THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
ACTION AGENDA SUMMARY

DEPT: Behavioral Health And Recovery Services **BOARD AGENDA #** B-16

Urgent ☐ **Routine** ■ **AGENDA DATE** June 11, 2013

CEO Concurs with Recommendation YES ☒ **NO** ☐ **4/5 Vote Required YES** ☐ **NO** ■
(Information Attached)

SUBJECT:

Approval to Adopt the Fiscal Year 2013-2014 Mental Health Services Act Annual Plan and Authorize the Behavioral Health Director to Submit the Annual Plan to the Mental Health Services Oversight and Accountability Commission; and Related Actions

STAFF RECOMMENDATIONS:

1. Adopt the Fiscal Year 2013-2014 Mental Health Services Act (MHSA) Annual Plan.
2. Authorize the Behavioral Health Director to sign and submit the Fiscal Year 2013-2014 MHSA Annual Plan to the Mental Health Services Oversight and Accountability Commission (MHSOAC).
3. Authorize the Auditor-Controller to sign the Annual Plan certifying that the fiscal requirements on the certification form have been met.

(Staff Recommendations Continued on Page 2)

FISCAL IMPACT:

Services under this plan are funded through the State Mental Health Services Act. Appropriations and estimated revenue in the amount of $21,211,172 have been included in the Department's Proposed Budget for Budget Year 2013-2014. This amount includes the proposed contract with Turning Point Community Programs, Inc. in the amount of $560,429. If approved, funding for the agreement with The Center on Collective Wisdom in the amount of $352,073 will be added during the Budget Year 2013-2014 Final Budget process. There is no General Fund impact associated with this request.

BOARD ACTION AS FOLLOWS:

No. 2013-284

On motion of Supervisor Withrow , **Seconded by Supervisor** De Martini
and approved by the following vote,
Ayes: Supervisors: O'Brien, Withrow, Monteith, De Martini and Chairman Chiesa
Noes: Supervisors: None
Excused or Absent: Supervisors: None
Abstaining: Supervisor: None

1) X **Approved as recommended**
2) _____ **Denied**
3) _____ **Approved as amended**
4) _____ **Other:**
MOTION:

Christine Ferraro

ATTEST: **CHRISTINE FERRARO TALLMAN, Clerk** **File No.**

STAFF RECOMMENDATIONS (Continued):

4. Approve the agreements with the Center for Collective Wisdom and Turning Point Community Programs, Inc. to provide Innovation Projects.

5. Authorize the Behavioral Health Director, or her designee, to sign the agreements discussed in this agenda item, and any amendments to add services and payment for services up to $75,000 per agreement, budget permitting, throughout Budget Year 2013-2014.

DISCUSSION:

In November 2004, residents of California passed Proposition 63, the Mental Health Services Act (MHSA). The law provides funding to counties to transform the public mental health system in the following areas:

- Community Services and Supports to provide services to children, adults, transition age youth, and seniors;
- Prevention and Early Intervention;
- Innovative Programs;
- Capital Facilities and Technological Needs; and
- Workforce Education and Training.

Stanislaus County was the first county in California to submit its MHSA Plan and implement the Community Services and Supports component in 2006. Since that time, all remaining components have been implemented. MHSA regulations require counties to submit an update to their plans on an annual basis that includes outcomes from the previous fiscal year and any planned changes for the upcoming fiscal year. Assembly Bill 1467, chaptered on June 27, 2012, contains language requiring that:

- Updates are required to be adopted by the County Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after adoption; and
- All plans and updates are required to include:
  - Certification by the county mental health director to ensure county compliance with pertinent regulations, laws and statutes of the Act, including stakeholder engagement and non-Supplantation requirements, and,
  - Certification by the county mental health director and the county auditor-controller that the county has complied with any fiscal accountability requirements and that all expenditures are consistent with the Act.

Behavioral Health and Recovery Services held a Representative Stakeholder meeting on April 15, 2013 to review the content of the proposed Update. The Annual Update

The Annual Update also includes two new Innovations projects. Innovations funding is intended for projects that will focus on and demonstrate ways to increase access to underserved groups, increase the quality of services including better outcomes, promote interagency collaboration, and increase access to services. All Innovations projects are expected to contribute to learning in the mental health field by introducing new approaches, making a change to an existing mental health practice, or introducing a new application of a promising community-driven approach that has been successful in a non-mental health context. The two new projects are:

- Stanislaus County Wisdom Transformation Initiative. This project will promote interagency and community collaboration by bringing together six non-profit community based agencies to share their knowledge to better respond to the adaptive dilemma confronting the behavioral health system throughout Stanislaus County and to facilitate a deeper level of collaboration among the six organizations and BHRS. This is a three year project effective July 1, 2013 through June 30, 2016 with an estimated cost of $844,445. The contract amount for Budget Year 2013-2014 is $352,073.

- Garden Gate Innovative Respite. This project will increase the quality of service, including better outcomes. The Department currently contracts with Turning Point Community Programs, Inc. to provide 5 respite beds at their 5th Street location. This project will expand and enhance the existing program by adding 5 more beds along with peer support and other supportive services. The goal of this project is to provide individuals who are discharged from crisis intervention and/or psychiatric inpatient services, with a safe and supportive short-term living environment to avoid potential isolation, relapse and re-hospitalization. This is also a three year project effective July 1, 2013 through June 30, 2016. The estimated cost of the project is $1,650,452. The contract amount for Budget Year 2013-2014 is $560,429.

POLICY ISSUE:

Approval of this item supports the Board of Supervisors' priorities of A Healthy Community and Efficient Delivery of Public Services by providing continued and improved access for constituents to behavioral health services.

STAFFING IMPACT:

Staff from Behavioral Health and Recovery Services is available to support this plan and monitor the new agreements. There are no additional staffing requests associated with this agenda item.

CONTACT PERSON:

Madelyn Schlaepfer, Ph.D., Behavioral Health Director. Telephone 525-6225.

was then posted for public review on April 24, 2013. A Public Hearing was held by the Mental Health Board on May 23, 2013. There were no comments submitted.

The Department uses the Results Based Accountability (RBA) framework to measure program outcomes. This framework is designed to answer the question "Is anyone better off?" by measuring how much was done, how well it was done, and what was the outcome. The attached report details outcomes in this format by each MHSA program. The table below highlights three specific outcomes of the four intensive full service partnership programs:

Days Homeless:

Program	# Days 12 Months Prior to Enrollment	# Days Post Enrollment (annualized)	% Reduction
Homeless Outreach	12331	1311	89.4%
Juvenile Justice			
Integrated Forensics	1925	50	97.4%
High Risk & Sr Access	2506	296	88.2%
Totals	**16762**	**1657**	**90.1%**

Days Incarcerated:

Program	# Days 12 Months Prior to Enrollment	# Days Post Enrollment (annualized)	% Reduction
Homeless Outreach	1976	362	81.7%
Juvenile Justice	1856	1104	40.5%
Integrated Forensics	2858	109	96.2%
High Risk & Sr Access	216	0	100.0%
Totals	**6906**	**1575**	**77.2%**

Days Hospitalized (psychiatric):

Program	# Days 12 Months Prior to Enrollment	# Days Post Enrollment (annualized)	% Reduction
Homeless Outreach	1598	315	80.3%
Juvenile Justice	18	7	59.4%
Integrated Forensics	433	69	84.1%
High Risk & Sr Access	761	7	99.1%
Totals	**2810**	**398**	**85.8%**

Stanislaus County

Striving to be the Best

StanUp for Wellness!

Support Mental & Emotional Health

Stanislaus County

Behavioral Health and Recovery Services

Mental Health Services Act

Program and Expenditure Plan

Annual Update FY2013-14

April 2013

WELLNESS • RECOVERY • RESILIENCE

TABLE OF CONTENTS

MHSA County Certification……..3

MHSA County Fiscal Accountability Certification……..4

About Stanislaus County…….....……...……5

Introduction and Overview…….....8

Summary Funding Request……...14

Community Program Planning and Local Review Process……..15

Community Services and Supports……..18

Workforce Education and Training……64

Prevention and Early Intervention……79

Technological Needs Projects……121

Innovation……124

- Final Report - INN 01…….....126
- Progress Report - INN 02-10……..134
- New Project Proposals - INN 11 and INN 12……159

Comment Form……..185

MHSA COUNTY COMPLIANCE CERTIFICATION

County: Stanislaus

Local Mental Health Director	Program Lead
Name: Madelyn Schlaepfer, Ph.D., CEAP Telephone Number: 209-525-6225 E-mail: mschlaepfer@stanbhrs.org	Name: Chong Yang, MFT, MHSA Coordinator Telephone Number: 209-525-5324 E-mail: cyang@stanbhrs.org
County Mental Health Mailing Address: 800 Scenic Drive, Modesto, CA 95350	

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 non-supplantation 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.

Madelyn Schlaepfer, Ph.D., CEAP _____
Local Mental Health Director/Designee (PRINT) Signature Date

County: Stanislaus

Date: _____

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

County/City: Stanislaus

☐ Three year Program and Expenditure Plan
☒ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Madelyn Schlaepfer, Ph.D., CEAP	Name: Lauren Klein, CPA
Telephone Number: 209-525-6225	Telephone Number: 209-525-6576
E-mail: mschlaepfer@stanbhrs.org	E-mail: kleinl@stancounty.com
Local Mental Health Mailing Address: 800 Scenic Drive, Modesto, CA 95350	

I hereby certify that the Three-Year Program and Expenditure Plan, Annual Update or Annual Revenue and Expenditure Report is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5,5830,5840,5847,5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for other counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached report is true and correct to the best of my knowledge.

Madelyn Schlaepfer, Ph.D., CEAP

Local Mental Health Director (PRINT) _____ Signature _____ Date _____

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

I declare under penalty of perjury under the laws of this state that the foregoing and the attached report is true and correct to the best of my knowledge.

Lauren Klein, CPA

County Auditor Controller / City Financial Officer (PRINT) _____ Signature _____ Date _____

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

About Stanislaus County

Stanislaus County was named because of the Stanislaus River and was founded in 1854. It is a vibrant community with beautiful parks, great education, outstanding healthcare and a variety of cultural and sporting events. The community features music, art, festivals, golf, river rafting, boating & much more. The motto at the County is "Striving to be the Best" and that is a vision hoped to be shared by those who visit Stanislaus.

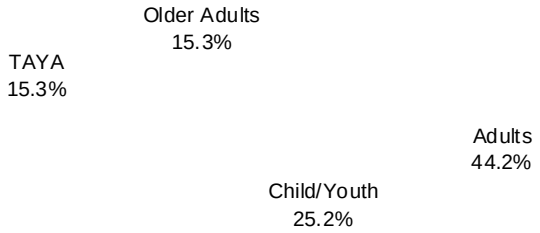
County Demographics

Stanislaus County is located in the San Joaquin Valley (the heart of California's Central Valley), approximately 90 miles from both Sacramento and San Francisco and nearly 115 miles from Yosemite National Park. Over 1,500 square miles in size, Stanislaus County includes rural agricultural areas, small and medium-sized towns including Ceres, Hughson, Newman, Waterford, Oakdale, Riverbank, Patterson, Turlock and Modesto (county seat). Stanislaus County is included in the Modesto Metropolitan Statistical Area, one of the nation's 100 largest metropolitan areas. Stanislaus County has a population of 514,453 residents (Census 2010).

Age

Stanislaus County has 44.2% adult residences, ages 26-59; 15.3% Transition Age Young Adult (TAYA) ages 16-25; 25.2% child/youth ages 0-15; and 15.3% older adult ages 60+. The average age in Stanislaus has increased from 29.2 years of age in 1980 to 32.8 years of age in 2010. Stanislaus County residents are younger, overall, than California residents, where the median age is 35.2 (US Census Bureau).

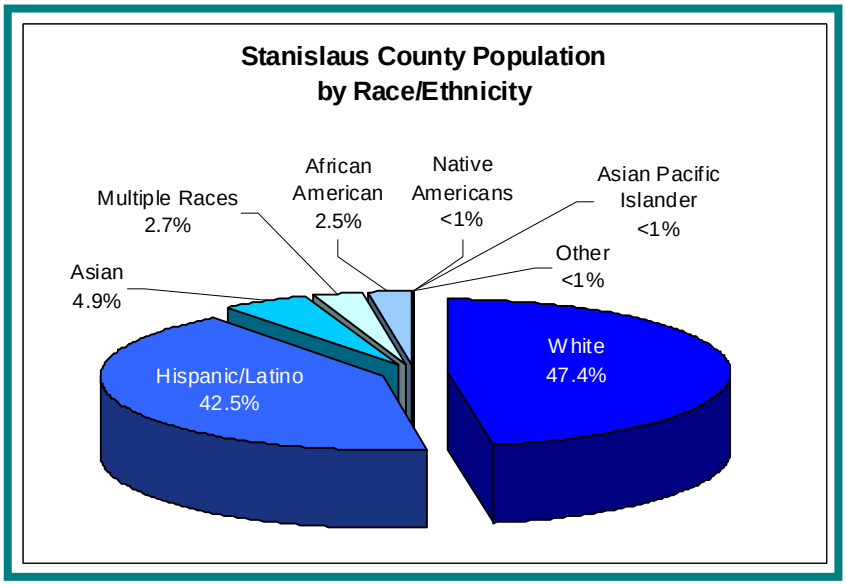
Stanislaus County Population
By Age Category



Source: California Department of Finance, Demographic Research Unity,
2010 Census Detailed Age by Race/Hispanic Origin by Gender

Race and Ethnicity

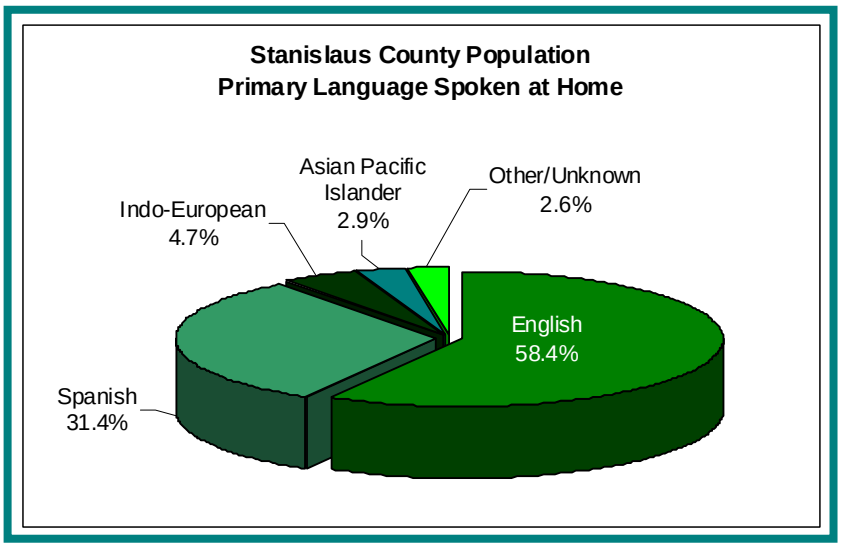
The county is home to a population of diverse race/ethnicities that is predominantly White (47.4%), Hispanic/Latino (42.5%), Asian (4.9%), African Americans (2.5%), Native Americans (<1%), Asian Pacific Islander (<1%), Multiple races (2.7%), and other races (<1%). The population growth of Latinos grew from 15% in 1980 to 41.9% in 2010. Stanislaus has a higher percentage of Latinos than the State, of which 37.6% of the population is Latino (Census 2010).



Source: U.S. Census Bureau, American FactFinder, *Profile of General Population and Housing Characteristics: 2010.*

Primary Language

Stanislaus County residents are linguistically diverse with English being the primary language for 58.7% of the population. 41.3% of residents speak a language other than English at home with Spanish being the single threshold language. Of those who speak another language at home, 31.6% speak Spanish, 4.5% speak other Indo-European languages, 2.8% speak Asian or Pacific Island languages, and 2.4% unknown languages.



Source: U.S. Census Bureau, 2009-2011 American Community Survey, *Language Spoken at Home*)

Introduction

This is an annual update report of Stanislaus County Behavioral Health and Recovery Services (BHRS) Mental Health Services Act (MHSA) funded programs in fiscal year 2011-2012 for community stakeholders. This report contains descriptions and an implementation progress report for all components of MHSA including Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Workforce Education and Training (WE&T), Capital Facilities/Technological Needs (CF/TN), Innovation (INN), and Long Term Supported Housing (CSS Housing).

BHRS Mission

In partnership with our community, our mission is to provide and manage effective prevention and behavioral health services that promote our community's capacity to achieve wellness, resilience, and recovery outcomes.

What is MHSA?

Before California voters passed MHSA in 2004, also known as Proposition 63, an estimated 60% of those living with a mental illness in our state were not receiving treatment. With funding available only to serve people who had already experienced a mental health crisis, California could not expect to address mental illness in a growing, aging, and diverse population.

With MHSA, BHRS is working to expand mental health services and at the same time transform our mental health system from a "fail first" to a "help first" approach that enables members of our communities to access services before they are in crisis, and invest dollars in services that comprise a full continuum of care including dedicated funding to prevention that reduces the need for costly intensive services.

MHSA Values

- ❑ Community collaboration
- ❑ Cultural competence
- ❑ Client/family driven mental health system
- ❑ Wellness, recovery, and resiliency focus
- ❑ Integrated service experiences for clients and family

Changes in Annual Update This Year

An annual report is required by MHSA statute (W&I Code 5847). Last year was the first year there were no guidelines for annual updates issued by California Department of Mental Health (DMH) as a result of the enactment of Assembly Bill 100 in March of 2011. This presents an opportunity for counties to format the report in ways that will continue to be meaningful to local stakeholders. In July of 2012, the passage of AB 1467 assigned the task of providing the MHSA oversight to the Department of Health Care Services (DHCS). This change also required annual updates to be locally approved by the Board of Supervisors (BOS) and Auditor Controller certification of expenditures and be submitted to the Mental Health Services Oversight Accountability Commission (MHSOAC). However, any new Innovation projects will require the approval of the MHSOAC before expending on new projects. There were no new guidelines provided for this year's annual update. However, basic instructions were provided by the MHSOAC to assist counties with the report.

What You will Find in this Year's Annual Update

What?

The instructions for the report this year is very similar to past annual updates. It covers one complete year of services, the most recent full year of data available, delivered July 1, 2011 – June 30, 2012, and gives a forecast of services to be delivered July 1, 2013 – June 30, 2014. As in the past, numbers of individuals served are shown by language, ethnicity, and age in the proportion they were served. Full Service Partnership outcomes are also reported using graphs to show program results. Highlights are included that may reflect success, challenges, and forecast for services in the coming fiscal year. A funding summary for FY2013-14 is also included showing budgeted amounts for each component.

How?

The format of the report this year is similar to what we started last year as we strive to make it easier to read and understand. To achieve this goal, each MHSA component has an overall narrative overview followed by a brief description of its programs. The individual programs layout includes highlights and challenges in FY2011-2012. The Results Based Accountability (RBA) section gives specific outcomes to what occurred in each program and may provide a story of how someone's life has changed because of the program. Some programs also include pie charts and bar graphs with color to illustrate the demographics of those served.

Why?

The intent is to provide a progress report for each of the components of MHSA: Community Services and Supports, Prevention and Early Intervention, Workforce Education and Training, Capital Facilities/Technology, and Innovation for community stakeholders. We hope these changes improve accessibility to BHRS MHSA annual report.

The Framework for Results Based Accountability (RBA) 101

BHRS has long been committed to continuous quality improvement processes and currently is working to bring alive a long-term change initiative to transform our public mental health system. Four commitments are at the heart of this transformation effort: a commitment to results; a commitment to community capacity-building; a commitment to fiscal sustainability; and a commitment to leadership development. This annual update will focus on expanding understanding of the commitment to results.

As discussed and reported in the previous MHSA Annual Update, BHRS is committed to incorporating a new method for developing, interpreting, and presenting program results known as Results Based Accountability (RBA). BHRS kicked off this effort in May 2010 by holding an introduction to Results Based Accountability (RBA) training that was attended by over 100 BHRS and contractor staff. BHRS then sponsored a two-day train the trainer process in October 2010 at which more than 25 BHRS and contractor staff were certified as RBA trainers.

In adopting this framework, a better way to evaluate effort and progress is sought to show how conditions of well-being for participants in BHRS programs are being created. This effort started with MHSA-funded PEI programs and one CSS program; gradually it is extending to other programs.

This approach incorporates our existing methods of collecting data and some of our current measures of program performance. Powerfully simple, the RBA framework poses that any program results can be interpreted with 3 questions:

1) HOW MUCH DID WE DO?
2) HOW WELL DID WE DO IT?
3) IS ANYONE BETTER OFF?

Over the next several years, BHRS will be aligning its development of performance measures and data collection methods with this approach and consistently reviewing the performance measure data. This is a way to track data, learn from it, and sustain successes or improve performance.

Example of Program Results Shown in RBA Framework

This year, a simple table showing a "snapshot in time" of results produced in FY11-12 will be used. An example is shown below:

Program Results Shown in RBA Framework	
• Measures of "how much" example: # of individuals served	**How Much?**
• Measures of "how well" example: % of diverse participants served	**How Well?**
• Measures of "better off" example: changes in attitude, knowledge, or behavior.	**Is Anyone Better Off?**

This is an exciting continuous effort by BHRS to present program data in a way that lays a foundation for BHRS' commitment to reporting of results that show changes to telling the story behind the change, and basing decision making on continuous tracking, reflection, and analysis of the data.

It will take time for programs and staff to master the RBA framework and for BHRS to develop the necessary data systems and learning structures to support this commitment to results. Even so, we do not have to wait to begin to think of the results we already have in this framework.

In future years, the annual update and integrated plan will continue to report on progress related to this aspect of transformation at BHRS.

