagement in a primary care medical home, and peer health and wellness coaches to assist consumers in the management of their health conditions.
Santa Barbara	Benefit Acquisition for High-Risk Indigent Individuals	Plan includes collaboration and shared commitment across all sectors that come into contact with high-risk group – including primary health, and medical records.
Santa Clara	Early Childhood Universal Screening	Parent administration of electronic developmental screening in "kiosks" located in pediatricians' offices -- The project studies how the use of kiosk impacts utilization by pediatricians.
Solano	Community Access to Resources and Education (CARE)	Implements a mobile support team to locations where people are already accessing other health and social services. Provides education and consultation to providers, including physicians.
Sonoma	Three-Pronged Integrated Community Health Model	Integration of primary care and behavioral health. Plan launches an integrated, multi-disciplinary team of peer health educators, physicians, nurses, psychiatrists, behavioral health specialists, and care managers. Provides off-site health education services where consumers live (e.g., shelters, group homes).
Tuolumne	Building a Life at Home Innovation Project	Nurse case manager to educate peers in monitoring medication, selectively monitor and track medication usage. They can also help peers to advocate and communicate clearly with their primary physicians about their medical needs.

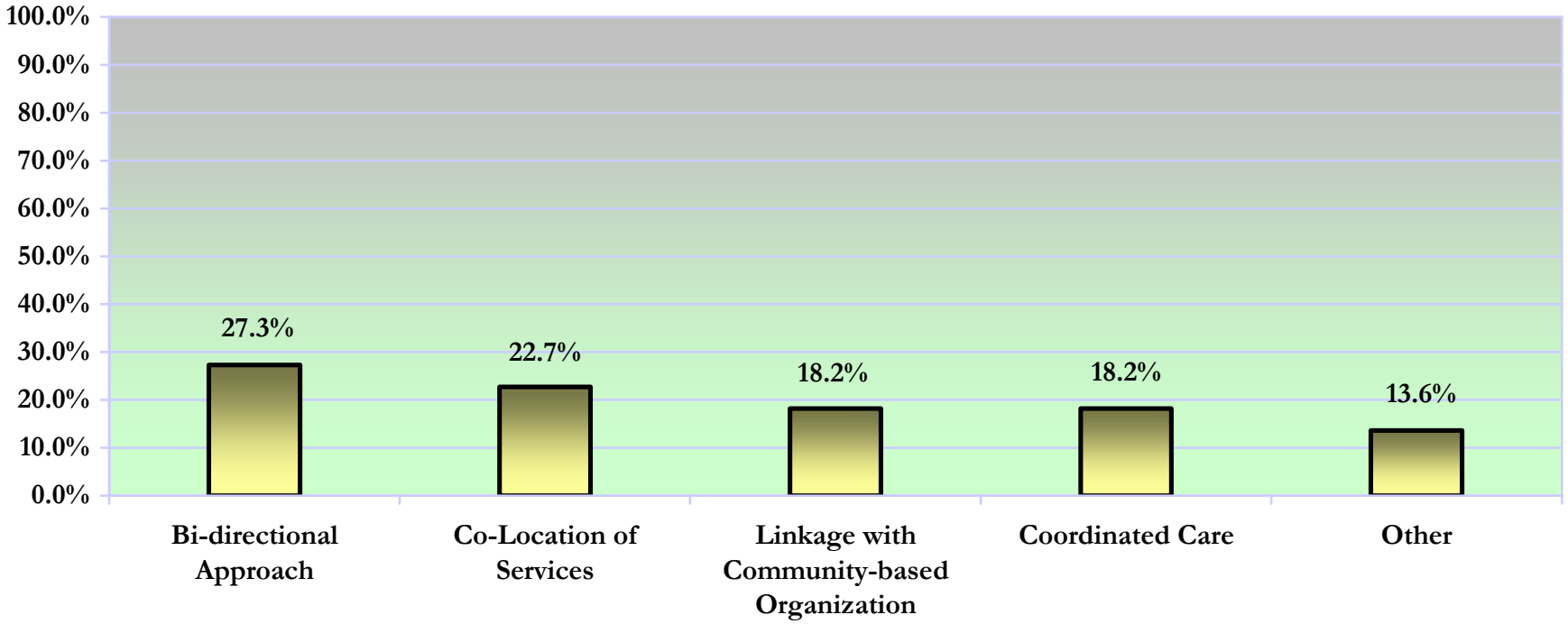
INN plans with an integration component blend physical health care with mental health care and/or Alcohol and Other Drug Services (AODS). Figure 7 presents the percentages for the type of integration in the work plans: Mental health only, AODS only, and both.