Next Steps

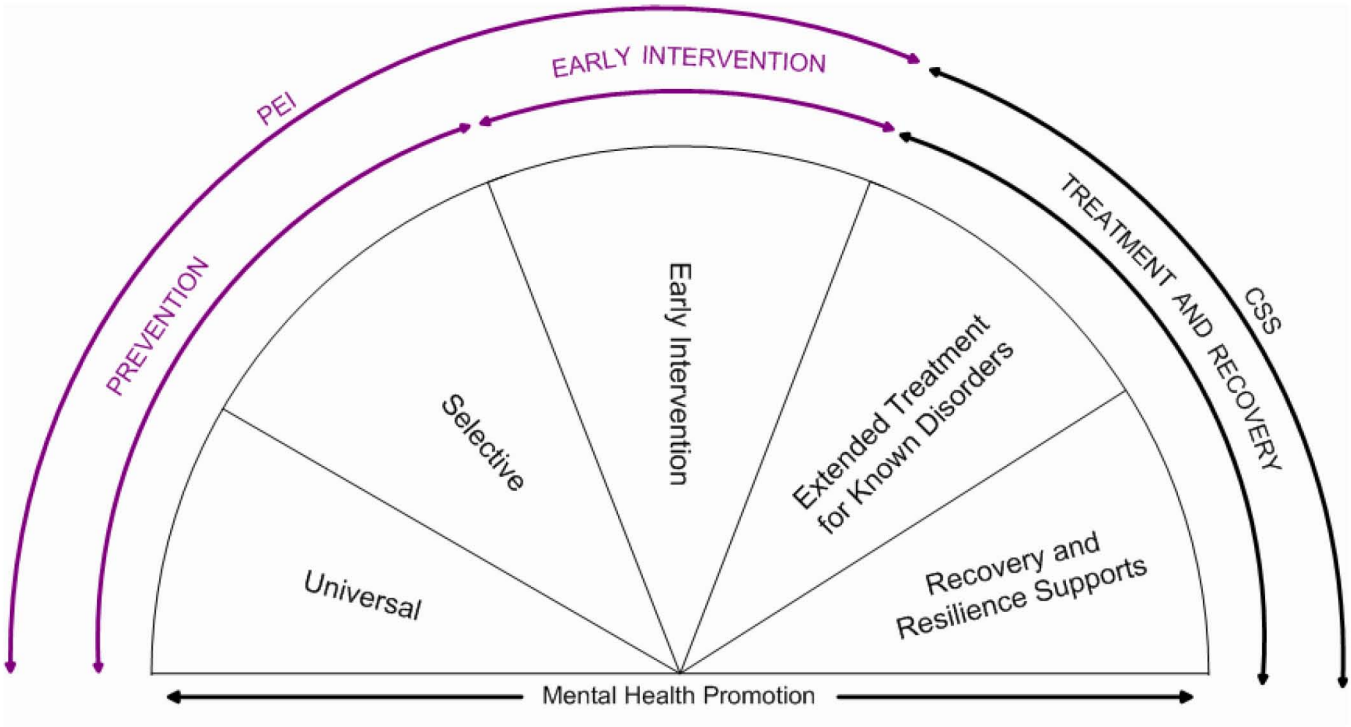
Now that all components of MHSA have been started throughout California, locally and statewide, attention is on several key areas; 1) the statutory requirement to develop an Integrated MHSA Plan that describes how MHSA funds/programs support transformation of the public mental health system, 2) continuing to refine and report results produced by MHSA-funded programs, and 3) attention to fiscal sustainability of programs and services.

Integrated MHSA Plan:

By statute (W&I 5847), an integrated MHSA plan is to be developed by counties based on existing approved plans. Though the statute does not specify, current interpretation throughout the state is that an integrated plan should include all components and show how all components of MHSA support overall system transformation. The OAC has taken the lead in collaboration with DHCS and CMHDA in developing instructions for the integrated MHSA plan as it has done in providing instruction for this year's annual update. It is anticipated that in FY2014-15; the OAC will develop and release instructions to assist counties in establishing their plan for integration of the transformation supported by MHSA.

In anticipation of this event, BHRS has developed a local approach from which to begin thinking about how all parts of the behavioral health system might be related to MHSA in an integrated plan. The Mental Health Intervention Spectrum Diagram was initially adapted from Mrazek and Haggerty (1994) and Commonwealth of Australia (2000) for use by California counties to show the continuum of mental health intervention in PEI plans. This diagram was first referenced in PEI guidelines. The diagram shows the spectrum of services (regardless of funding source) and MHSA components that reach across the entire system.

The diagram below illustrates levels of behavioral health care currently available from universal prevention, treatment and recovery. Additionally, the MHSA components CSS and PEI are shown in relationship to the levels of service. Cross-system components that support all services are shown across the entire spectrum; WE&T CFTN support essential infrastructure and INN supports learning and contribution to new and better practice. This has taken one additional step toward defining and developing this diagram as a useful framework by adding an analysis of the cost per participant across program services/activities in CSS and PEI programs. The diagram shows the cost per participant along the service continuum from PEI to the most intensive service in CSS programs. The PEI cost per participant is $7. The CSS cost per participant ranges from $964 to $7,337.



Workforce Education & Training - Capital Facilities/Technological Needs - Innovation

COST PER PARTICIPANT

Universal	Selective	Early Intervention	O & E	GSD	FSP
	$.35 - $1,220*		$3,279*	$284 - $2,311*	$2,655 - $10,640*

Calculations based on FY11-12 actual expenditures
*Range of cost per participant for programs in each category (O&E only has one program)

Focus on Results:
BHRS will continue to work to refine data systems, reporting methods, and develop learning structures to align with the framework of RBA. The focus of a commitment to results is not solely on collecting data; instead, the focus is on determining priority measures, then learning from the data collected for those measures as well as improving program impact over time. A number of BHRS and contracted programs have already begun using RBA to assess their work and impact, and to evolve what they do to improve their participant results. In future annual updates, data and outcomes will continue to be presented in this framework.

Fiscal Sustainability:
Starting in FY12–13, the distribution of Mental Health Services Act funds takes place on a monthly basis (W&I Code Section 5892(j)(5)). Counties are responsible for ensuring that funds are spent in compliance with W&I Code Section 5892(a) - 20% for Prevention and Early Intervention programs, 80% for Community Services and Supports (System of Care), 5% of total funding shall be utilized for Innovative programs. Annually, based on an average of the past five years allocation, up to 20% of CSS funds may be used for any one or a combination of Workforce, Education and Training; Capital Facilities/Technological Needs or Prudent Reserve.

Counties now receive monthly payments from the California State Controllers office based on a cash available basis. As we have always known, Mental Health Services Act is a volatile funding source driven by the state of the economy and the way in which state taxes are paid. Cash flow issues are a possibility and BHRS will continue to allocate MHSA funds based on the recommendations put forth by California Mental Health Director's Association's fiscal consultant.

Immediately following this section, an estimated budget for FY13-14 is included. It reflects the best estimates available for MHSA funds in the coming year.

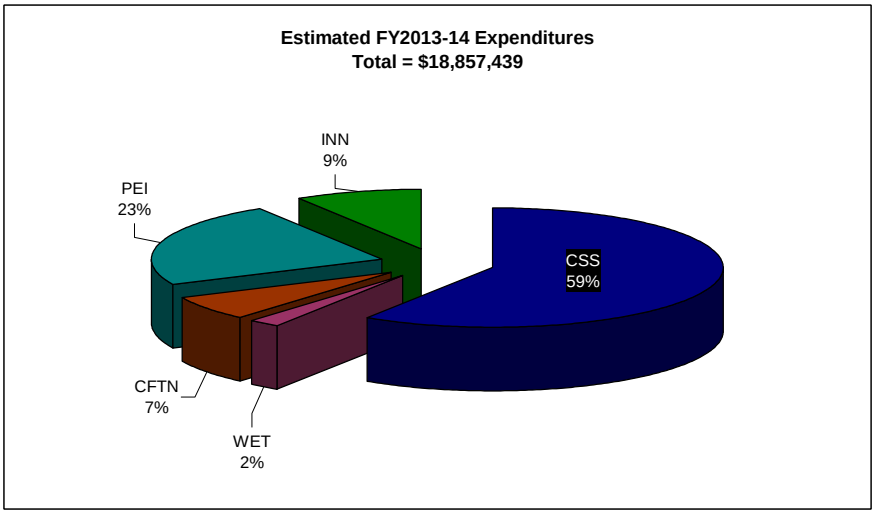
FY 2013/14
MHSA FUNDING SUMMARY

County: **Stanislaus** **Date:** **4/9/2013**

	MHSA Funding					
	CSS	**WET**	**CFTN**	**PEI**	**INN**	**Local Prudent Reserve**
A. Estimated FY 2013/14 Component Allocations						
1. Estimated Unspent Funds from Prior Fiscal Years	$4,152,926	$811,507	$2,481,242	$5,359,519	$2,917,536	
2. Estimated New FY 2013/14 Funding	$10,983,733			$2,745,933	$722,614	
3. Transfer in FY 2013/14[a/]						
4. Access Local Prudent Reserve in FY 2013/14						
5. Estimated Available Funding for FY 2013/14	$15,136,659	$811,507	$2,481,242	$8,105,452	$3,640,150	
B. Estimated FY 2013/14 Expenditures	$11,181,560	$379,593	$1,255,963	$4,351,796	$1,688,527	
C. Estimated FY 2013/14 Contingency Funding	**$3,955,099**	**$431,914**	**$1,225,279**	**$3,753,656**	**$1,951,623**	

[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 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	$500,000
2. Contributions to the Local Prudent Reserve in FY 13/14	$0
3. Distributions from Local Prudent Reserve in FY 13/14	$0
4. Estimated Local Prudent Reserve Balance on June 30, 2014	$500,000



Community Planning & Review

Who Participated

Since 2005, BHRS has continued to engage ongoing stakeholder input with the purpose of creating transparency and facilitating an understanding regarding all of the community planning processes. This year, the BHRS MHSA Planning Manager attended a Promotoras workshop (6/25/12) and a Consumer and Family Member Steering Committee meeting (10/9/12) in an effort to encourage more diverse individuals and consumer and family members perspectives in the local MHSA planning. The general information about MHSA and how to be involved in the planning processes if interested was provided.

All stakeholders are welcome to participate in MHSA planning processes. Per Title 9 of the California Code of Regulations, sections 3300 and 3315, the MHSA Representative Stakeholder Steering Committee (RSSC) is comprised of all required sectors and partner organizations including, but not limited to, consumers of services and family members, social services, education, underserved communities, providers of health care, contract providers of public mental health services, representatives from diverse communities, law enforcement, courts, probation, alcohol and drug services, health care, faith-based community, labor organizations, Stanislaus County Chief Executive Office, BHRS staff, Area Agency on Aging, and regional geographical areas of Stanislaus County including the South and Westside of the county. Representative Stakeholders' role includes giving important input on all plans and updates as well as sharing information about MHSA plans with other members of their represented community or group.

March 18, 2013, the RSSC was convened to develop shared understanding about the next steps for Innovation and achieve consensus on further development of the proposed Innovation projects. Building on the extensive stakeholder input gained in past planning processes from CSS, PEI and INN, the evening meeting included a review of existing Innovation projects, local learning edges established in past planning processes, funds available for future projects and current issues to be addressed in new projects proposed. Stakeholders were invited to participate in workgroups designed to have more stakeholder input in the development of the project proposals for OAC approval and implementation. Five workgroup sessions (3/21, 3/28, 4/2, 4/3, 4/4) were held resulting in two projects that are proposed to address two primary purposes 1) increased quality of services including better outcomes and the 2) promotion of interagency collaboration. Both project proposals are included in this Annual Update.

April 15, 2013, the RSSC was convened to consider the MHSA Annual Update FY13-14 which includes a progress report of all MHSA-funded programs that existed in FY11-12. The agenda for the meeting included a report of highlights of program outcomes and results from the Innovation workgroups. Lastly, some discussion was included to consider future planning processes designed to develop the MHSA Integrated Plan and impacts of Affordable Health Care Act on the behavioral health system.

Summary of stakeholder meetings conducted for this Annual Update included:

- March 6, 2013 - Workforce Education & Training (WE&T): Presentation, input and discussion with the Workforce Development Council members
- March 18, 2013 - RSSC meeting to discuss Innovation
- April 15, 2013 - RSSC meeting to review and discuss Annual Update progress report
- April 24- May 23, 2013 - 30 day posting for public review and comments
- May 23, 2013 - Public Hearing

Handouts given at the RSSC meetings on 3/18/13 and 4/15/13, along with the draft of annual update, are posted on the BHRS MHSA website www.stanislausmhsa.com for general stakeholder access.

Local Review Process

This Annual Update will be posted for 30-day public review and comment April 24, 2013 – May 23, 2013. Notification of the start of public review and access to copies of the update are available through these methods:

- ✓ An electronic copy was posted on the County's MHSA website: www.stanislausmhsa.com
- ✓ Paper copies were sent to Stanislaus County Public Library resource desks throughout the County
- ✓ Electronic notification was sent to all BHRS service sites with a link to www.stanislausmhsa.com, announcing the posting of this report
- ✓ Representative Stakeholder Steering Committee, Mental Health Board members, Advisory Board for Substance Abuse Programs as well as other stakeholders were sent notice informing them of the start of the 30-day review, and how to obtain a copy of the annual update
- ✓ Public notice posted in nine newspapers throughout Stanislaus County including a newspaper serving the Latino community. The notice included reference to www.stanislausmhsa.com and a phone number for requesting a copy of the annual update.
- ✓ BHRS Cultural Competency Newsletter

Additional opportunities to learn and participate are offered throughout Stanislaus County through informational outreach meetings as follows:

May 2, 2013, 11:00am-12:00pm – PEI Community Room, 1904 Richland Avenue, Ceres, CA

May 9, 2013, 11:00am-12:00pm – Main Conference Room, 800 Scenic Drive, Modesto, CA

Comments may be submitted through a Comment Form attached to the document; informational meetings; a required public hearing; via the Stanislaus County MHSA website and via e-mail, fax or U.S. mail to Chong Yang, MFT, MHSA Planning Manager.

PUBLIC HEARING

Mental Health Board Meeting

Thursday, May 23, 2013, 5:00 p.m.

Ceres Community Center

2701 4th Street

Ceres, California 95307

All community stakeholders are invited to participate. All public comments are considered and substantial comments will be included in the final Annual Update.

Substantive Comments and Response

To be added following 30 day review and comment period.

Community Services and Supports (CSS)
a.k.a. "Systems of Care"

Community Services & Supports (CSS) was the first component of MHSA to be funded in 2005 and implementation began in FY2006-07. CSS funds systems of care and provides mental health services and support to individuals of all ages who have serious mental illness or serious emotional disturbance. MHSA mandates that the majority of CSS funds must be used to provide intensive services to a relatively small group of consumers in Full Service Partnerships (FSP). This intensive approach has been shown to foster sustained improvement for consumers while attaining cost savings (such as reduction in hospitalization, police response, and emergency room visits) for the behavioral health system and other community services. Additionally, two other levels of service complete the approach to system of care services. General System Development (GSD) programs were established to serve many by increasing the system's capacity to provide services to consumers and families throughout the system. Outreach & Engagement (O&E) programs were established in recognition of the special activities needed to reach diverse underserved communities that are not able to access services when needed.

Stanislaus County currently has nine CSS programs including four FSP programs, four GSD programs, and one O&E program. Each type of program has a unique approach that incorporates MHSA values of cultural competency, community collaboration, wellness, recovery/resiliency, client/family-driven services, and an integrated service experience for clients and their families.

Full Service Partnership funded programs were established to provide a full array of integrated services to those who are the most unserved or underserved and who are high risk for homelessness, incarceration, hospitalization, and out-of-home placement. FSP strategies are considered a "wraparound" approach to engaging service recipients in their own self-care, treatment, and recovery. In doing so they can achieve and sustain stability in medical and psychiatric well-being, end their homelessness, stabilize living situations, decrease social isolation, and create new recovery practices that lead to individuals' goals for meaningful life activity such as employment and volunteerism. Program results include reduction in incarceration, homelessness, psychiatric hospitalizations, and avoidable medical hospitalization.

Full Service Partnership Programs in Stanislaus County in FY11-12:

- FSP-01 – Stanislaus Homeless Outreach Program (SHOP)
- FSP-02 – Juvenile Justice (JJ)
- FSP-05 – Integrated Forensic Team (IFT)
- FSP-06 – High Risk Health & Senior Access (HRHSA)

General System Development funded programs were established to increase capacity to provide crisis services, peer/family supports, and drop-in centers for individuals who have mental illness. These programs are focused on reducing stigma, encouraging and increasing self-care, participation in recovery, wellness and resiliency practices, and accessing community resources that further overall well-being and decrease the need for more intensive and expensive services.

General System Development Programs in Stanislaus County in FY11-12:

- GSD-01 – Josie's Place Transitional Age Young Adult Drop-in Center
- GSD-02 – Community Emergency Response Team/Warm Line
- GSD-04 – Families Together at the Family Partnership Center
- GSD-05 - Consumer Empowerment Center

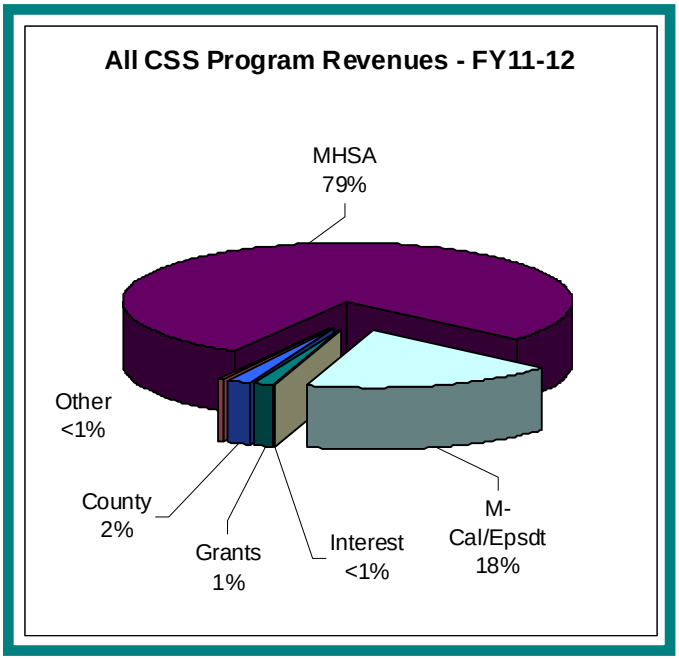
Outreach & Engagement funded programs were established in recognition of the special activities needed to reach diverse underserved communities that have high needs and are disproportionately unserved by traditional types of mental health services. Strategies include community outreach by diverse community based organizations, education, depression screening, and resource linkages for individuals and families who are reluctant to engage in traditional agency services. Crisis-oriented respite housing was also established to avoid unnecessary incarceration, provide short-term housing, and linkage to services.

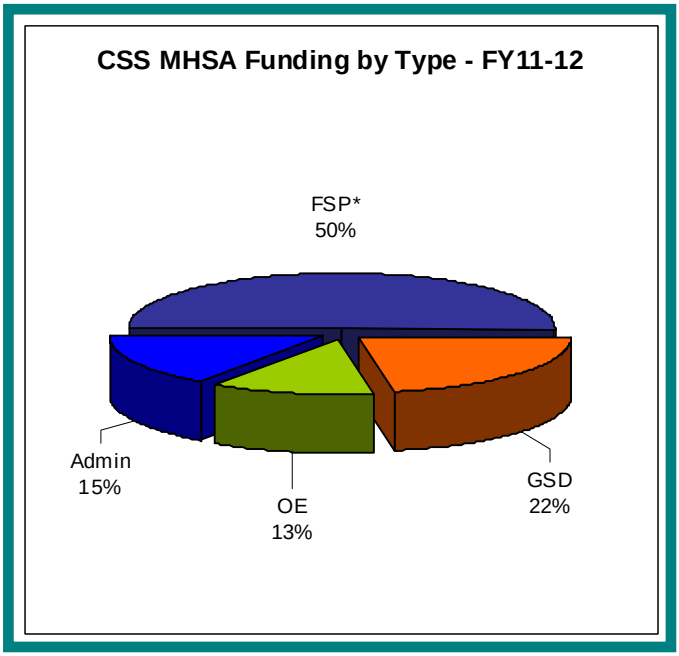
Outreach & Engagement Programs in Stanislaus County in FY11-12:

- O&E-02 - Garden Gate Respite

CSS Budget & Expenditures	
FY11/12 Total Requested MHSA Funds	**FY11/12 MHSA Funds Expended**
$11,450,631	**$9,264,258***

*Unexpended funds in the FY are due to operating reserve, salary savings, efficient use of wraparound funds and additional Medi-cal funds received.





*State mandates that 51% of CSS funds must be allocated to FSP. As allowed by DMH, FSP program Medi-Cal revenues were used to meet the 51% FSP requirement.