Figure 7: Physical Health Care Integration with Mental Health and AODS for Work Plans with Integration Component (N=21)



INN plans with an integration component (N=22) have been categorized into the following five groupings, according to the approach outlined in the work plan: bi-directional integration where each partnering entity accepts referrals and provide care; permanent co-location of services whereby two organizations share the same office/clinic location; integration occurring within community-based or free-standing agencies with co-location of two or more disciplines; integration via coordinated care, such as participation on a multi-disciplinary team with regular meetings to coordinate care, or communication between providers; and Other[27]. Figure 8 presents the percentages of each category of integration approaches in the work plans.

Figure 8: Integration Approach for Work Plans with Integration Component (N=22)



INN work plans often include supportive services that augment the integrative component. Supportive services identified within the 22 integrative work plans have been organized into 17 groupings. The percentages for each grouping are presented in Table 10.

Table 10: Supportive Services Provided within Work Plans with Integration Component[28]

Supportive Service	Percentage[29] of Plans with Service (N=22)	Supportive Service	Percentage of Plans with Service (N=22)
Coordinated care	68.2%	Case management	22.7%
Link to resources	63.6%	Support groups	22.7%
Peer mentoring/coaching/support	54.5%	Counseling (licensed)	18.2%
Medical and/or mental health assessment/screening	50.0%	Medi-Cal/benefits enrollment	18.2%
Medication assistance	36.4%	System navigation	18.2%
Assist consumers with wellness plans/goals	36.4%	Housing referral or assistance	13.6%
Physical health, mental health, psycho-social education and/or skill building	31.8%	Teaches self-management	13.6%
Transportation assistance	31.8%	Employment/vocational assistance	4.5%

Table 11 presents a description of the staff and provider training(s) and/or education included in each work plan with an Integration component. This table includes all available information on staff/provider training for each plan; some plans provided more detail than others on trainings.

Table 11: Training or Retooling of Staff/Providers for Work Plans with Integration Component (N=22)

County	Work Plan Name	Training or Retooling of Staff/Providers
Butte	Homeless Shelter Collaboration	Work plan will teach behavioral health, public health, and social services staff to

		work as a team utilizing strength based recovery approaches with homeless consumers. Specific training for this not specified. Staff will be trained in cultural competence focusing on the unserved and underserved populations in Butte County. Project does not request funds for training consultant contracts.
Contra Costa	Promoting Wellness, Recovery and Self-Management in an Integration Pilot Project	Peer Wellness Coaches will attend two intensive three-day advanced peer support, chronic disease self-management and wellness coaching training given by Recovery Innovations, Inc. This training will certify the coaches to use the self-management Health and Recovery Peer (HARP) Program curriculum. The trainings will supplement the HARP curriculum, adding sessions in wellness basics, mental health recovery, role modeling, and advanced wellness-coaching skills. Wellness coaches will educate primary and mental health care staff about mental health recovery principles as well as mental health "consumer culture." Project requested $10,000 for training consultant contracts in FY 2010/11.
Kern	The Freise Hope House Project	The peer staff will complete an 80-hour Peer Employment Training course given by Recovery Innovations, Inc. Additional tools like "Advanced Peer Training" and "Wellness Recovery Action Plan (WRAP) for Work" will be used. All staff will be trained in the six dimensions of wellness: physical, emotional, intellectual, spiritual, social, and occupational. Project does not request funds for training consultant contracts.
Los Angeles	Integrated Clinic Model	Staff training and Team orientation to the model. Service Provider Management Team will train staff/others who will be screening clients and providing referrals. No further details of training provided. Project does not request funds for training consultant contracts.
Los Angeles	Mobile Health Team	Work plan includes specially trained housing/employment/benefit establishment specialists and peer/family/parent advocates. No further details of training provided. Project does not request funds for training consultant contracts.