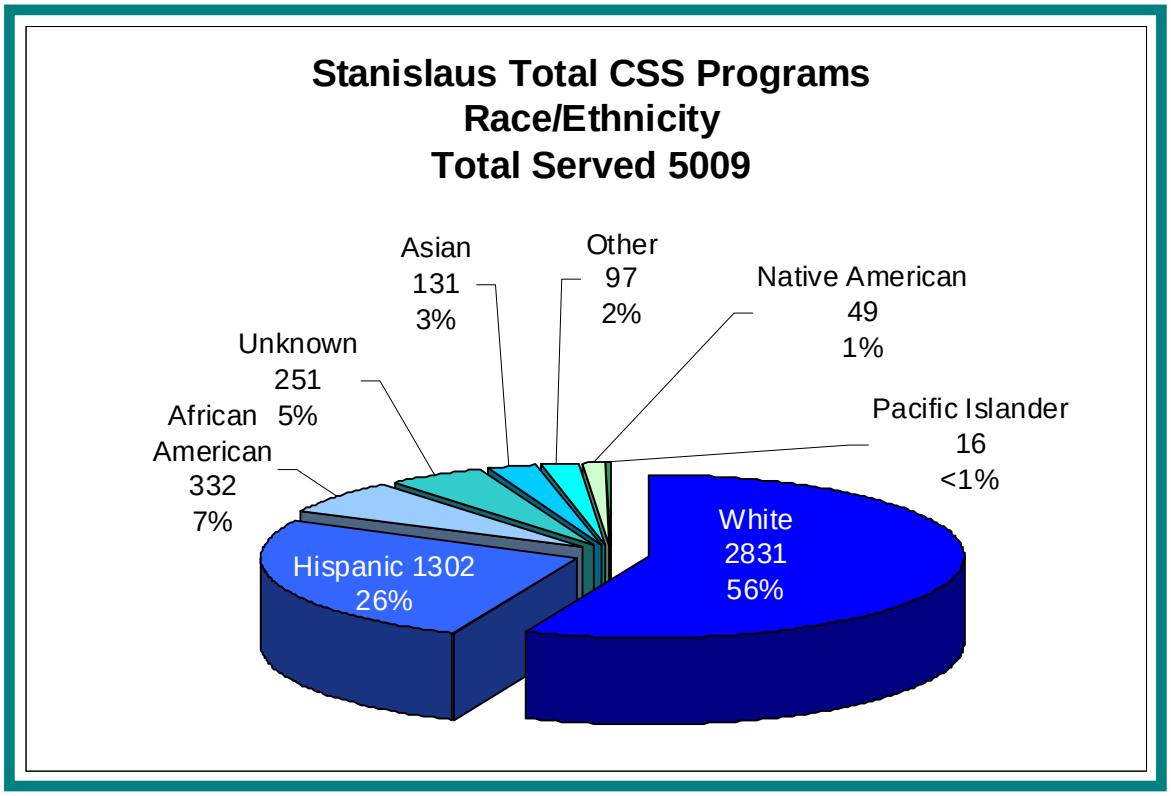
CSS Demographics

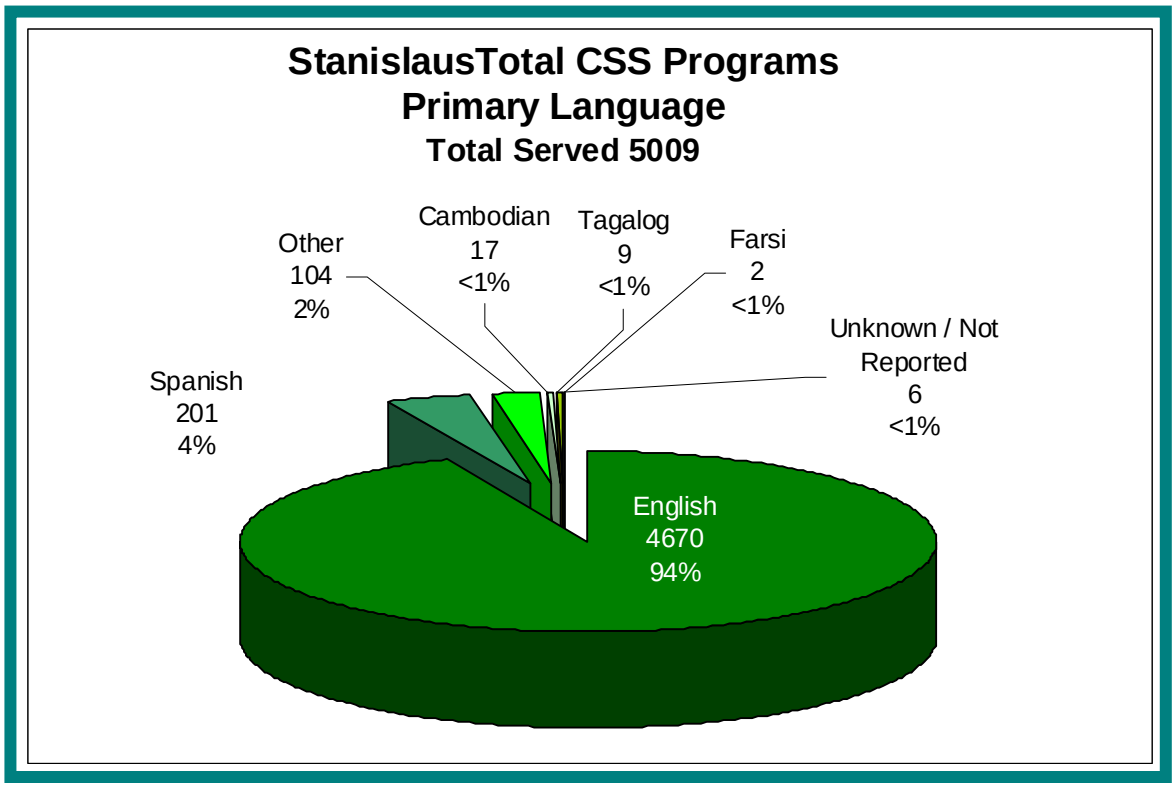
BHRS collects data on all programs and individuals who receive services. This is done largely through billing processes for direct services provided. All data collection is important and some of the data collected is personal to service recipients and disclosure of the information is voluntary and/or confidential.

MHSA data collection and reports focus on how many individuals were served by each program and whether programs were meeting service targets showing how much is being done. Data collected about service recipient characteristics that describe age, gender, race, where they live and primary language spoken provides an indication of how well we are doing in reaching unserved/underserved and diverse populations.

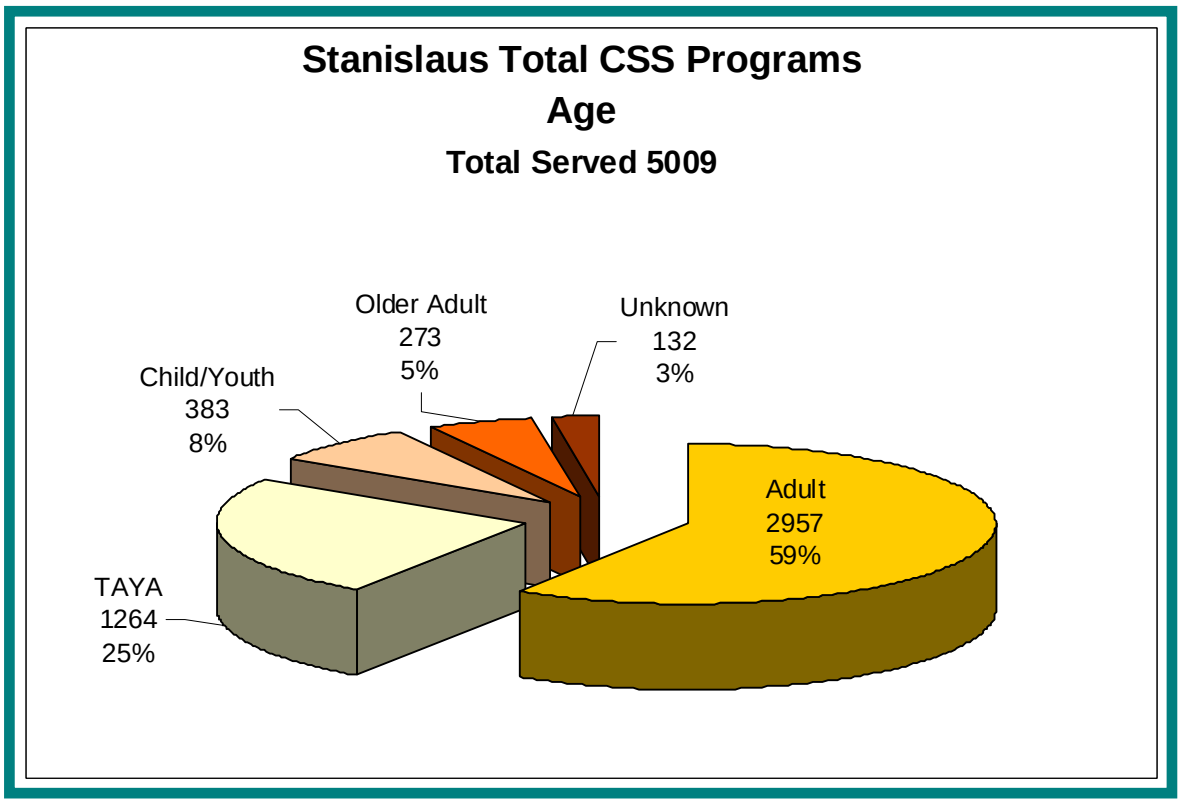
Note: The data collected across all CSS programs will be reported with client duplications as clients may receive services in multiple programs. Within each CSS program and across its level of care the data reported for clients served will be unduplicated.

All percentages shown in graphs are rounded to the nearest percent and therefore may not equal 100%.

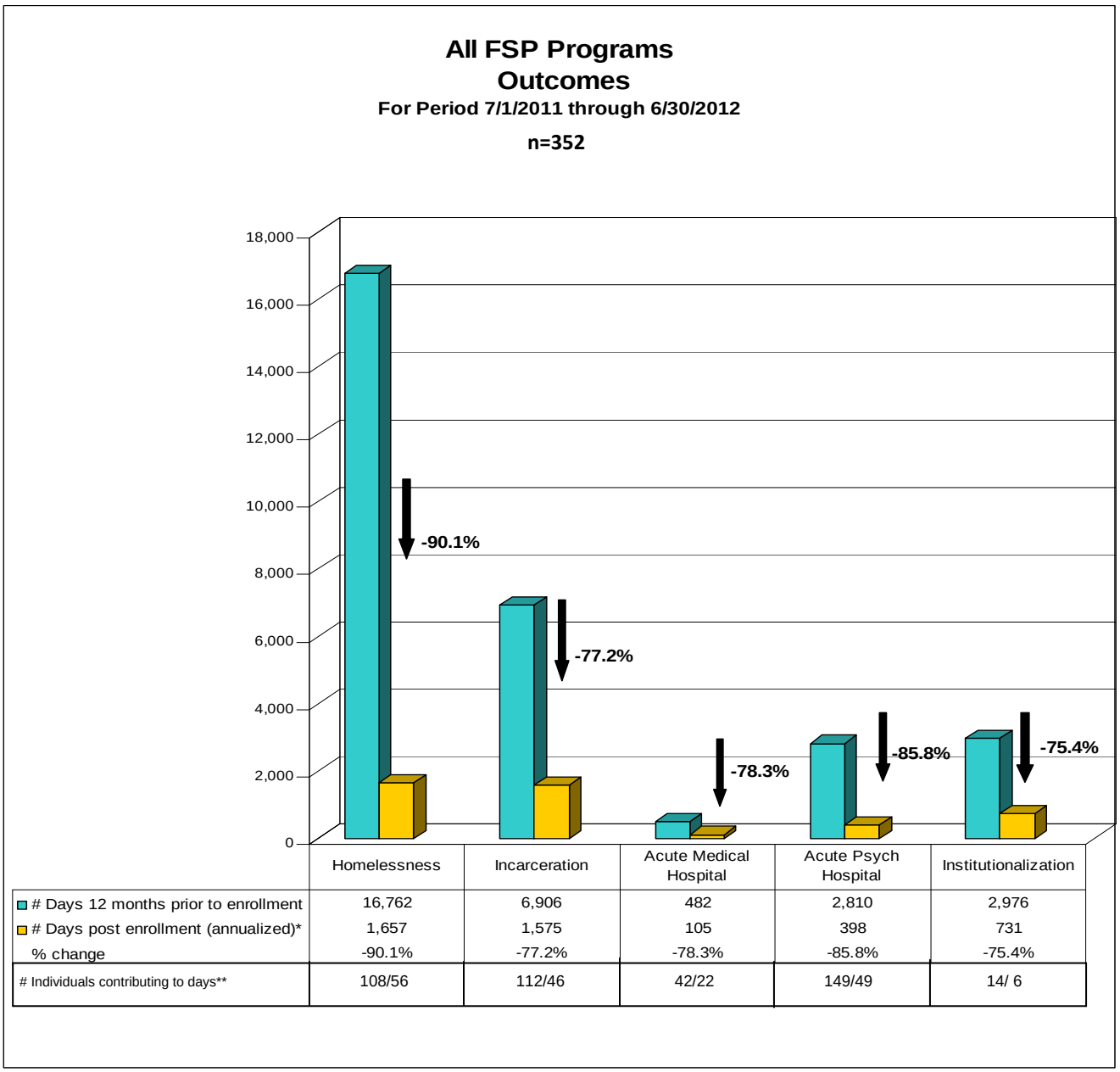




All graphs showing ages served are based on the following categories; child/youth 0-15 years, transition age young adults 16-25 years, adults 26-59 years and older adult 60+ years.



Highlights



	Homelessness	Incarceration	Acute Medical Hospital	Acute Psych Hospital	Institutionalization
# Days 12 months prior to enrollment	16,762	6,906	482	2,810	2,976
# Days post enrollment (annualized)*	1,657	1,575	105	398	731
% change	-90.1%	-77.2%	-78.3%	-85.8%	-75.4%
# Individuals contributing to days**	108/56	112/46	42/22	149/49	14/ 6

*In order to compare one year historical data to post data, a computation called annualization must occur. Annualization is determined by taking the # of days of the calendar year and dividing into the # of days enrolled.
**Number of individuals contributing to days – Individuals 12 months prior/Individuals post enrollment
Note: Institutionalization represents a combined count for State Hospital and Long Term Hospital

CSS - Stanislaus Homeless Outreach Program (SHOP) – FSP-01

Operated on Contract to Telecare Corporation within BHRS Adult System of Care

Stanislaus Homeless Outreach Program (SHOP) offers 3 levels of care: 1) Full Service Partnership (FSP), 2) Intensive Support Services, and 3) Wellness/Recovery. This approach allows individuals to enter the program at an appropriate level of service for their need and then move to a less or greater level of care as needed. SHOP provides services to a diverse unserved and underserved population of transitional aged young adults (TAYA), adults, older adults who have co-occurring issues of mental health and substance abuse, who are uninsured/underinsured, and involved with other agencies. The goals are to reduce the risk for emergency room use, contact with law enforcement, homelessness, and psychiatric hospitalization.

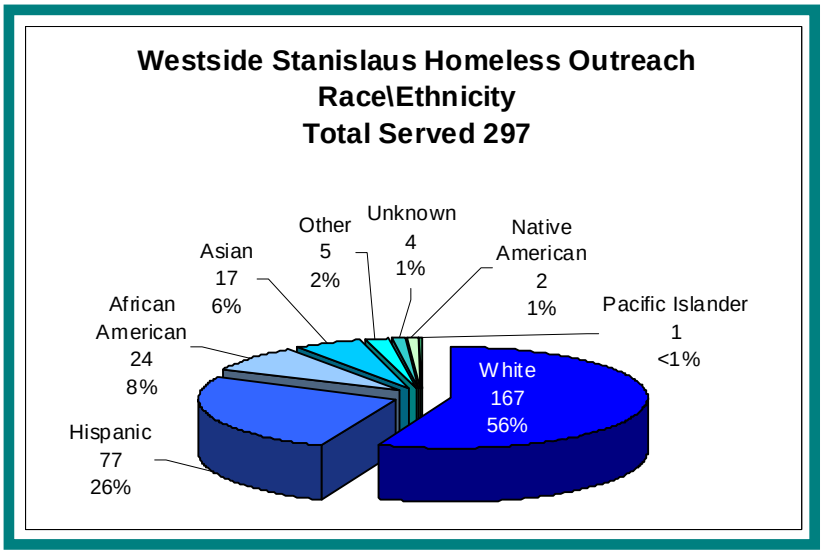
The FSP level of care has 3 tracks: 1) Westside SHOP, 2) Partnership Telecare Recovery Access Center (Partnership TRAC), and 3) Josie's Telecare Recovery Access Center (Josie's TRAC). Full service partnership strategies include integrated, intensive community services and supports with 24/7 availability with a known service provider. SHOP utilizes a "housing first" approach with recovery and client- and family-centered focus that inspires hope.

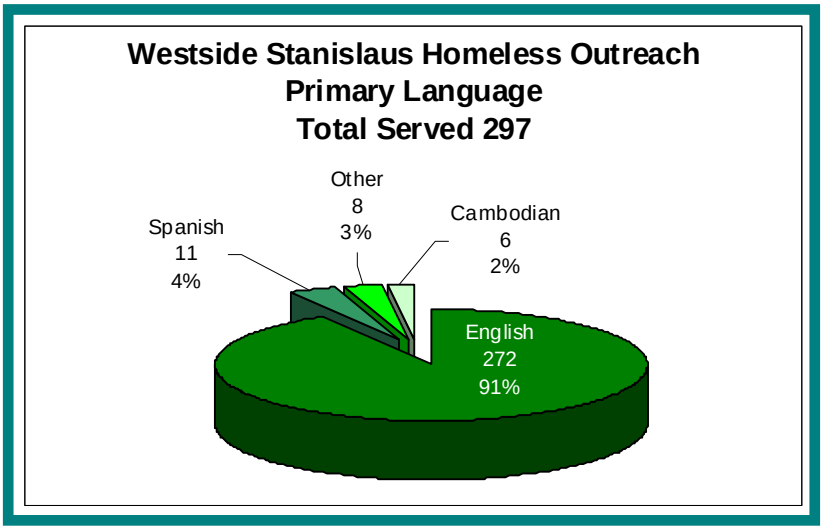
Funded by General System Development funds (GSD), Intensive Support Services level of care has 1 track: Fast TRAC. The Wellness/Recovery level of care has 1 track: Wellness TRAC. Group supports led by clinical service staff are offered to individuals, as are peer-led wellness/recovery support groups. All levels of care include a multi-disciplinary approach. Graduated levels of care allow more individuals to access the full service partnership level of service only when needed. To ensure effectiveness, the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS), an assessment tool developed by American Associations of Community Psychiatrists for determining appropriate level of care in outpatient services, is utilized.

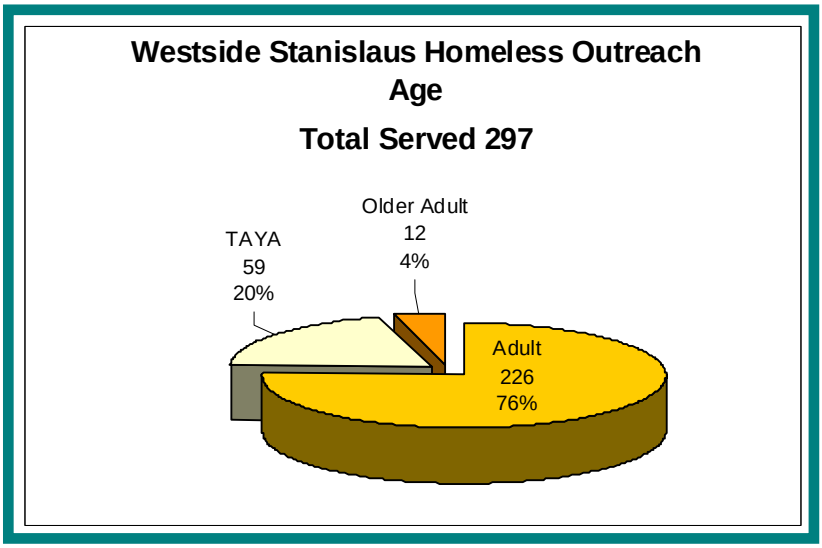
FY13-14, there are no proposed changes to the target population or the strategy to be used. In the November 5, 2012, MHSA stakeholder planning process, a program expansion to increase staff capacity to serve an additional 12 transitional age young adults and 24 adults in the FSP; an additional 25 adults to be served in the Intensive Support Services level was recommended and to be effective February 2013.

Estimated number of individuals projected to be served at any one time FY13-14 is 294; 164 in Full Service Partnership and 130 in Intensive Support Services and Wellness/Recovery.

Demographics



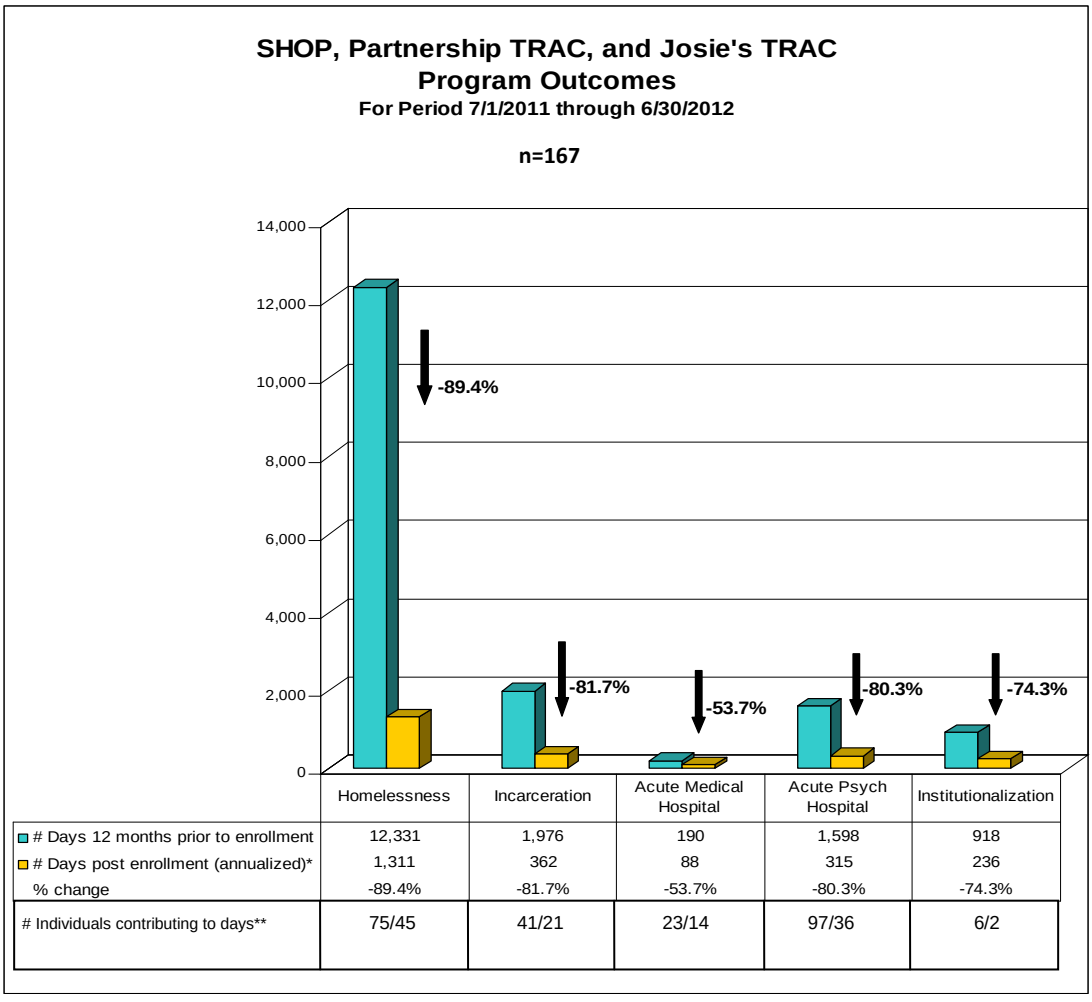




Highlights

There has been a dramatic increased need of services for individuals that are uninsured and those with both a mental health and alcohol or drug diagnosis. The successful collaboration with county Alcohol and Drugs services to serve many of the co-occurring population has been impactful. SHOP staff has been successful in getting qualified uninsured individuals benefited or self-sufficient within a 6 month period as well. This level of coordination of care has maintained the efficiency of the program and the medication resources that were provided.

Due to the uniqueness of the FSP programs, there has been success in supporting client recovery by reducing barriers and providing a continuum of care that meets the need of individuals receiving services. This progress can be seen by an individual who moves from the FSP to a less intensive wellness level service because of the growth they have made without a change in their team of psychiatry, nursing staff, individual therapy provider or group therapy. This has helped individuals to become active in their recovery and has led many of them to reconnect to family members as they gain more independence. It has always been an important goal to support individuals with connecting to meaningful community resources and strengthen their own network of support whenever it is possible.



	Homelessness	Incarceration	Acute Medical Hospital	Acute Psych Hospital	Institutionalization
# Days 12 months prior to enrollment	12,331	1,976	190	1,598	918
# Days post enrollment (annualized)*	1,311	362	88	315	236
% change	-89.4%	-81.7%	-53.7%	-80.3%	-74.3%
# Individuals contributing to days**	75/45	41/21	23/14	97/36	6/2

*In order to compare one year historical data to post data, a computation called annualization must occur. Annualization is determined by taking the # of days of the calendar year and dividing into the # of days enrolled.
**Number of individuals contributing to days – Individuals 12 months prior/Individuals post enrollment
Note: Institutionalization represents a combined count for State Hospital and Long Term Hospital

Challenges

The phenomenon across California with increased and repeated psychiatric hospitalization for uninsured individuals and those with both mental health and alcohol or drug diagnosis was a challenge. Many of these individuals requiring re-admit have had no prior contact with the mental health system at all. This situation has been puzzling and even though SHOP has been working diligently to manage this crisis, if this trend persists the current resources will not be enough to address this problem. There will be a need to strategically plan how to address this emerging unmet need.

An important part of the work would be to meet the needs of reaching culturally diverse and unserved/underserved populations. The engagement with cultures that have strong stigma towards mental health services has been an ongoing challenge.

Program Results Shown in RBA Framework	
• 297 individuals were served (across all levels of care combined) • 1,110 individual therapy contacts were made • 1,212 group therapy contacts were made Examples of groups offered: Harm reduction in the area of substance and sexual activity, Spirituality, Stress Management, Seeking Safety, and "Healthy Lifestyles"	**How Much?**
• 128% of annual targeted number were served (297/233) • 17 months - average length of treatment in highest levels of care • 25 months - average length of treatment in lower levels of care • 15 individuals with severe mental illness from the Asian community were engaged and participated in treatment • 88% (118/134) of surveyed participants were satisfied with services • 89% (40/45) of surveyed participants indicated that "Staff believed I could change"	**How Well?**
• 76% (34/45) of surveyed participants indicated that they deal more effectively with daily problems as a result of services • 60% (26/43) of surveyed participants indicated that they feel they belong to their community as a result of services • 89.4% decrease in homelessness days of participants • 81.7% decrease in incarceration days of participants • 80.3% decrease in psychiatric hospitalization days of participants	**Is Anyone Better Off?**
How Lives Have Changed	
G, a young married father with a 5 month old baby initially came to our attention when he was hospitalized in 2012 with his first mental health break down. His experience with intrusive thoughts, hearing voices, seeing things that are not there, and the constant feelings of suspicious towards others were so severe he became a danger to himself which required hospitalization.	

The “help first approach” afforded by MHSA was impactful to G and his recovery. He was quickly engaged by the FSP team. He received psychiatry, therapy, case management and medication services as needed. His sincere desire to get well was also a driving force to his remarkable progress in over just a few months of intensive services. He was able to move to a lower lever of care because of the services he was receiving.

His feelings of suspiciousness towards others have become manageable and, with medication he has not re-experienced hearing voices or seeing things that people do not normally see. He has become optimistic about his well-being and has been better able to socialize with others. G can be seen with a smile often and presents his great sense of humor around others when he comes in for services. He shared having an outstanding relationship with his wife. He hopes to return to work soon and now has a goal to start his own carpet cleaning business.

CSS - Juvenile Justice (FSP-02)

Operated by Behavioral Health and Recovery Services in the Children's System of Care

Juvenile Justice FSP is part of Stanislaus County's well-developed Juvenile Justice/Mental Health systems that is known as one of the best in California for the excellent collaboration that occurs to serve youth (primarily ages 13-19) and their families.

All of the youth served have a diagnosis of serious mental illness or a serious emotional disturbance and are on formal or informal probation. Many of these high-risk youth are victims of trauma and have not successfully been engaged by traditional methods of treatment for a variety of reasons. As a result of not getting timely or effective services, symptoms can worsen and aggressive behavior persists or escalates resulting in arrest, incarceration or psychiatric institutionalization.

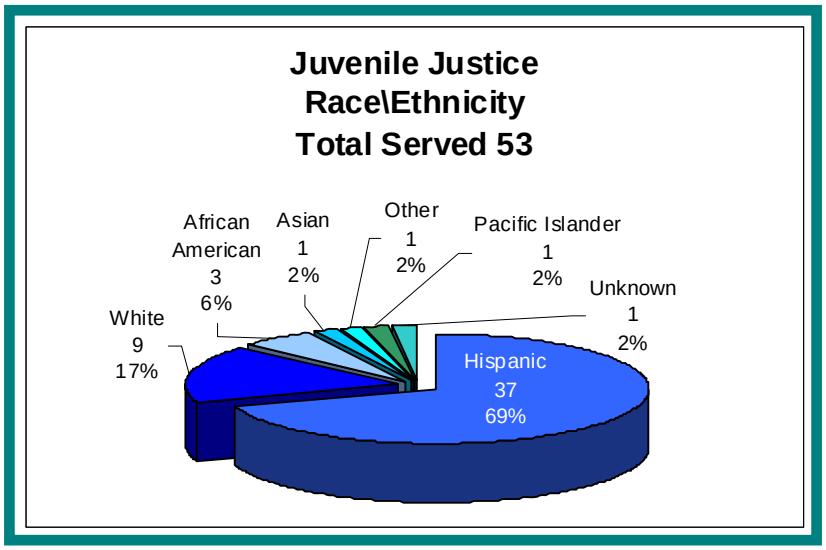
Strategies include 24-hour-a-day, 7-day-a-week crisis response services in which half of the services are provided outside of the office to youth in the nine cities throughout the County. Creative methods are employed to engage youth that involve consistent access to a known provider to build trust with these high-risk youth.

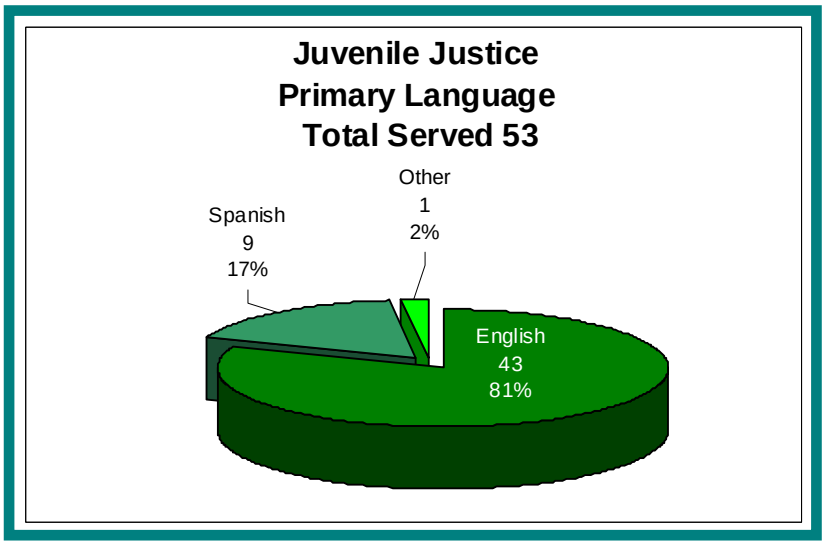
Aggression Replacement Training and Seeking Safety are evidence-based models employed to teach youth alternative behaviors that are healthier. Parent support group is offered to families who wish to receive support in navigating the juvenile justice system or support in improving parenting skills. Three staff members are bilingual/bicultural in Spanish which supports outreach and service to families and youth from underserved diverse culture.

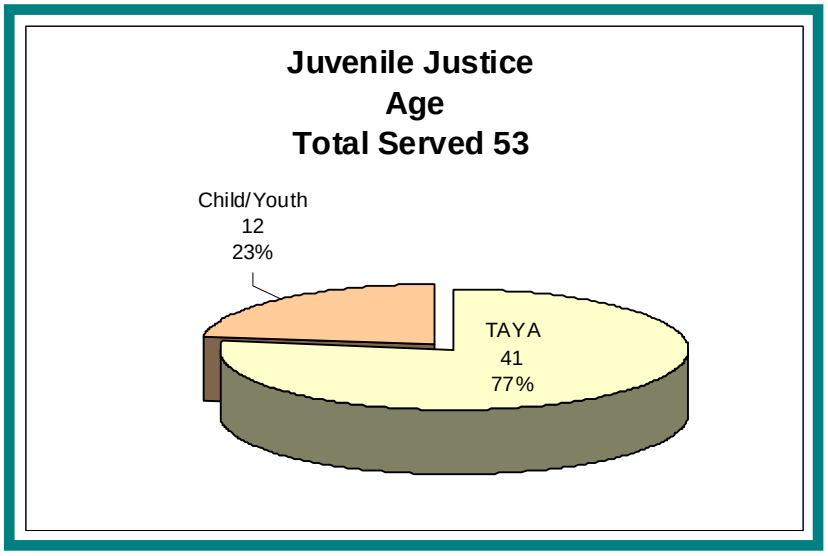
FY13-14, there are no proposed changes in the population to be served and strategy to be used. In the November 5, 2012 MHSA stakeholder planning process, a program restoration was recommended to increase staff capacity to provide peer and family support services to this target population effective February 2013.

Estimated Number of individuals projected to be served in FY13-14 will be a total of 25; 13 child/youth and 12 transition age young adults.

Demographics



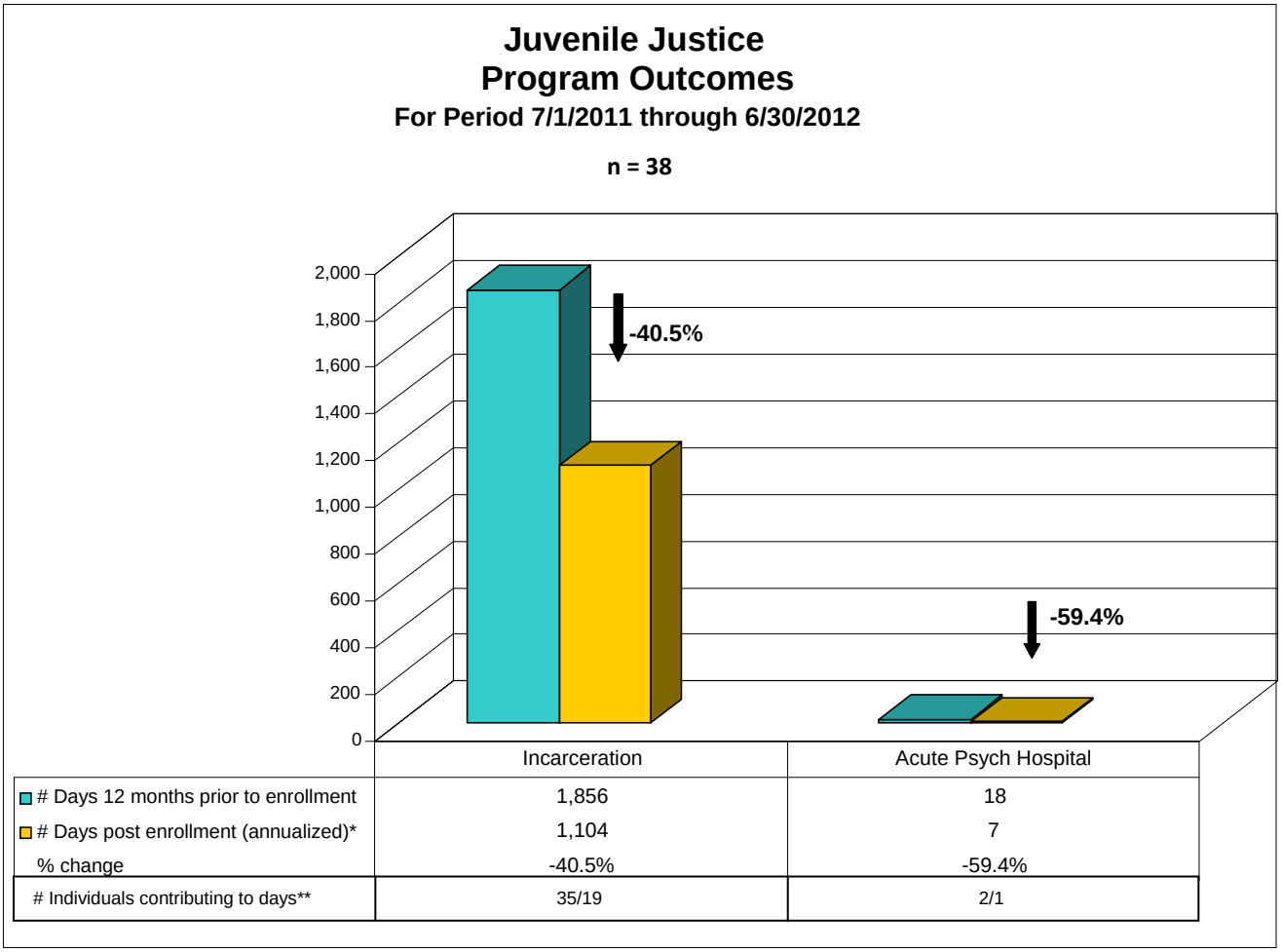




Highlights

A few highlights of the successes in the Juvenile Justice programs include the "Parent Support Group", which has given parents/grandparents an opportunity to participate and understand about the Juvenile Justice system. This has become a place for the parents to be heard and give support to one another. The parents have been receptive to the support group, which is crucial to building strong supportive factors to assist their youth from re-entering the legal system.

The "help first approach" to services made the difference in assisting a family from losing their home. In addition, a total of 13 youth who were on informal/formal probation were successfully dismissed for meeting their goals and having no further contact with the law. After showing growth with their services, two youth were able to return to public school without difficulties. Another two youth making growth in their treatment were connected to an employment program. One of the youth completed 200 hours of on the job training, with the other working on the third week of employment placement and working on his GED.



	Incarceration	Acute Psych Hospital
# Days 12 months prior to enrollment	1,856	18
# Days post enrollment (annualized)*	1,104	7
% change	-40.5%	-59.4%
# Individuals contributing to days**	35/19	2/1

*In order to compare one year historical data to post data, a computation called annualization must occur. Annualization is determined by taking the # of days of the calendar year and dividing into the # of days enrolled.
**Number of individuals contributing to days – Individuals 12 months prior/Individuals post enrollment

Challenges

One of the continued challenges for Juvenile Justice is increasing the collaboration with parents. There is still great distrust of the legal system among youth and their families. This lack of trust limits the ability of Juvenile Justice to fully engage families who have been underserved and are not familiar with services being offered when their youth enters the legal system. The initial engagement of these families takes time to effectively provide the immediate support needed. It has been suggested by the parents that it would be beneficial to have parent partners in the engagement process who have similar experiences. "Parent Partners" would be an adult who has successfully gone through the Juvenile Justice system with their youth and understand from a "been there" perceptive to assist new families through the legal system. It would be desirable for staff to include parent partners in the engagement process.

Program Results Shown in RBA Framework	
• 53 unduplicated individuals were served • 6 individuals participated in two ART group sessions (a total of 27 classes) • The average number of clinical services and case management contacts was two contacts per week (phone and face to face)	**How Much?**
• 212% of annual targeted number were served (53/25) • 11.9 months – Average length of treatment • 30% of clients are from primary Spanish speaking family and received services from Spanish speaking staff • 81% of clients engaged have some form of gang affiliation, either personally or through family • 100% (9/9) surveyed participants and caregivers were satisfied with services • 100% (9/9) surveyed participants and caregivers indicated that they participated in treatment • 83% (5/6) of participants in ART successfully completed the program	**How Well?**
• 100% (6/6) of ART participants did not pick up any new charges • 100% (6/6) of ART participants reported increase use of skills taught and reduction in overall aggression • 30% of clients were dismissed from probation due to positive change in behavior/choices • 23% of clients were discharged after successfully completing their treatment goals • 40.5% decrease in incarceration days of clients	**Is Anyone Better Off?**

How Lives Have Changed
J is a 17 year old youth who has had a number of contacts with the legal system since the 7th grade. There were many difficult factors in J's life that had the odds stacked against J including struggles with mental health issues, challenges in the home environment that provided little hope and was constantly in a mess, and had frequent contacts with the law.

How Lives Have Changed

These situations resulted in J being placed on probation and in a non-public school setting because of the ongoing problems. With the continued support and engagement from Juvenile Justice, J has made steady growth over the years. The coping skills and social skills J has learned in the course of treatment have come in to play.

This year, J has made tremendous growth in that J was both dismissed from probation and re-enrolled in a public high school as a junior in Modesto. J has transitioned well and has had no contact with the law, hospitalization, or needed to return to juvenile hall. J has a new outlook on life and has become a leader and role model to other peers. J will be expected to graduate next year. Although J has made significant progress personally, J's home environment has not changed much. However, this no longer presents a barrier to stop J from continuing to make the most out of life. J hopes to be part of the change and to inspire other individuals in like situations to believe they can make the most out of their life. J will be one of the few youth from Stanislaus attending the REACH conference in March 2013 for inspired young leaders.

CSS - Integrated Forensic Team (FSP-05)

Operated by Behavioral Health and Recovery Services in the Forensics System of Care

The Integrated Forensic Team (IFT) partners closely with the Stanislaus County Criminal Justice System to serve the target populations that include transition age young adults (18 – 25 years), adults (26 - 59 years) and older adults (60+ years) who have Serious Mental Illness (SMI) or co-occurring substance abuse issues with SMI and who are involved with and at risk for more serious consequences in the criminal justice system.

Strategies include a multidisciplinary team that provides a "wrap around" approach that includes 24/7 access to a known service provider, individualized service planning, crisis stabilization alternatives to jail, re-entry support from state hospital, linkage to existing community support groups, peer support and recovery groups for individuals with co-occurring health and mental health disorders. Both service recipients and family members are offered education regarding the management of both mental health issues, benefits advocacy support and housing support. Culturally and linguistically appropriate services are provided to racially and ethnically diverse consumers.

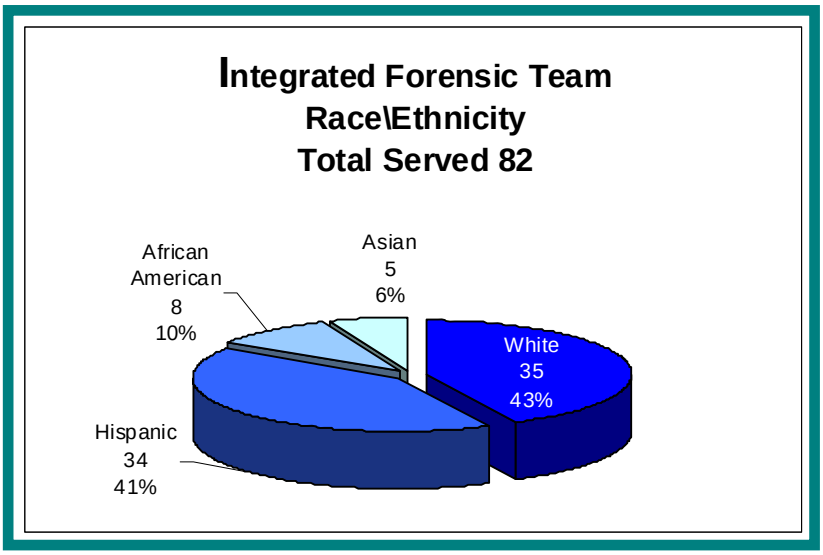
Collaboration with partner agencies is central to reducing disparities and achieving an integrated service experience for consumers and family members. In addition to law enforcement agencies and probation, collaboration occurs with agencies including but not limited to, Turning Point Community Programs, Salvation Army, United Samaritans Homeless Services, and Golden Valley Health Clinics (a Federally Qualified Health Clinic).