Table 11: Training or Retooling of Staff/Providers for Work Plans with Integration Component (N=22) (continued)

County	Work Plan Name	Training or Retooling of Staff/Providers
Los Angeles	Community Designed Integrated Service Management (ISM)	Work plan includes specially-trained and culturally competent peer "service integrators" that help clients use the resources of both "formal" and "nontraditional" networks of providers The work plan will provide training, education, and coaching to community organizations and leaders. Work plan will

		train peers to provide outreach, engagement, and linkage services. Training of culturally diverse staff in resources, including multiple self-help peer-run resources, team building, reporting methods and safety issues. Project does not request funds for training consultant contracts.
Madera	Increase Access from Crisis Services	The peer, clinical, and clerical staff will be trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural and/or linguistic population or community. The work plan will purchase training for peer staff on crisis intervention services and how to provide peer engagement and support to individuals and families. Training would also be developed and/or purchased on cultural competency issues in working with families and individuals. Training would also be provided for the ER staff and other hospital staff. Project does not request funds for training consultant contracts.
Madera	Linkage to Physical Health by Pharmacist and Reverse Integration from Mental Health to Physical Health	Work plan will provide training to the primary care staff (not only including medical, but also support staff) on mental illnesses, stigma, Mental Health First Aid, client culture, etc. Project does not request funds for training consultant contracts.
Madera	Integrated Peer Support and Clinical Services in a Small Rural County Mental Health System	Training will be available for all rural health clinic staff (including clerical and support staff) to increase their cultural competency and reduce stigma when working with patients who may have mental health issues. The peer and clinical staff will be trained to understand and effectively address the needs and values of the particular racial/ethnic, cultural and/or linguistic population or community. Rural health clinic staff (including professional and support staff) will be trained in Mental Health First Aid. Training would also be purchased for clinical staff on recovery principles, working with peer staff as equal members of a team, short-term crisis resolution services and other clinical training as appropriate. Project does not request funds for training consultant contracts.

Table 11: Training or Retooling of Staff/Providers for Work Plans with Integration Component (N=22) (continued)

County	Work Plan Name	Training or Retooling of Staff/Providers
Modoc	Taking Integration Personally	Work plan will provide basic training on cultural awareness and cultural responsiveness, with specialized training provided on Latino and Native American cultures. Training provided in recovery and resilience; client-& family member centered approach, stigma, and discrimination. Also provides cross

		training in organizational culture & language, along with other MHSA principles. Training to be provided on use of assessment tool. Project requested $3,000 for training consultant contracts in FY 10/11 and requests $20,000 for FY 2011/12.
Monterey	Alternative Healing and Promotores de Salud	Promotores will receive training by clinical staff on issues relating to holistic approaches to managing issues such as stress. In turn, Promotores, consumers and family members will provide clinical staff with training regarding the traditional approaches to healing often used by Latinos. Project does not request funds for training consultant contracts.
Monterey	Mental Health Evaluation Model, Outcome Data, and Reporting Plan	Work plan will train behavioral health program and service managers in participatory evaluation methods and reporting. No further training specified. Project does not request funds for training consultant contracts.
Monterey	Positive Behavioral Intervention Supports	School admin team will work to provide training and implementation for teachers, support staff, family members and students. No further training specified. Project requested $110,000 for training consultant contracts in 09/10.
Orange	Integrated Community Services	Intensive training of consumer and family member employees to become mental health workers or medical care coordinators. Project requested $41,000 for training consultant contracts in FY 2009/10.
San Bernardino	Holistic Campus[30]	No information available on training for this work plan.
San Diego	Physical Health Integration	Work plan provides for education and training for all staff members, both clinic staff and primary care providers, at the clinic in order to reduce stigma, increase cultural competence and provide skills necessary to work with the population. Project requested $240,000 for training consultant contracts in FY 2009/10.
San Mateo	Total Wellness	Work plan utilizes trained "Peer Health and Wellness Coaches" as wellness group facilitators or co-facilitators, and as partners with Nurse Care Managers, Nurse Practitioners, and other members of care teams. Project requested $50,000 for training consultant contracts in FY 2010/11.