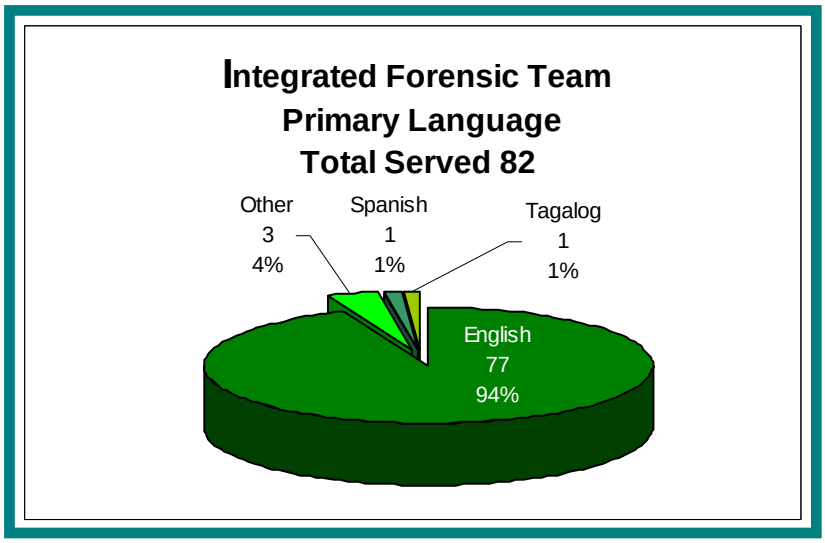
A combination of Full Service Partnership (FSP) and General System Development (GSD) funds provides 3 levels of care; Full Service Partnership, Intensive Support Services, and Wellness/Recovery. This allows individuals to enter the program at an appropriate level of service for their need and then move to lesser or greater intensities of service as needed. Graduated level of care allows more individuals to access the full service partnership level of service when needed. To ensure effectiveness, the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS), an assessment tool developed by community psychiatrists for determining appropriate level of care in outpatient services is utilized.

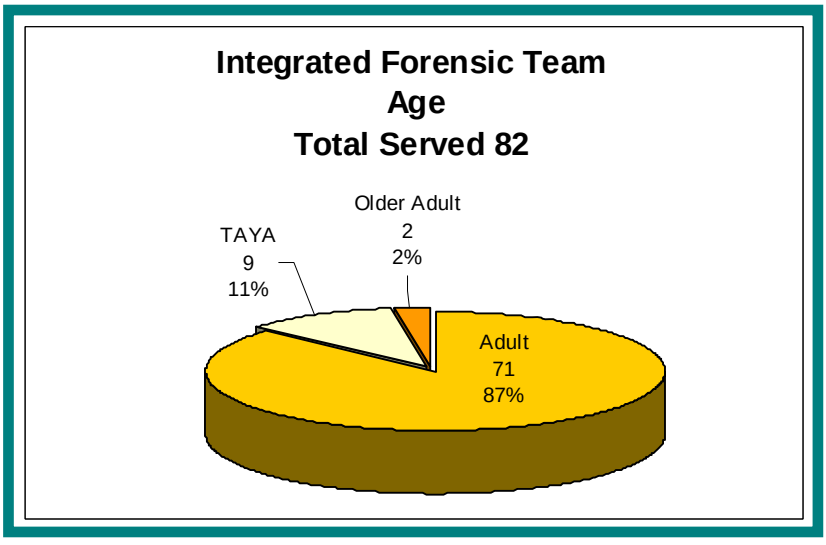
FY13-14, there are no proposed changes in the population to be served and strategy to be used. In the November 5, 2012 MHSA stakeholder planning process, a program expansion was recommended to serve an additional 12 transition age young adults and adults in FSP; an increase of staff capacity to provide Intensive Services and Support level services, and enhance peer support team for this target population effective February 2013.

Estimated number of individuals projected to be served in FY13-14 is 92; 52 full service partnership level and 40 in intensive support services or wellness/recovery levels.

Demographics





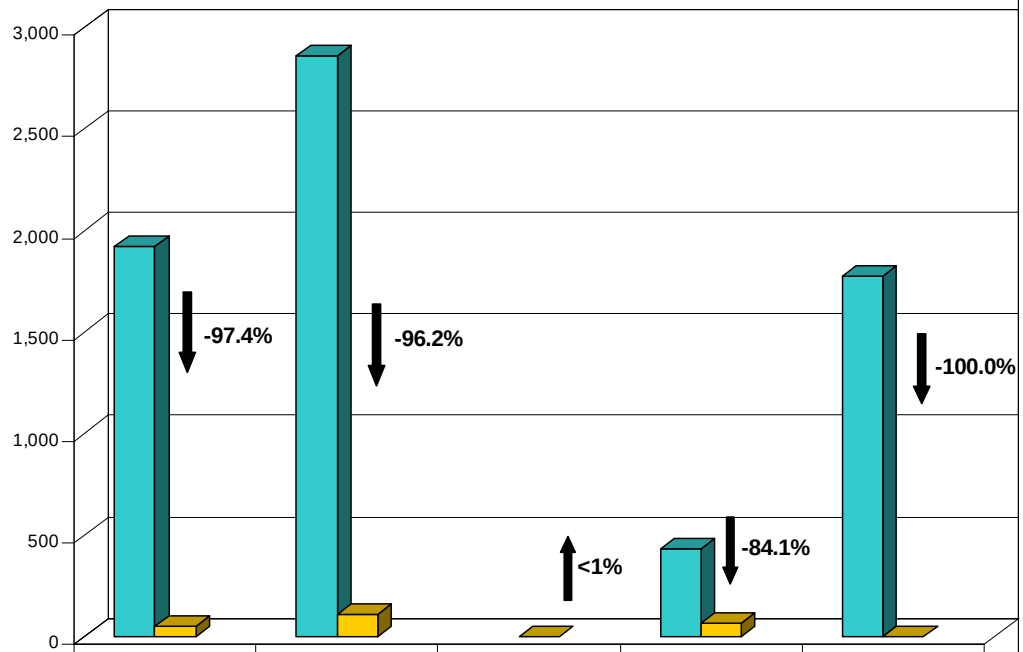


Highlights

IFT continued to contribute to the local Mental Health Court effort. The Criminal Justice Realignment Act of 2011, a.k.a. AB 109 benefited IFT clients with expansion of like services. Due to this change, groups have become larger which, does provide an opportunity for some clients to take on a mentorship role with their peers. Many clients have successfully transitioned to a lower level of care, with either a successful terming of their probation and/or they were able to maintain stability and growth in their treatment.

Integrated Forensic Team
Program Outcomes
For Period 7/1/2011 through 6/30/2012

n=35



	Homelessness	Incarceration	Acute Medical Hospital	Acute Psych Hospital	Institutionalization
# Days 12 months prior to enrollment	1,925	2,858		433	1,777
# Days post enrollment (annualized)*	50	109	3	69	0
% change	-97.4%	-96.2%	0.0%	-84.1%	-100.0%
#Individuals contributing to days**	18/4	30/6	0/1	15/10	7/0

*In order to compare one year historical data to post data, a computation called annualization must occur. Annualization is determined by taking the # of days of the calendar year and dividing into the # of days enrolled.
**Number of individuals contributing to days – Individuals 12 months prior/Individuals post enrollment
Note: Institutionalization represents a combined count for State Hospital and Long Term Hospital

Challenges

The IFT team currently has a challenge with moving clients through the system as indicated by the retention numbers in the program. However, the co-location of the multiple teams in IFT, they can begin to look at this issue and address the challenges needed to move clients to a lower level of care as appropriate.

Program Results Shown in RBA Framework	
• 82 unduplicated individuals were served (across all levels of care combined) • 52 unduplicated individuals were served by the FSP. • 3 or more groups a week are offered by IFT • 15 individuals, on average, attended the two primary weekly groups (out of a caseload of under 80)	**How Much?**
• 103% of annual targeted number were served (82/80) • 43 months - average length of treatment in the highest level of care • 100% (12/12) of surveyed participants were satisfied with services • 92% (11/12) of surveyed participants indicated that "Staff believed I could change"	**How Well?**
• 83% (10/12) of surveyed participants indicated that they deal more effectively with daily problems as a result of services • 67% (8/12) of surveyed participants indicated that they feel they belong to their community as a result of services • 97.4% decrease in homelessness days of participants • 96.2% decrease in incarceration days of participants • 84.1% decrease in psychiatric hospitalization days of participants • No one returned to State Hospital (1555 pre-enrollment days to 0 post-enrollment).	**Is Anyone Better Off?**

How Lives Have Changed
T was a client that had long standing struggle with both mental health and substance abuse issues. T first came to IFT through the Mental Health Court process because of struggles with getting into recovery. T was at risk for homelessness, hospitalization, and re-entering into the criminal justice system. IFT engaged T at his own pace to build a strong relationship that values T's readiness for taking action towards recovery. T had some successes and set backs early on in treatment which was able to be overcome with the resources that were provided by the IFT team. T was connected to Clean and Sober Living and then successfully moved into Transitional Living where T was able to live in an apartment independently. Like many challenges in recovery, T hit a rough patch in life that resulted in a relapse. IFT was able to place T in treatment with Stanislaus Recovery Center. However, getting back into recovery was not easy. T ended up being dismissed from Mental Health Court and losing the benefit of having his case dismissed and probation terminated early because the issues affected T's ability to meet the

targeted goal. IFT remain on board with engaging T and providing appropriate support to assist with T's issues.

T was helped to connect with Teen Challenge and successfully completed the program. T felt such a connection with recovery there, T had opted to stay on at Teen Challenge to become a driver, do presentations at Juvenile Hall, and run support group meetings. T has now successfully completed probation as well as no longer needing the services of a FSP like IFT.

CSS - High Risk Health & Senior Access (FSP-06)

Operated by Behavioral Health and Recovery Services in the Managed Care/ Older Adult Services

The High Risk Health and Senior Access (HRHSA) program target populations includes transition age young adults (18 – 25 years), adults (26 - 59 years) and older adults (60+ years) who have significant, ongoing, possibly chronic, health conditions co-occurring with Serious Mental Illness (SMI). Older adults may also have functional impairments related to aging. Outreach and services are focused on engaging diverse ethnic/cultural populations and individuals, as well as those who have mental illness and are homeless, at risk of homelessness, at risk of institutionalization, hospitalization or nursing home care or frequent users of emergency rooms.

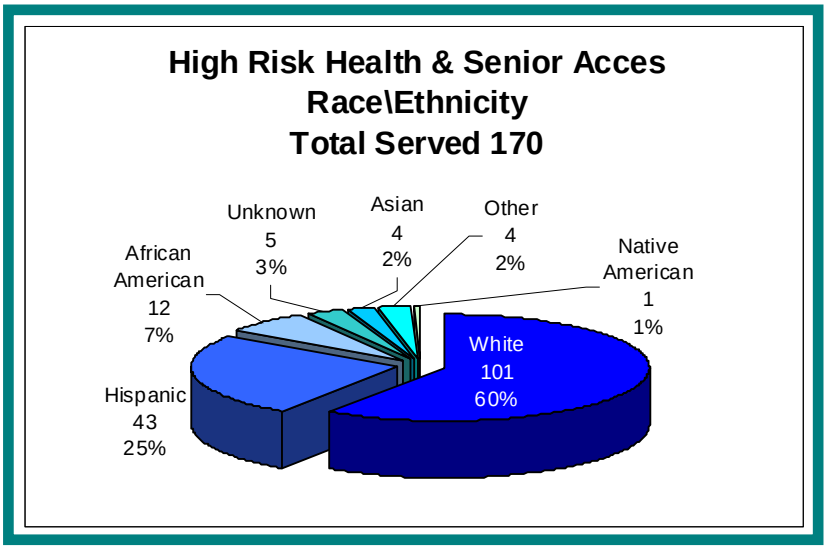
Strategies include 24/7 access to a known service provider, individualized service plan, multidisciplinary treatment approach, wellness and recovery focused group and peer support, linkage to existing community support groups, peer support and recovery groups for individuals with co-occurring health and mental health disorders. Both service recipients and family members receive education regarding the management of both health and mental health issues as well as benefits advocacy support and housing support.

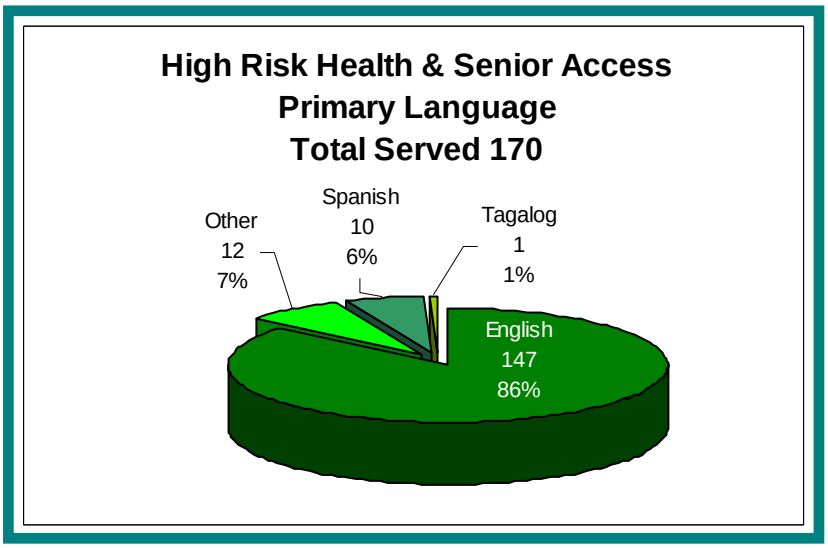
A combination of Full Service Partnership (FSP) and General System Development (GSD) funds provides 3 levels of care; Full Service Partnership, Intensive Support Services, and Wellness/Recovery. This allows individuals to enter the program at an appropriate level of service for their need and then move to lesser or greater intensities of service as needed. Graduated level of care allows more individuals to access the full service partnership level of service when needed. To ensure effectiveness, the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS), an assessment tool developed by community psychiatrists for determining appropriate level of care in outpatient services is utilized.

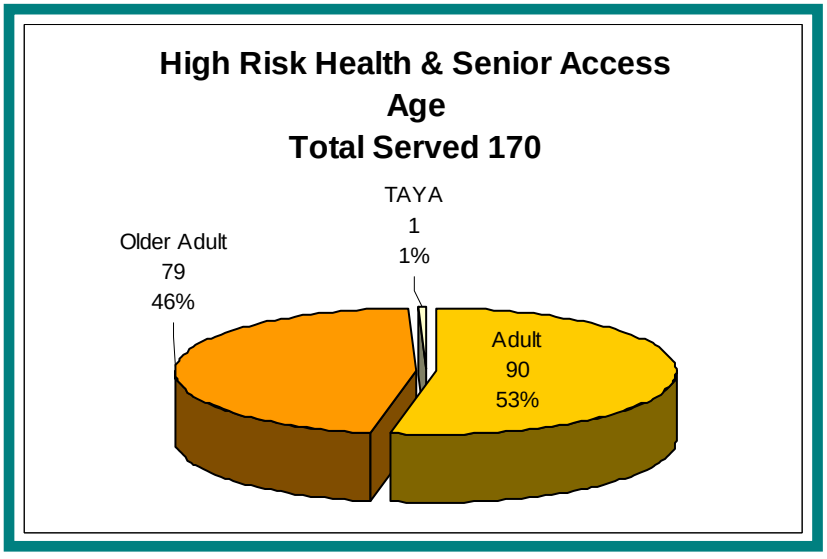
In FY13-14, there are no proposed changes in the population to be served and strategies to be used. In the November 5, 2012 MHSA stakeholder planning process, a program expansion was recommended to serve an additional 12 adults and older adults in FSP; increase staff capacity to meet the service needs for this target population effective February 2013.

Estimated number of individuals projected to be served in FY13-14 is 122; 56 adults (ages 26–59) and 66 older adults (age 60+).

Demographics







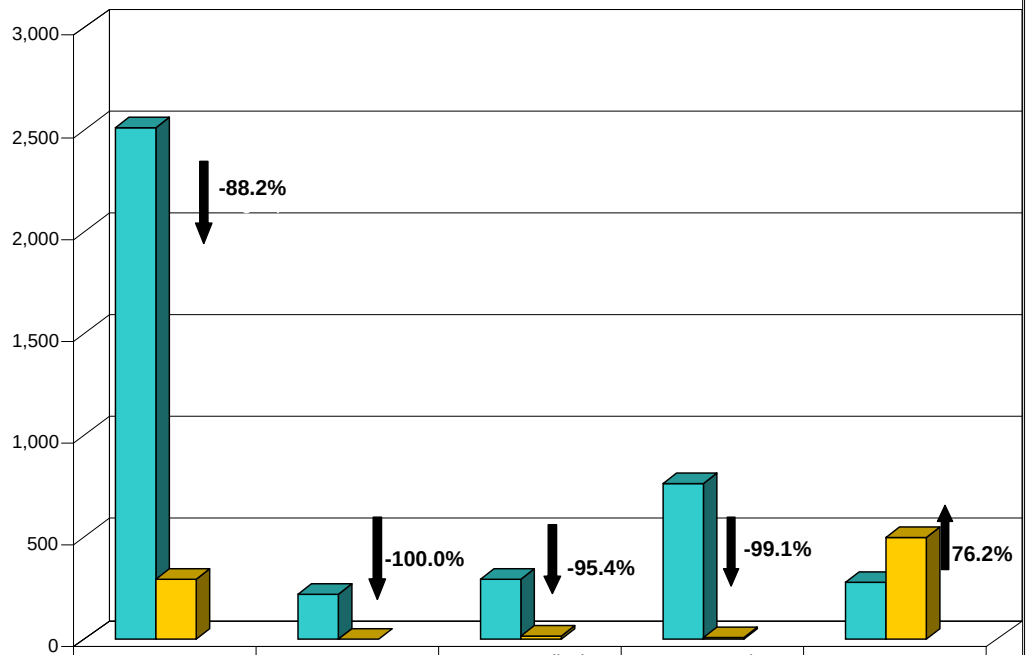
Highlights

HRHSA has an ethnically diverse workforce that included: African American, Hispanic, Filipino, and Caucasian. The program has made continuous efforts to reach diverse and underserved community through engagement in community events, including National Depression Screening Day and the week afterward. HRHSA completed 61 depression screenings in five cities in Stanislaus County. Our "One Stroke Paint" peer support group has taken place at the Empowerment Center. HRHSA also participated as a mental health rotation site for nursing students at Modesto Junior College and CSU, Stanislaus.

High Risk Health and Senior Access Program Outcomes

For Period 7/1/2011 through 6/30/2012

n=97



	Homelessness	Incarceration	Acute Medical Hospital	Acute Psych Hospital	Institutionalization
# Days 12 months prior to enrollment	2,506	216	292	761	281
# Days post enrollment (annualized)*	296	0	13	7	495
% change	-88.2%	-100.0%	-95.4%	-99.1%	76.2%
# Individuals contributing to days**	15/7	6/0	19/7	35/2	1/4

*In order to compare one year historical data to post data, a computation called annualization must occur. Annualization is determined by taking the # of days of the calendar year and dividing into the # of days enrolled.
**Number of individuals contributing to days – Individuals 12 months prior/Individuals post enrollment
Note: Institutionalization represents a combined count for State Hospital and Long Term Hospital

Challenges

With efforts to reach our target population, it has continued to be a challenge having access to serve underserved populations on the Westside of Stanislaus County. There were capacity issues in regards to providing transportation to client's that needed the support. Also, unforeseen impact of program staffing issues that required program adjustment to fulfill client needs has been a challenge as well.

Program Results Shown in RBA Framework	
• 170 individuals were served (across all levels of care combined) • 8 groups were offered each week for a total of 12.5 weekly hours of group time available for clients • 61 depression screens were completed across the county during National Depression Screening Day and the following week	**How Much?**
• 155% of annual targeted number were served (170/110) • 36 months – average length of treatment in the highest level of care • Increased socialization opportunities for all clients, including events, recreation, Safety Fair, and dinners • 90% (36/40) of surveyed participants were satisfied with services • 88% (35/40) of surveyed participants indicated that "Staff believed I could change"	**How Well?**
• 81% (29/36) of surveyed participants indicated that they deal more effectively with daily problems as a result of services • 67% (26/39) of surveyed participants indicated that they feel they belong to their community as a result of services • 88.2% decrease in homelessness days of participants • 100% decrease in incarceration days of participants • 99.1% decrease in psychiatric hospitalization days of participants • 95.4% decrease in medical hospitalization days of participants	**Is Anyone Better Off?**
How Lives Have Changed	
Three years ago, K came into treatment wearing every piece of clothing K can possibly put on at the same time. K had a pull along luggage that had all the other clothes that K could not put on. K had difficulties engaging with peers and was easily overwhelmed with self critical thoughts. K would get anxious about going out into the community causing K to stay away from others. HRHSA realized the severity of K's mental heath and set forth the utilization of the MHSA philosophy of "what ever it takes" to engage treatment and support to K. The time intensive process needed to build a positive and trusting relationship as well as a continuum of care needed to support K's well-being was only possible within a MHSA program. Over a year of continuous engagement with K, HRHSA had a strong enough relationship with K to	

assist with taking some positive risks. The break through finally came with K taking a step outside of K's comfort with joining a paint group. There was some lack of consistency at first with participation. K slowly, but steadily began taking the skills learned about developing relationships and support from HRHSA to reach out to K's peers. K began to also gradually shed the layers of clothes.

The ongoing support provided to K was well worth the time and efforts. K has made tremendous growth and now enjoys going out to the community at least once a week. K engages peers without overwhelming fears. The self critical behavior has become manageable. This has allowed K to work on gaining more insight on how to maintain better self care. K also has taken more risks in the community that benefits K's overall well-being.

CSS - Josie's Place Drop-in Center (GSD-01)

Operated by Behavioral Health & Recovery Services Children's System of Care

Josie's Place Drop-in Center is a bustling center of activity with diverse transition age young adults (TAYA) interacting with the culturally diverse staff that includes African American, White, Hispanic, and Asian individuals. Outreach to and participation from Lesbian, Gay, Bi-sexual, Trans-sexual and Questioning (LGBTQ) youth is present in the social milieu and cultural sensitivity of services.

Josie's Place is a membership-driven "clubhouse" type model that also has service teams in the center: Josie's Place Intensive Services and Supports (ISS) and a Full Service Partnership (FSP) called Josie's TRAC (operated by Telecare Recovery Access Center). Services are offered in English, Spanish, Laotian, and Thai languages at all levels of service. Seeking Safety groups as well as Aggression Replacement Training groups were offered as part of the array of services at the Center.

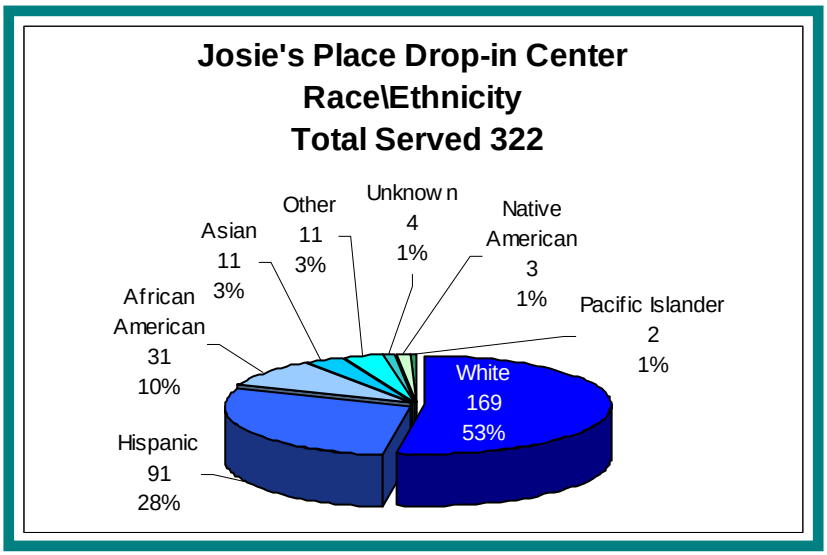
In addition, Stanislaus County Transitional Aged Young Adult Partnership (STAY) is a key collaborative that brings together BHRS, Community Service Agency, Probation, Health Service Agency and other key community providers working with transitional aged young adults to strengthen collaborative efforts and resources for the young adults with mental illness.

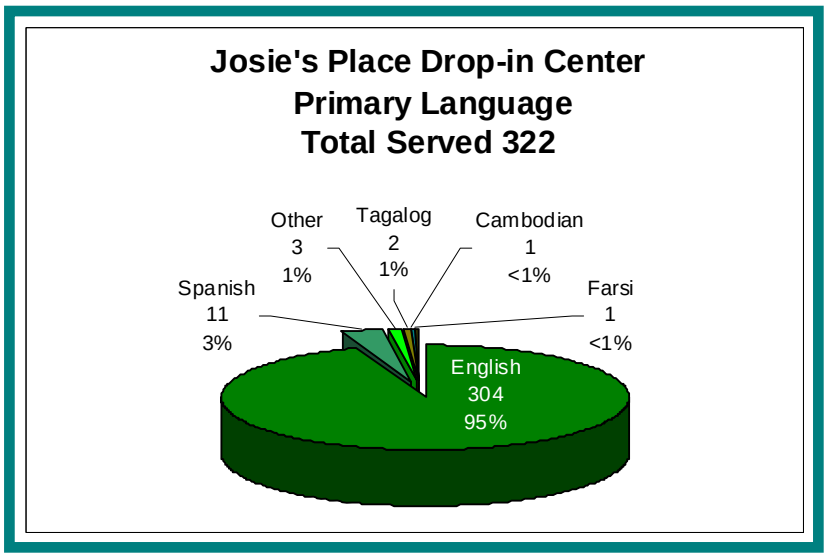
The Young Adult Advisory Counsel (YAAC), a consumer based counsel, provides leadership opportunities for the young adults and a greater voice in the daily activities and operation of Josie's Place Drop-in Center overall. Because of an earlier recommendation by YAAC, more peer support and groups were established. Josie's Drop-in Center currently offers the following groups: Seeking Safety; Aggression Reduction Therapy (Teaching Pro-Social Skills); gender specific peer support; and an active LGBTQ support group.

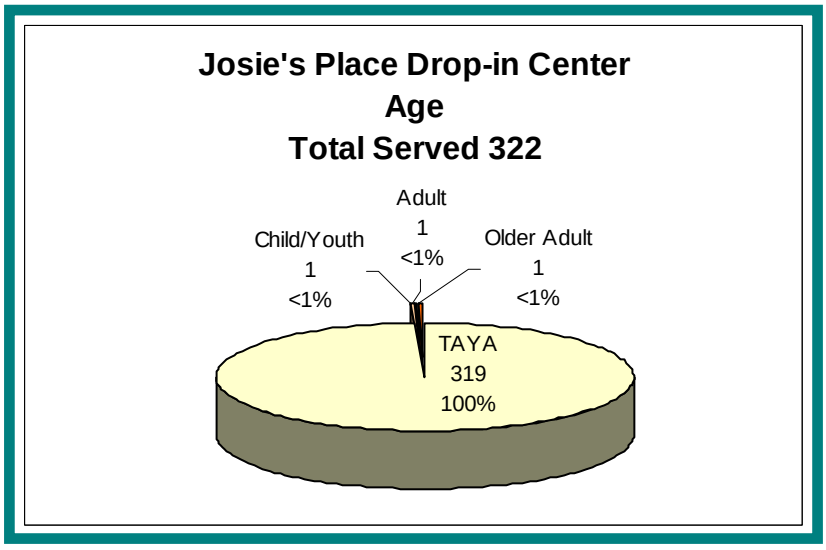
FY13-14, there are no proposed changes in the population to be served and strategies to be used. In the November 5, 2012 MHSA stakeholder planning process, a program restoration was recommended to increase staff capacity to meet service needs.

Estimated number of individuals projected to be served in FY13-14 is 250.

Demographics







Highlights

Peer support groups are thriving at Josie's place. Support groups are offered to TAYA on issues that are most concerning them. The groups do outings to support each other around development of social skills and related coping skills. Groups included skill building such as "Music for the Soul" which teaches youth social skills through learning to read music and play guitar. Other groups include art groups and physical health related group activities that provide life skills as well. The groups are open to both youth who receive mental health services and those who only use the drop in center for support.

Youth from Josie's Place attended community events throughout the county that included the Modesto Pride Conference, Mental Health Diversity Week Celebration, Community Outreach forums in Turlock and with Youth Leadership Conference in collaboration with MHSA Prevention and Early Intervention Program. In addition, the YAAC decided not only to focus on TAYA needs at Josie's but also to give back to the community. In November they conducted a canned food drive and put together care packages for TAYA with families in need. In December they held a coffee and doughnut outreach to the Homeless population in Modesto.

Two youth who have shown interest in leadership were chosen to participate in a conference sponsored by California Youth Empowerment Network (CAYEN). This statewide organization has the goal of empowering and inspiring Transition Aged Youth to create positive change in the mental health system. Through targeted advocacy, CAYEN supports TAYA across the state to have a meaningful impact in the policies that shape their lives. In addition, Josie's Place hired four youth who have lived experience as a consumer or family member to the center and developed four volunteer opportunities for youth to help with group support, outreach and peer related activities that engage youth where they are at.

Challenges

The challenge of having consistency with the TAYA population is always shifting. The constant life changing circumstances they go through makes it difficult to work with all youth to build personal strengths and skills to help with the various projects. We strive to meet the needs and challenges of TAYA population which include housing and employment. The limited resources make this an ongoing challenge as well.

Program Results Shown in RBA Framework	
• 322 unduplicated individuals served (across all levels of care combined) • Approximately 150 unduplicated youth served in the drop in center • 6 groups per week, on average were held, for approximately 312 groups during the year (not including activity-related groups)	**How Much?**
• 129% of annual targeted number were served (322/250) • 12-18 months – average length of treatment for highest level of care • 8-18 months – average length of treatment for lower levels of care • 100% (20/20) surveyed participant were satisfied with services • 95% (18/19) surveyed participants indicated that "Staff believed I could change"	**How Well?**
• Skills overall for TAY youth are increasing and the desire for knowledge and participation is increasing overall as the consumers find confidence in their voice being heard in advocating for their population in multiple areas throughout the county. • 4 TAYA volunteered to assist with group, engagement, and outreach to other diverse, unserved and underserved young adults • 4 TAYA were hired for the Drop-in Center • 80% (16/20) of surveyed participants indicated that they deal more effectively with daily problems as a result of services • 67% (12/18) of surveyed participants indicated that they feel they belong to their community as a result of services	**Is Anyone Better Off?**

How Lives Have Changed

J was first introduced to Josie's Place after having experienced J's first panic attack and was diagnosed with an anxiety disorder. Although J was hesitant to use Josie's Drop-In Center at first, J found immediate connection with the warmth and welcoming environment Josie's Place was able to provide. J stated, "I found a place for myself to participate in groups and hang out as often as possible."

Two months later, J became a member of Josie's Place and shortly was offered an opportunity to volunteer. J responded, "I was so excited and I jumped at the opportunity". The volunteer experience ignites J's passion to make a difference in the mental health field. J soon enrolled in the CASRA program at Modesto Junior College. J felt Josie's Place was a strong supporter of J going back to school stating, "…the staff supported me, and offered their help to me 100% of the way." As the same time, J was also involved with attending leadership, mental health conferences and other trainings with Josie's Place. After a year and half, J was hired as peer support counselor for Josie's Place.

J credited Josie's Place for providing opportunities that has lead J to have made relationships across the state and with "people who understand me…" J stated that this has open other doors and opportunities. J is now an active member of the California Youth Empowerment Network (CAYEN). J stated, "I am able to have a voice in different bills, and pieces of legislation that will affect young adults with mental health issues…" "I am so passionate for the work I am now doing; I want to be able to help people the way I was helped." J's story is one of many that are shared by many youth that have made a connection to Josie's Place.

CSS – Community Emergency Response Team & Warm Line (GSD-02)

CERT/Warm Line is operated by Behavioral Health and Recovery Services in the Adults System of Care and Turning Point Community Programs

Commonly referred to as “CERT/Warm Line”, the program combines consumer and/or family team with a team of licensed clinical staff to provide interventions in crisis situations. The consumer-operated “Warm Line” is administered under contract with Turning Point Community Programs. CERT is operated by BHRS. Warm Line serves as the first point of contact for all incoming calls and provides non-crisis support, referrals, and follow-up contacts.

The population served includes all ages: Children, Transition Age Youth, Adults and Older Adults. Primary focus is on acute and sub-acute situations of children and youth with serious emotional disturbances (SED) and individuals with serious mental illness (SMI). Emphasis with each age group is placed on provision of age-appropriate outreach, engagement in the recovery process, and crisis intervention that include family and natural systems of support when available.

Collaboration is central to the success of emergency mental health assessment and referral and occurs on a daily basis with families, consumers, law enforcement, and medical hospital emergency room personnel. Referrals are available for individuals who need ongoing agency-based mental health services or hospitalization as well as services and supports that are available in the community.

The Mobile-CERT component provides site-based as well as mobile crisis response in the community allowing individuals in crisis to see a mental health provider in locations outside of a traditional mental health office. Mobile-CERT is a partnership of BHRS clinical staff and patrol officers from the Modesto Police Department. Licensed clinical staff may accompany MPD Patrol officers to act as a resource in the community and to patrol officers who encounter individuals with mental health needs.

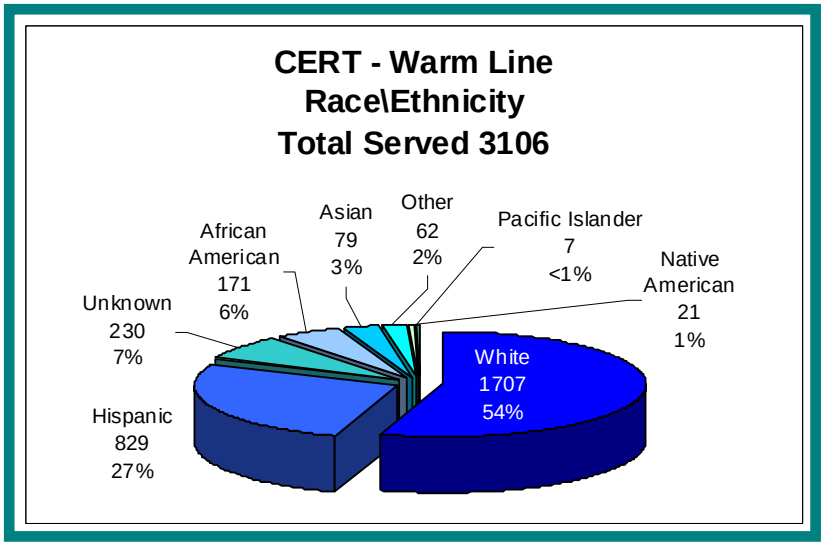
Warm Line is part of CERT that offers non-crisis services delivered by a team of individuals who are not treatment providers. Warm Line staff is a critical second point of contact, following assessment for crisis by clinical staff. Warm Line responds to incoming calls and as such, provides to many individuals a resolution to issues through non-crisis support, referrals and follow-up contacts.

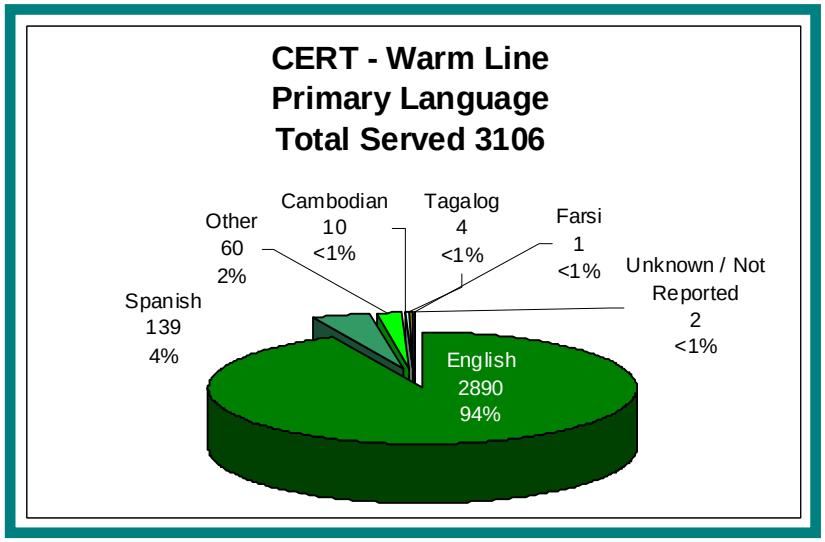
Each Warm Line team member has their own lived experience as a consumer of mental health services and/or a family member of a person with lived experience to draw upon in supporting others. They offer support from a place of “been there” and carry the message of hope that recovery is possible to every contact. Emphasis is placed on hope, peer support, recovery and resiliency.

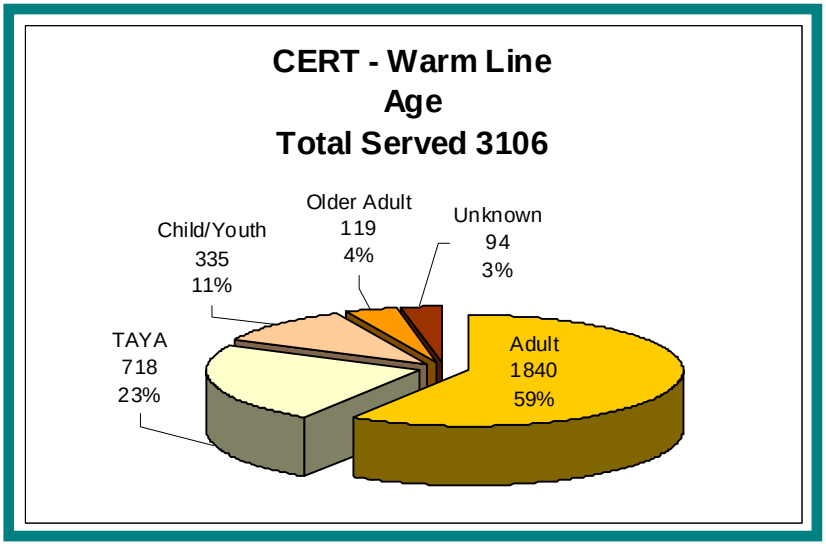
FY13-14, there are no proposed changes in the population to be served and strategies to be used. In the November 5, 2012 MHSA stakeholder planning process, a program expansion was recommended to increase staff capacity to meet service needs to this population.

Estimated number of individuals projected to be served in FY13-14 is 3000.

Demographics







Highlights

Mobile-CERT continues to be a very successful partnership between Behavior Health and Recovery Services and Modesto Police Department. The clinical assessment staff of the Community Emergency Response Team (CERT) and its mobile component provides mobile crisis response in the community. All CERT Staff is trained to ride with patrol officers to expand the capacity to respond to crisis situations.

The Warm Line provided outreach and business cards to several agencies in an effort to increase the awareness of individuals and family members with lived-experiences regarding available resources and our 24/7 Peer Support and Access line.

Challenges

The need for mental health crisis services has increased rapidly due to a variety of factors across all counties in California. CERT/Warmline services are stretched to the limits of time and budget to provide 24/7 coverage that includes an immediate response to all who need crisis interventions and the needs of the Modesto Police Department.

Program Results Shown in RBA Framework	
• 1,084 unduplicated individuals were served through Warm-line • 20,421 calls were received, an average of 1,702 calls per month • 9,349 CERT calls were received (45.8% of total) • 7,839 Peer-support calls were received (38.4% of total). • 12,000 Warm Line outreach cards were provided throughout Stanislaus County.	**How Much?**
• 104% of annual targeted number were served (3105/3000) • Numbers of unduplicated individuals served increased by 111 (11.4%) from FY10-11 • 120 (0.6%) call-backs were requested, indicating a high level of engagement • 16 Warm Line staff have experience as either or both a consumer and family member • 2 Warm Line Staff are Spanish speaking • 100% of Warm-line staff utilized evidenced base practices: Motivational Interviewing, Harm Reduction, and Consumer Driven Strength Based Philosophy	**How Well?**

A Peer Support Specialist providing 24/7 Warm Line services shared how being on the frontline providing crisis support to callers in Stanislaus County has enhanced the individual's life. The individual stated that it is a privilege to work in an area that has a direct impact on people's life. Many of the calls Warm Line staff receives are from callers who are in a life-threatening state of crisis. This requires a Peer Support Specialist to efficiently coordinate communication with representatives of Community Emergency Response Team (CERT) and law enforcement to intervene and save the lives of our community members. This individual has aimed to take every call with the utmost importance to recognize risk at hand, be an active listener, and give referrals/resources as appropriate. Although not every caller will give feedback on how helpful the services were; some callers have shared with this individual how grateful and helpful the Warm Line staff has been to these callers life. This individual stated that knowing the quality of life for callers has been impacted has been what keeps this individual coming to work everyday. The individual stated, "I know that we can't make a difference in everyone's life, but it is fulfilling to know we do make a difference to our callers". This individual also added, "…I am proud to be part of the team that makes a difference!"	**Is Anyone Better Off?**

CSS - Families Together (GSD-04)

Operated by Behavioral Health and Recovery Services; a collaboration of Consumer & Family Affairs System of Care and Children's System of Care

Families Together (FT) is the MHSA funded program at the Family Partnership Center (FPC). Three other programs: Family Partnership Mental Health Program: a multi-disciplinary treatment team; Kinship Support Services Program, and Parent Partnership Project are co-located to create a robust effort to assist families. The central goal is to provide a "one stop shop" experience for youth and their families including one-to-one peer support; service coordination; advocacy; respite for youth, adults, and families; transportation; and wraparound-style services.

Family Partnership Mental Health provides mental health and psychiatric services, and linkage to the other programs at the Family Partnership.

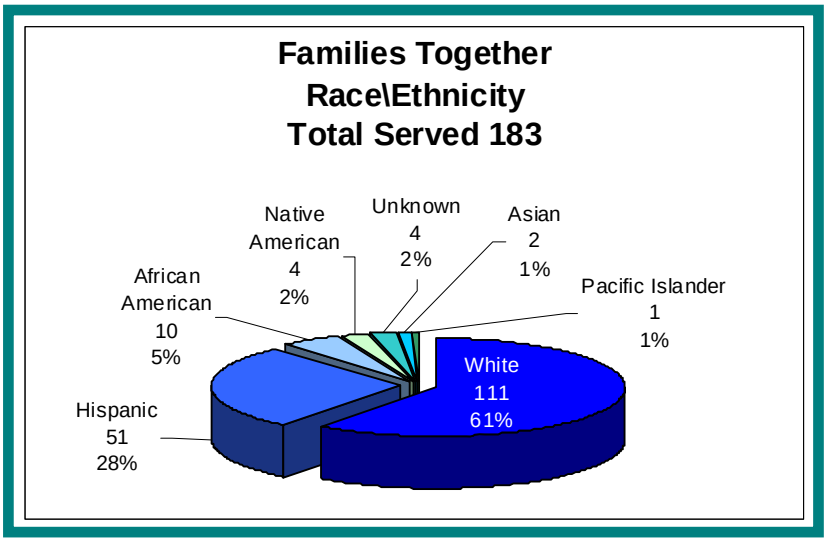
Parent Partnership Project promotes collaboration between parents and mental health service providers. Parent participation is encouraged and as they access services for their children and family they may contribute to policy development, program implementation methods, and refinement of services. Many opportunities exist for parents to provide support to peers as well.