Table 11: Training or Retooling of Staff/Providers for Work Plans with Integration Component (N=22) (continued)

County	Work Plan Name	Training or Retooling of Staff/Providers
Santa Barbara	Benefit Acquisition for High-Risk Indigent Individuals	Train all team members as "benefits specialists" focusing on the benefits acquisition process, including how to fill out benefits forms effectively and how to document disability. Staff will participate in cultural competency training offered annually through the County's Alcohol Drug and Mental Health Services Department. Project requests $45,000 for training consultant contracts in FYs

		2010/11, 2011/12, and 2012/13.
Santa Clara	Early Childhood Universal Screening	Work plan timeline states "complete all necessary training." No further training specified. Project does not request funds for training consultant contracts.
Solano	Community Access to Resources and Education (CARE)	Work plan provides for education and consultation to providers, including primary care doctors, on mental health treatment options, and "training in evidence based practices." No further training specified. Project does not request funds for training consultant contracts.
Sonoma	Three-Pronged Integrated Community Health Model	Work plan will train an integrated, multi-disciplinary team of peer health educators, physicians, nurses, psychiatrists, behavioral health specialists, and care managers. Provide training for consumer and non-consumer staff in developing working relationships. Trainings will also be conducted regularly with all Community Mental Health Model team members and core partners to ensure services are culturally and linguistically appropriate. Project does not request funds for training consultant contracts.
Tuolumne	Building a Life at Home Innovation Project	Work plan offers ongoing training and outreach to Task Force members and staff from members' organizations and advocacy groups and the community at large regarding stigma and mental illness and information about intensive case management and peer recovery services. The case managers will be trained in the Peer Recovery, Wellness and Resilience model. Project does not request funds for training consultant contracts.

Some work plans with an integration component mentioned the names of specific organization(s) that would be partners or would have some role in implementing the work plan[31]. Those organizations, the county's work plan in which they will be involved, and a brief description of their roles are presented in Table 12.

Table 12: Specific Organizations Involved in Work Plans with Integration Component

County	Work Plan Name	Name of Organization	Role Organization will Play
Contra Costa	Promoting Wellness, Recovery and Self-Management	West County Adult Mental Health Clinic (EI Portal)	Work plan targets those receiving services at this site.
		three county-operated adult mental health clinics	Work plan targets those receiving services at this site. Additionally, Wellness coaches will be placed in the clinics to provide services.

		Recovery Innovations	Contracted to provide staff/provider training
Kern	The Freise Hope House Project	Bethany Services	This non-profit social service organization owns the facility. Work plan proposes to contract with Bethany Services to provide facility, and specific program components related to consumer housing support, employment, education, community connections and events.
		Recovery Innovations	Contracted to provide staff/provider training
Madera	Increase Access from Crisis Services	Madera Community Hospital	Work plan targets those who received crisis mental health services in the Madera Community Hospital Emergency room.
Modoc	Taking Integration Personally	TEACH Inc, Strong Family Health Center	Work plan may explore using local non-profits including TEACH, Inc. or the Strong Family Health Center to coordinate funds and assure that coordinated care is delivered.
Santa Barbara	Benefit Acquisition for High-Risk Indigent Individuals	Santa Maria Crisis and Recovery Emergency Services (CARES) facility	Location where one of the two benefits acquisition teams will provide services.
		Santa Barbara Crisis and Recovery Emergency Services (CARES) facility	Location where one of the two benefits acquisition teams will provide services.
		local ADMHS Recovery Learning Centers	Clients will be linked to the services provided by the learning centers.
Sonoma	Three-Pronged Integrated Community Health Model	Orenda Center (detox program), Interlink Self-Help Center, The Wellness and Advocacy Center, Empowerment Center	Community partners
Tuolumne	Building a Life at Home Innovation Project	Peer Help Center, Mother Lode Job Training, Teen Center, Meals on Wheels, Lifeline, Catholic Charities	Clients will be linked to these and other peer recovery and support services to ensure they receive the help and assistance needed to live safely and independently when they return to the community.