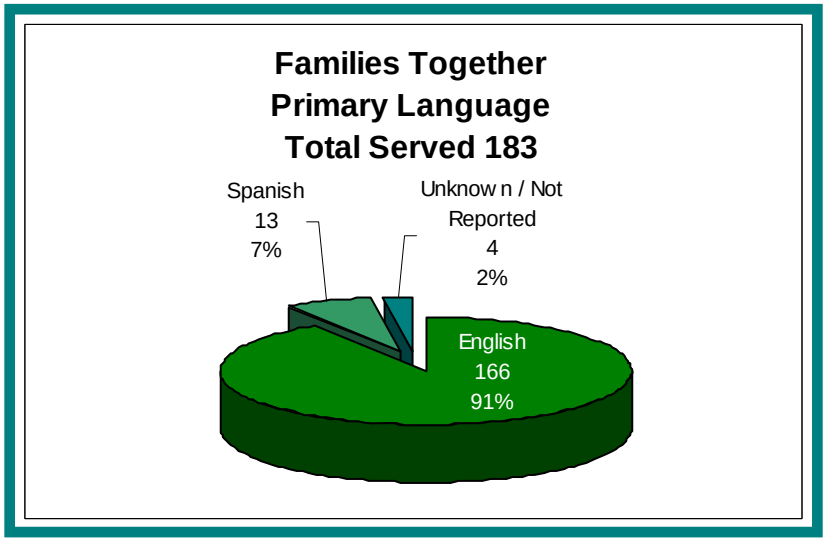
Kinship services are provided primarily by staff members who are Kinship caregivers. Kinship caregivers are often grandparents and other relatives who find they need to serve as parents for children whose own parents are unable to care for them. Sometimes, the arrangement is an informal, private arrangement between the parents and relative caregivers; in other situations, the child welfare system is involved. Services to kinship children and their caregivers include help navigating the guardianship process, court process, and peer support in addressing the challenges of raising kinship children and youth.

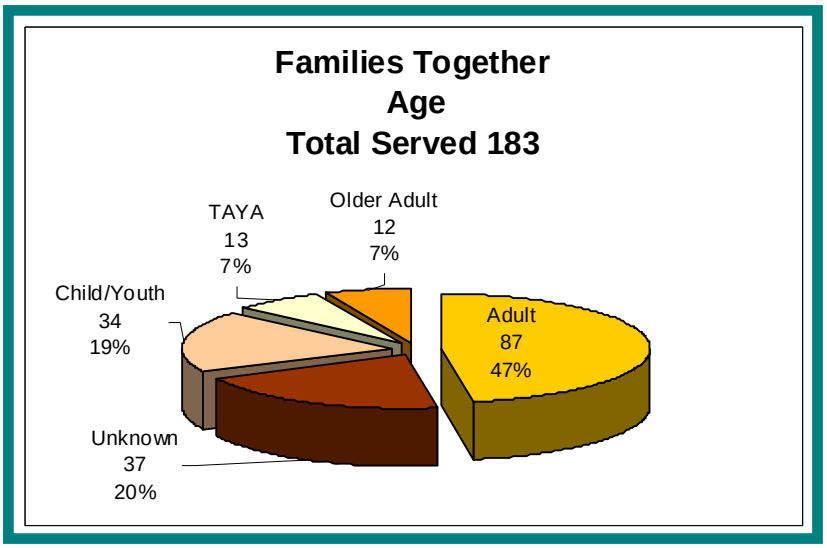
FY13-14, there are no proposed changes in the population to be served and strategies to be used. In the November 5, 2012 MHSA stakeholder planning process, a program restoration was recommended to increase staff capacity to meet service needs to this population.

Estimated number of individuals projected to be served in FY13-14 is 80.

Demographics







Highlights

Families Together continues to provide a relaxing, tranquil space for parents and caregivers to read and socialize as a means of peer support when they bring their children in for services. Support groups are offered including a Men's group that has continued to grow. Outreach and collaborative partnership with multiple school districts' Education Disability (ED) panels and sites with separate administrators are conducted. Through these partnerships, mental health issues are identified for children and youth who are at risk for school failure. Referrals to the Family Partnership Center provide support and services needed to succeed and stay in school.

The Beading Group, a social/recreational group for parents and caregivers meets weekly for two-hours of relaxation and creativity. Participants share ideas, teach each other beading techniques, and set the worries of the day aside for a little while. The participants create beautiful beaded jewelry as gifts for others or a treat for themselves. It is not uncommon to hear newcomers comment that they "are not creative" or "don't know anything about beading". After awhile, changes in these individuals could be heard, "Wow, I made that!" or "I didn't know I could do that." Some members of the Beading Group have shared their love of beading with other families at the Center through classes and workshops held during Friday Morning Social and Gift Making Respite.

Challenges

The Special Education Local Plan Area (SELPA) committee was dismantled. This resulted in a restructuring of the educational processes governing special education services for students with learning disability, mental health, and behavioral challenges that needed additional time and efforts to reconnect to the newly formed committees.

Program Results Shown in RBA Framework	
• 183 unduplicated individuals were served • Two-hour social/recreational groups were offered weekly	**How Much?**
• 229% of annual targeted number were served (183/80) • Collaborative partnerships were established with multiple school districts	**How Well?**

L, is a Hispanic single mom of three children between 7-19 years. She made contact with the program because the middle child was having mental health issues in school. As frequently happens at Families Together, children's need for services brings other issues to light and it became clear that severe anxiety and depression were barriers for Mom to be an effective parent and children to thrive. Through Families Together, mom received assistance in accessing a multitude of resources and services; e.g Medi-cal, transportation, and connection to a Parent Advocate to provide advocacy and support with many complex school-related issues. A strong connection with the parent partner support was established and when one child attempted suicide the parent partner provided a solid connection for Mom to maintain hope, be of support to her child and connect the child to mental health services. Today, though L has moved through many barriers, she is not comfortable driving herself beyond her immediate neighborhood. All three children have gained confidence and moved on in their lives and are achieving successes such as a degree from Modesto Junior College, anticipating graduation from beauty school, and academic success in elementary school. Seeking support through services or peer support is now a part of what they know to do for a continued state of well-being.	**Is Anyone Better Off?**

CSS - The Consumer Empowerment Center (GSD-05)

Operated by Turning Point Community Programs
in the BHRS Consumer & Family Affairs System of Care

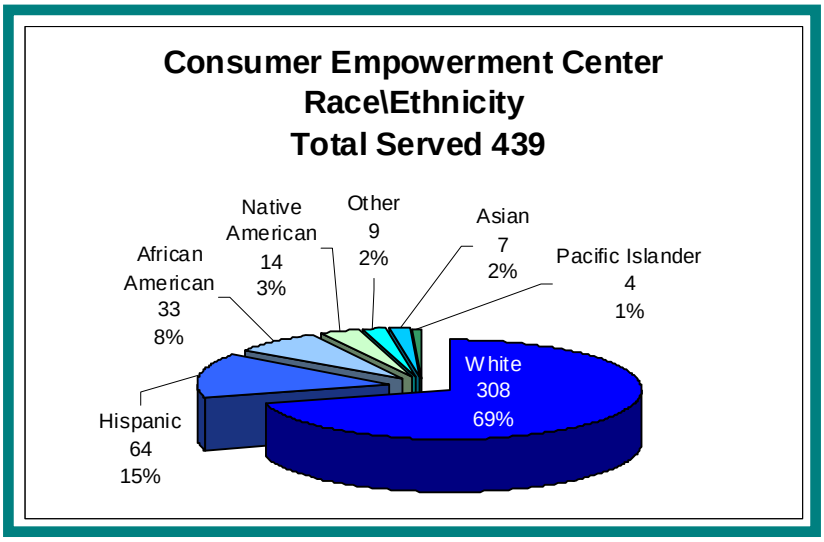
The Consumer Empowerment Center (CEC) provides behavioral health consumers and family members a safe and friendly environment where an individual can flourish emotionally while developing skills. CEC is a culturally diverse center where individuals can gain peer support and recovery-minded input from peers to reduce isolation, increase the ability to develop independence and create linkages to services related to treatment of serious mental illness and co-occurring substance abuse. CEC is 100% staffed by behavioral health consumers and family members. It is a safe place where transitional age young adults, adults and older adults can work toward independence and get support for coping with mental health issues. A culinary training program called The Garden of Eat'n is part of the center. This program provides consumers and family members an opportunity to learn skills such as food preparation, sanitization, catering, and safe food practices with the goal of gainful employment after completing their training. CEC offers group space for all consumer and family organizations and self help groups to reserve for meetings.

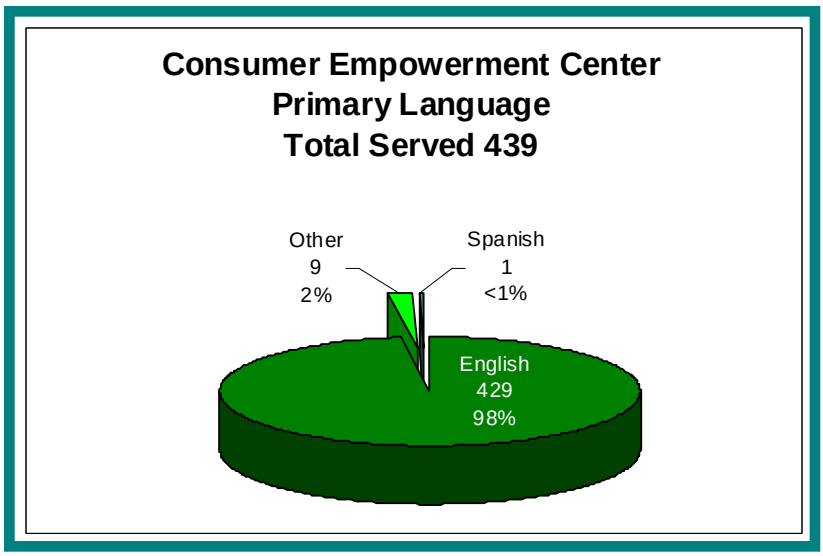
CEC staff assists members in obtaining community resources and linkages to housing, employment, and education. As a team, they provide peer support and introduce self-sufficiency tools and coping techniques to members. These skills are designed to enhance personal empowerment and professional confidence. Safe and ethical social behaviors appropriate for the community, workplace or a shared living environment are introduced and modeled to members. Opportunities are available that promote self-determination, empowerment, lifelong learning, and employment and training. A supported transportation service called Community Activities and Rehabilitation Transportation (CART) is also offered by CEC.

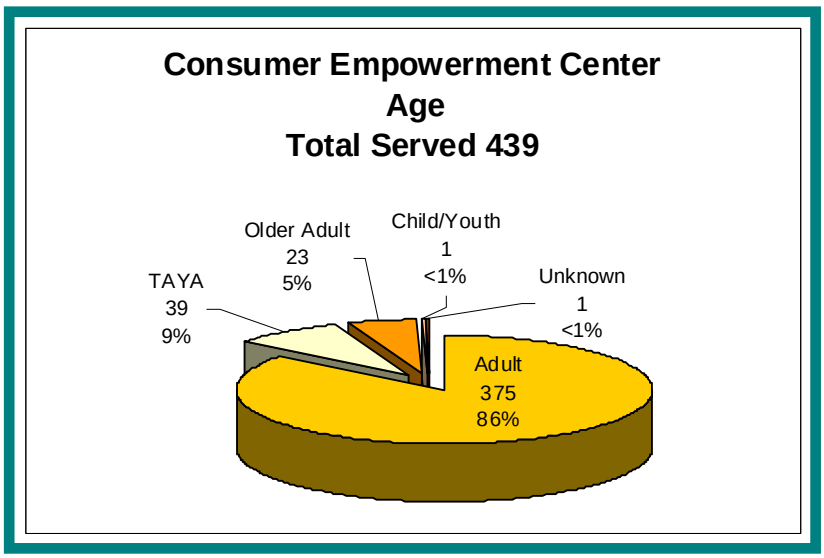
FY13-14, there are no proposed changes in the population to be served, service target or funding levels.

Estimated number of individuals projected to be served in FY13-14 is 500.

Demographics







Highlights

Through the Garden of Eat'n kitchen training program, individuals were provided an opportunity to become a ServSafe certified California food service worker Food Handler. There were eight (8) individuals enrolled in the program and they were all successful in completing the training and receiving their Food Handler card.

The MHSA funded Technological Needs Consumer Family Access to Computer Resource project provided four new computers, speakers, and Wi-Fi access to the center. The equipment was beneficial to the members with accessing resource information, registering for class, setting up personal appointments with other agencies or organizations.

Challenges

Participation at CEC has come strictly by individuals coming on their own because they want to be here. It would be nice to have vehicles to assist with transportation to those that may need more assistance to utilize CEC. Although the Well-being survey provided very good information, the drop in number completing the updated survey could be an area of improvement.

The CEC has had 11,517 visits from 439 members, an average of 26 visits per member. Individuals were met "where they are," rather than "where they would like to be" and individuals return because they find the tools and support they need.

Program Results Shown in RBA Framework	
• 439 individuals were served • 11,517 visits were made to the CEC • Approximately 3,319 individuals participated in 271 events held at the CEC • Provided Well-being survey to all participants at enrollment, updated survey conducted at each quarter on a voluntary basis	**How Much?**
• 88% of annual targeted number were served (439/500) • An average of 92.5% of surveyed individuals report having received the services they came for within any given month • 76.1% of the individuals who attended events at CEC are members of CEC • 96% (78/81) surveyed participant were satisfied with services • 94% (78/83) surveyed participants indicated that "Staff believed I could change"	**How Well?**

• 8 individuals completed the Occupational Skills Training and received their Food Handler card by participating in the Garden of Eat'n. • 55% increase in participants responding favorably to "I generally feel good about my life" (Well-being Survey, initial n=212; subsequent=121) • 17% increase in participants responding favorably to "I feel good about my future" (Well-being Survey, initial n=212; subsequent=121) • 41% increase of participants responding that they have 4 or more people they can call upon for support when they are in need of it (Well-being Survey, initial n=212; subsequent=121) • 22.6% decrease of participants residing in a shelter (Well-being Survey, initial n=212; subsequent=121) • 15.1% increase of participants residing in a house or apartment that they either own or rent (Well-being Survey, initial n=212; subsequent=121) • 81% (59/73) of surveyed participants indicated that they deal more effectively with daily problems as a result of services (Annual Consumer Perception Survey) • 63% (46/73) of surveyed participants indicated that they feel they belong to their community as a result of services (Annual Consumer Perception Survey)	**Is Anyone Better Off?**

How Lives Have Changed

N, a participating member at the Consumer Empowerment Center stated, "When I first came to the CEC, I had a lot of issues. I was depressed and angry. I was on the streets, going to the mission for a meal, shower, and a bed". N also said, "My medical issues were unstable, my diabetes and my feet were facing problems due to how I was living. I learned about the clinics available and I have been able to get my insulin and get care with my feet."

N utilized the opportunities that were present at the CEC such as linkages to resources and training for employment. After completing the job training at CEC he was assigned a job for 30 days and worked schedules that were given. N made tremendous growth in his life and reflected, "…I believe God had brought me to Modesto to get into the program and do right".

CSS – Garden Gate Crisis Outreach (OE-02)

Operated through contract with Turning Point Community Programs

Garden Gate Respite Center (GGRC) is a 6-bed respite home open 24 hours a day, 7 days a week located in a residential neighborhood that maintains “good neighbor” relationships in the community and with immediate neighbors. The respite center is co-located with a 13 apartment and 1 house transitional supportive housing that together offer three levels of temporary housing (3 to 5 day respite housing; 5 to 20 day extended respite housing; and 6 months to 2 years of temporary supportive housing). Staff members of Garden Gate represent diverse cultures and most have lived experience as consumers or family members of consumers of mental health services.

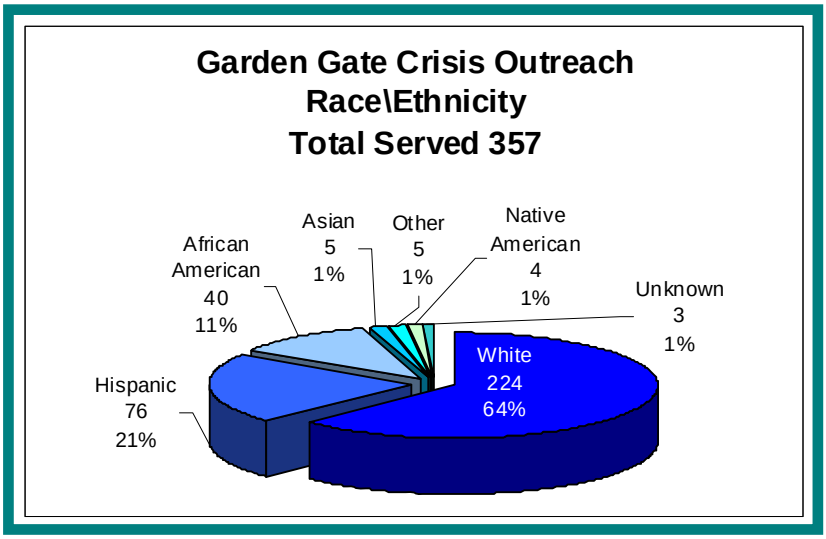
“Housing first” is a priority value for collaboration between Garden Gate Respite and Stanislaus Homeless Outreach Program (SHOP). Garden Gate Respite Center was originally developed as an AB-2034 “housing first” program and was expanded in 2006 with MHSA funds in keeping with community stakeholder priorities. The population to be served includes transition age young adults, adults and older adults from diverse populations with serious mental illness who are homeless or at risk of becoming homeless, at risk of psychiatric hospitalization or institutionalization, medically ill high risk, law enforcement involved, hard to engage, racially and ethnically underserved, and/or individuals with co-occurring disorders. The primary referral agency is law enforcement.

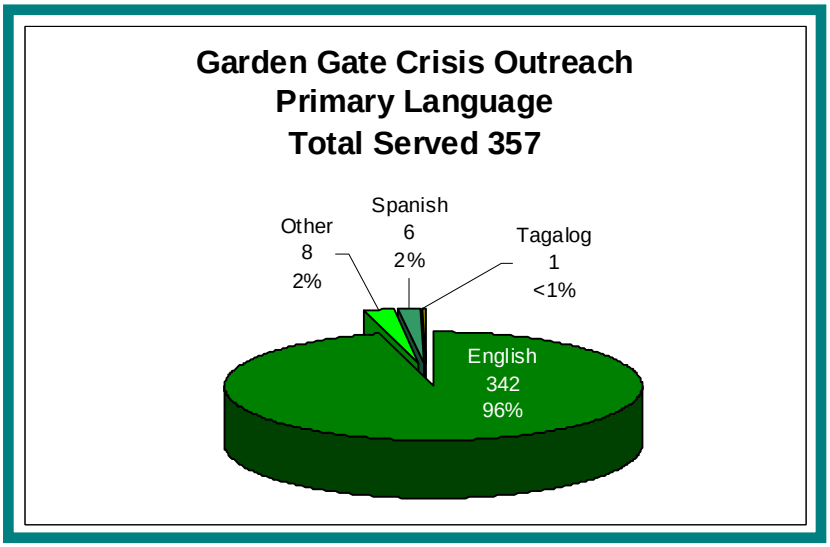
Not a treatment program, Garden Gate Respite Center serves as an engagement program that provides a safe haven with a philosophy of “moving toward wellness”. GGRC often is a first point of contact for individuals who need mental health treatment, access to medical care and other services. For some individuals simply deciding to trust enough to accept respite care is a challenge. Steps toward wellness begin from the first day in respite as GGRC staff will begin to refer individuals to the service needed and encourage them to make calls to reconnect with family or other support systems. For those who are already connected to mental health services, calls are made to existing service providers.

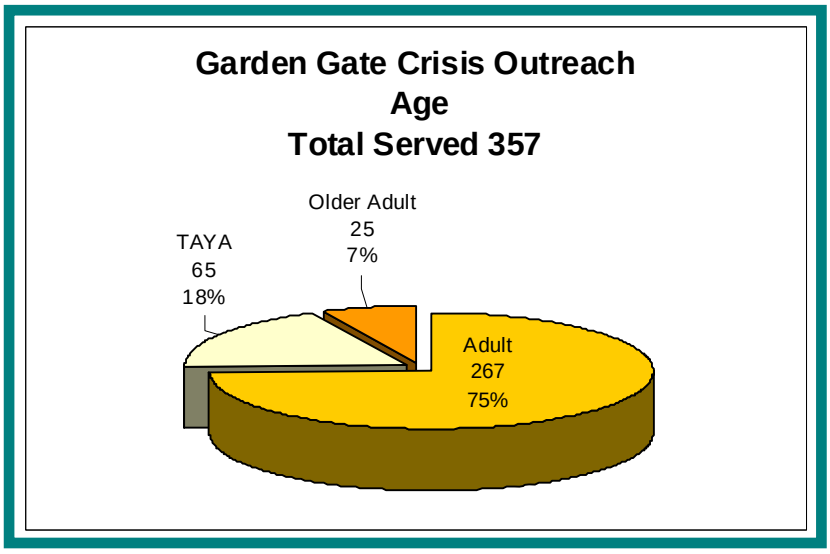
FY13-14, there are no proposed changes in the population to be served, service target or funding levels.

Estimated number of individuals projected to be served in FY13-14 is 97.

Demographics







Highlights

GGRC staff collaborates with referral sources to address “at risk for homelessness” status, and with Telecare Stanislaus Homeless Outreach Program (SHOP) Team to increase the likelihood of successful linkages to mental health and/or other community resources that may include but not limited to medical care, options for longer term temporary or permanent supportive housing, culturally appropriate support services, supportive education at the Consumer Empowerment Center, client advocacy agencies for criminal justice issues, and ongoing outreach if individuals remain homeless after leaving respite housing.

Successful collaborative relationships exist with many key agencies in Stanislaus County. For example, collaboratingpolice officers completed surveys, and 99% reported satisfaction with the referral process and services. In addition, 97.3% of the residents served stated they were either “Satisfied” or “Very Satisfied” with the services provided, attesting to the quality of services offered by the program.

Challenges

The greatest challenge of GGRC seems to be the program’s ability to outreach to an even larger proportion of individuals in underserved populations in order to ultimately link them to community resources they may have otherwise not known were available to them. GGRC relies completely on external referral sources so direct outreach does not occur from GGRC. It is the hope of GGRC to expand capabilities to increase services to larger proportion of underserved populations.

Program Results Shown in RBA Framework	
• 357 unduplicated individuals were served	**How Much?**
• 368% of annual targeted number were served (357/97) • 2.3 days - average length of stay • 97% of residents surveyed indicated that they were satisfied with the manner in which staff interacted with them • 97% of residents surveyed indicated that they were satisfied with the services provided • 95% of residents surveyed indicated that they satisfied with the level of safety at the facility • 99% of residents surveyed indicated that they felt welcome • 28.7% individuals were from underserved populations, including those of Latino (15.7%), African American (10.2%), Native American (1.6%), and Southeast Asian (1.2%) descent	**How Well?**

• 100% (6/6) of surveyed participants indicated that they deal more effectively with daily problems as a result of services • 86% (6/7) of surveyed participants indicated that they feel they belong to their community as a result of services	**Is Anyone Better Off?**

How Lives Have Changed

S was referred to Garden Gate by Modesto Police who found him wandering on the streets late at night. When S first arrived at GGRC he was withdrawn, guarded, and soon left GGRC without saying a word.

Soon after S was again found wandering the streets and police brought him back to the Center. During the second stay, S began to relax a bit and respond to staff efforts to engage him. As he began to trust, he started to share his struggle with hearing voices. GGRC staff was able to assist him with getting mental health services for medication and service coordination.

S's story of lost hope and the challenge of being homeless is one heard often by GGRC staff. This story turned out differently because GGRC is here in Stanislaus County and because the police trust and use respite as a resource, because GGRC staff accept the reluctance of people and continue to be supportive of individuals who have lost hope, and because S accepted help.

Because S took the risk to trust, he was able to find his way to personal growth and path to recovery. Eventually because S gained enough stability in recovery, he was able to find a stable living in transitional housing and began classes at Modesto Junior College. He is pursuing educational goals and enjoying a sense of well-being and inclusion in a community.

Long Term Supported Housing (CSS-Housing)

Long term supported housing funds are a one-time amount of funding, appropriated from CSS funds in FY07-08. In 2008, Stanislaus County assigned $4.8 million for CalHFA to hold in a sub-account for Stanislaus. These funds may only be used for long term supported housing, which is separate from but complimentary to, CSS program funds that provide emergency and transitional housing for the homeless and mentally ill residents of Stanislaus County. Counties were required to assign CSS housing funds to the California Housing Finance Agency (CalHFA) prior to developing housing projects. To complete a project, MHSA funds must be leveraged with other forms of financing (e.g. HUD). Long term supported housing must be designed with the goal of establishing and/or strengthening partnerships that result in development of housing that reflects local priorities and expands safe, affordable options for individuals with serious mental illness or youth with serious emotional disturbance and their families.

Highlights

Behavioral Health and Recovery Services has a history of successful collaboration with key community partners that produced results and developed supported housing projects for individuals who have mental illness. This history of collaboration combined with stakeholder input obtained during the initial CSS Community Planning Process that addressed unmet housing need for all age groups, it will be utilized in developing permanent supportive housing.

Discussions have been ongoing since FY08-09 with local partners to continuously investigate opportunities for additional funding and suitable properties for development into supported housing sites. One project was successfully developed to warrant a housing application.

Bennett Place Housing Project

In February 2013, the Bennett Place Project application was resubmitted to CalHFA. The project includes housing for transition age young adults (TAYA), adults, and older adults. This resubmission coincides with input developed with local stakeholders during the original planning process to address homelessness and ensure services to all age groups.

Approval of the Bennett Place Project, an 18 unit apartment complex, is anticipated to occur in FY13-14. There are ongoing efforts with our community partners such as Housing Authority, Stanco, City of Modesto, and other local service providers to develop other MHSA housing projects in which MHSA Housing funds can be utilized to provide housing for this target population.

Challenges

Factors contributing to challenges are: the program began during an economic recession, State Housing Community Development funding significantly decreased during this period, tax exempt bond funding became limited, local funding sources were being redirected or eliminated such as predevelopment funds, and sources of operating subsidies and services funding have diminished.

There is a lack of funding designated for affordable housing. This presents a challenge as MHSA housing funds are intended to be leveraged with other funds to develop housing projects. These funds have strict program rules and limited flexibility that cause barriers to a local environment that does not have the housing development resources of larger counties; and restrictions on the use of these funds for rental subsidies are prohibitive when new construction is not a realistic or a cost-effective option.

Workforce Education and Training (WE&T)

Workforce Education and Training (WE&T) was the second component of MHSA to be planned and implemented beginning in FY06-07. WE&T funds are a one time allocation. Future allocations to sustain WE&T may come from the MHSA Community Services and Supports (CSS) annual appropriated fund. The WE&T components are unique to the development of the workforce in public mental health to address:

- Shortage in the workforce
- Identify hard to fill positions
- Incorporate MHSA values into practice
- Develop career pathways for diverse populations and individuals with lived experience

Unlike many of the MHSA programs, WE&T programs do not provide direct services. The overarching goal of WE&T is to develop a diverse and well-trained mental heath workforce skilled in delivering services to clients and the community that incorporates the MHSA values of:

- Cultural competency
- Community collaboration
- Wellness
- Recovery/resiliency, client/family driven services
- Integrated service experience for clients and their families throughout their interaction with the mental health system.

Stanislaus County had seven WE&T programs operating during FY11-12 including:

- WE&T Coordination and Implementation
- Workforce Development
- Consumer Family Member Training and Support
- Expanded Internship and Supervision
- 2 Outreach and Career Academies
- Consumer and Family Member Volunteerism
- Targeted Financial Incentives to Increase Workforce Diversity

In FY 11-12, WE&T Coordination and Implementation continues to work closely with our implementation partner, the Workforce Development Council which includes community-based organizations, consumers and family members, BHRS Training Coordinator and BHRS Human Resources Director. The council is facilitated by the WE&T Manager. The Workforce Development Council reviewed WE&T programs and recommended ways to achieve fiscal sustainability in keeping with the objectives of the approved plan.

Progress in this area for 11/12 included: the multiple training courses offered; establishment of stipend and fiscal incentive programs to support career pathways; and the further development of volunteer protocols and processes. These efforts furthered the administrative structures and support the management of long-term workforce development. In addition, through the various WE&T programs, we continued our efforts to engage students at all levels to promote interest in careers in public mental health.

Highlights

Through the implementation of the WE&T components, we have seen more collaboration with community partners and the positive impact it has had on our focus to deliver recovery-oriented, culturally competent, consumer and family driven services through outreach, education, and training. Also, in 11/12, those participating in the WE&T programs began to enter into the public mental health workforce and they brought with them the MHSA values, recognizing the difference they can make at all levels of the mental health system.

Challenges

We are still experiencing the impact of the economic down turn that has affected many organizations for the past few years. The economy and its effect on the high unemployment rate has contributed to an increase in the number of job applicants, therefore it has difficult to assess the hard-to-recruitment nature of our workforce, as it was identified in 2008. In addition, the BHRS workforce has shrunk in size due to the continued strategic hiring freeze that was put in place by BHRS. Recruiting and retaining diverse bilingual/bicultural clinical staff continues to be a challenge to BHRS and partner agencies.

Project Budget & Expenditures	
FY11/12 Total Requested MHSA Funds	**FY11/12 MHSA Funds Expended**
$511,299	**$408,319***

*Unexpended funds in the FY are due to operating reserve, salary and other cost savings, and delays in contract negotiations with academic institutions.

WE&T – Workforce Development

Operated within Human Resources and Training Division of Behavioral Health and Recovery Services in collaboration with partner agencies

The overarching goal of training is to further the implementation of MHSA essential elements throughout the existing workforce and expand capacity to implement additional components of MHSA. Training addresses a variety of key content areas that were identified during the planning process including but not limited to:

- Community collaboration skills
- Resiliency and recovery
- Treatment of co-occurring disorders
- Welcoming consumers and family members perspective in the workplace as a way to ensure an integrated service experience
- How to work with people from diverse cultures to ensure a culturally competent service experience. Training is designed from a consumer and family member perspective and use consumer and family member trainers when appropriate.

Training is offered to BHRS and organizational provider staff to enhance knowledge and skills, especially in the areas of recovery and resilience.

The following trainings were supported by MHSA/WE&T funding in FY2011-2012:

a) California Brief Multicultural Training (CBMCS)
b) Can we Talk? Working with Consumer and Family Member Staff in Behavioral Health training
c) Community Capacity Building training
d) Results-Based Accountability training
e) NAMI- Provider Education course

Program Highlights

For fiscal year 2011-12, the Workforce Development Council revised the focus of the WE&T training plan to include seven trainings that would support a strategic effort to support behavioral health and well being of staff, partners, and the people served. The training plan included the following classes: 1) Community Capacity Building, 2) Results Based Accountability, 3) Fiscal Sustainability, 4) Leadership Development, 5) Effective Strategies for Integration of Staff with Lived Experience into Mental Health, 6) NAMI-Provider Education Course and 7) California Brief Multicultural Training Course.

A highlight was a 6-session training effort facilitated by Luminescence Consulting, each BHRS Coordinator and Manager received a binder titled: Help Along the Way, A Guide to Support the Transformation of BHRS at the end of the sessions. This binder contained training material for the Four Transformation Commitments, including Results, Community capacity-building, Fiscal Sustainability and Leadership Development.

Another highlight was the development of the training course title: Can We Talk? Working with Consumers and Family Members in Behavioral Health. This course created a further dialogue among staff regarding the workplace environment for staff with lived experience and the importance of reducing stigma and improving understanding. In addition, NAMI offered three (3) provider education courses. There were a total of 44 staff who attended including BHRS and partner agency staff.

The Workforce Development Council and the BHRS Training Committee also met on June 20, 2012, to report on progress from the last fiscal year and to review the BHRS annual training plan recommendations for the upcoming fiscal year 2012-2013.

Challenges

A challenge has been the low attendance at training generally due to a variety of factors including furlough days, budget concerns, program reductions, and the implementation of the new electronic health record.

Program Results Shown in RBA Framework	
• 12 trainings provided in FY11-12 • 270 BHRS and contractor staff attended	**How Much?**
• 123/148; 83% of participants completed evaluations of training • 90% of participants reported improved understanding of the subject • 86% of participants reported improved skills • 84% of participants agreed training content included family/consumer perspectives	**How Well?**
Comments from participants at trainings: • RBA - Participant comment: "I liked the simplicity of a common language. Asking people if they are better off and asking how we treated them and if we helped them with their problem." • Can we talk? - Participant comment: "Training provided an opportunity to dialogue as to what all of us can do to assist in creating a work environment that is open and accepting and thank you for the new concepts."	**Is Anyone Better Off?**
How Lives Are Changing	
G, a participant of the NAMI provider education course reported that the experience "…significantly changed my view on mental illness in the family." G felt that the information was very helpful at many levels in G's personal and professional life as a mental health provider. G stated that this course inspired him/her to further his/her training in mental health. In addition, G has been impressed that the trainers are individuals with lived experience themselves. G stated, "I believe it takes a lot of strength to overcome a mental illness and to teach others about mental illness…" G felt so strongly about the course that he/she plans to recommend this course to other colleagues in the mental health field.	

WE&T - Consumer Family Member Training & Support

Operated by Human Resources and Training Division of Behavioral Health and Recovery Services in partnership with community-based organizations and Modesto Junior College

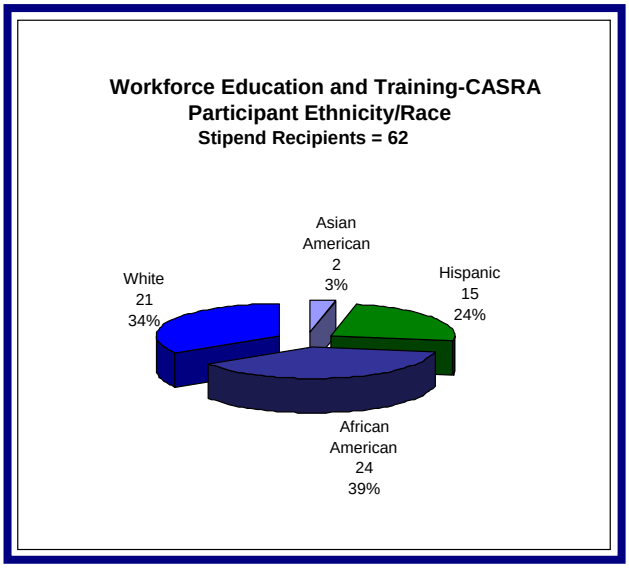
The initial community planning process and workforce needs assessment identified gaps and barriers in the employment of consumers and family members. Initially, the WE&T component was developed to prepare consumer and family members in the basics of becoming employed in the public mental health system. Subsequently, it has evolved to include a priority to impact the work environment to be welcoming and incorporate the perspective of lived experience. One specific effect was the "Can We Talk? Working with Consumers and Family Members in Behavioral Health" and the CASRA program.

The training is entitled "Can we talk? Working with Consumers and Family Members in Behavioral Health" supports inclusion of diverse perspectives and the need for consumer and family members to contribute their perspective in the workforce. This is an effort to reduce stigma of mental illness in the workplace.

The California Association of Social Rehabilitation Agency (CASRA) program partnership with Modesto Junior College (MJC) provides a structure to integrate academic learning to real life field experience in the adult public mental health system. Before this partnership, MJC did not have a mental health curriculum in their program. The initiative taken by BHRS to purchase the CASRA curriculum signifies the efforts to fill the gaps for employment of consumers and family members in public mental health. This is a nine (9) unit certificated course program at MJC that provides individuals with the knowledge and skills to apply goals, values, and principles of Recovery oriented practices to effectively serve consumer and family members. The certificated units also count towards the Associate of Arts Degree in Human Services.

The CASRA program includes student stipends to assist with school fees, bus and parking passes, and school supply vouchers, as needed. We also have a textbook loan program. In addition, CASRA students receive ongoing peer support and academic assistance to maximize their opportunity for success.

Demographics



Highlights

All CASRA stipend recipients are either consumer/family members or from a diverse/underserved community. In this fiscal year, there were a total of sixty two (62) student recipients of CASRA stipends. There were three (3) CASRA certificated students who completed a minimum of two thousand, five hundred (2500) field experience hours to meet the requirements for the CASRA national certification examination. One of the three students was hired by BHRS in FY11-12.

The staff training, "Can we talk?" Working with Consumers and Family members in Behavioral Health" is intended to reduce stigma of mental illness and includes consumer and family members' perceptive in the workforce. This training is very was well received. Twenty-five (25) participated in the training, four (4) were from BHRS administration.

Challenges

Although CASRA is a very successful program, the recruitment of Asian/Southeast Asian American into the behavioral health field continues to be a challenge. Another challenge was the amount of assistance needed to help coordinate the CASRA students finding a placement that matched their interest.

Program Results Shown in RBA Framework	
• 62 CASRA students received education stipends in FY11-12 • 9 CASRA students were placed in field placement with BHRS • CASRA students, HR Director and WE&T Manager participated in a total of 7 events to promote WE&T: Day of Hope, Mental Health Promotion Campaign, Cultural Diversity Celebration, MJC Career Fair, MJC Psychology Club, Turlock Benefit Fair, and CASRA Orientation. • 1 training was held for staff about stigma on mental illness to reduce stigma in the workforce	**How Much?**
• 100% of CASRA stipend recipients have lived experience as consumers or are from diverse cultural backgrounds • 100% of CASRA students completed field placement • The "Can we talk? Working with Consumers and Family Members in Behavioral Health" training included perspectives shared by consumer and family members staff • 25 staff with 4 from administration participated in the training	**How Well?**
• 3 CASRA students completed the academic requirements and a minimum of 2,500 hours and are eligible for National CASRA certification • 2 CASRA volunteers were hired in the public mental health system; 1 by BHRS and 1 by a partner agency	**Is Anyone Better Off?**

How Lives Are Changing

M, a CASRA student reported the involvement with CASRA was both very healing, emotionally and physically. M credited the participation with CASRA for being the calm and supportive factor that helped with stabilizing M's well being. M stated, "When I am depressed and overwhelmed, this is the place I can come to just forget about everything else and find some peace." M expressed the appreciation of how wonderful it is to be able to use what others may identify as a disability as a strength to help make a difference in others life. M added, "I will continue to do what I am best at, until I no longer want to do it anymore".

WE&T - Expanded Internship and Supervision Program

Operated by Human Resources and Training Division of Behavioral Health and Recovery Services in collaboration with Sierra Vista Child and Family Services; Center for Human Services; Telecare; AspiraNet; Modesto Junior College, CSU, Stanislaus; and CSU, Fresno

The community planning process initially identified challenges regarding 1) the identification of internships and 2) staff to provide clinical supervision. Participating in an internship is important at all levels of the educational experience (high school, community college, baccalaureate and graduate levels). The barriers related to adequate staffing for internship programs were similarly identified as the barriers to providing clinical supervision for professional development of pre-licensed staff.

In FY11-12, objectives of this action to expand internships and provide supervision were met through partnership with community organizations and academic institutions in the following ways:

- MSW/MA student internships in public mental health
- MJC CASRA/Human Services student internship in public mental health
- Undergraduate nursing and LVN students from MJC and CSU, Stanislaus practicum placement in public mental health
- Provided two supervision workshops for staff that provide clinical supervision for MSW associates and MFT interns.
- Contracts with non-profit agencies (Sierra Vista Child and Family Services, Center for Human Services, Telecare, and AspiraNet) to provide clinical supervision to pre- and post-licensed staff in their clinical settings

Highlights

Through our efforts as part of WE&T, sixteen (16) master's level students were placed from either the CSUS Social Work or Psychology program, in a BHRS service site for clinical internship. All sixteen students completed their internship hours. In addition, two (2) clinical supervision workshops were provided to 24 licensed clinical staff to develop additional capacity for offering clinical supervision within the licensed individual's agency.

Challenges

The hope to attract nurse practitioners working towards their psychiatric certification to complete their preceptorship with BHRS was a challenge. Perhaps, the commute distance for these students traveling from Fresno to Stanislaus was a factor. Also, many nurse practitioners are already working in the field and it may not be feasible for them to commute to another county for their preceptorship.

Program Results Shown in RBA Framework	
• 16 master's level MS/MSW students were placed in internships for clinical supervision. This was an increase of 2 students from the prior year. • 2 Clinical Supervisor Workshops were provided to 24 clinical supervisors. • 4 non-profit agencies contracted to provide clinical supervision for pre-licensed individuals at Sierra Vista, Center for Human Services, Telecare, and AspiraNet. • 1 CSU, Fresno nurse practitioner continued her Preceptorship with BHRS	**How Much?**
• 160% of the goal to place 10 master's level MS/MSW internship students was achieved when 6 additional students were placed • 372 hours of clinical supervision claimed by contracted agencies for pre and post licensed supervision	**How Well?**
• 100% of MS/MSW internship students completed their internship hours. • Comments from the Clinical Supervision Training: " Excellent, informative, important topic" "Course was positive, informative and inspiring" " I would love if there was a consultation group for supervisors similar to this training"	**Is Anyone Better Off?**
How Lives Are Changing	
C was a Master of Science student completing his/her internship at BHRS. C was in the dual Behavioral Analysis and Marriage and Family Therapy track. Before C's internship and supervision with BHRS, C felt strongly the Behavioral Analysis track was more for him/her. C's experience with BHRS was so impactful, C decided that clinical practice is more what he/she wanted to pursue. C was recently hired by BHRS.	

WE&T - Outreach and Career Academies

Operated in Human Resources and Training Division
of Behavioral Health and Recovery Services and on contract to
Davis High School Health Academy and Westside King Kennedy Neighborhood Collaborative

The Outreach and Career Academies was established during the initial community planning for WE&T in response to the strong input for the need to acquaint students early and reach diverse populations/community with career paths into public mental health. Two approaches continued to be implemented in FY11-12:

Davis High School Health Academy

Davis High School Health Careers Academy is a four year college preparatory academic program that offers vocational experiences for careers in health care. The partnership between BHRS and the Health Academy provides students an early exposure to career paths in public mental health. This includes an opportunity to volunteer/field placement at a BHRS site. WE&T offers six (6) scholarships for Health Academy students in their junior/senior year who are interested in pursuing a degree in psychology or behavioral health.

Westside King Kennedy Neighborhood Collaborative Wellness Project

The Westside King Kennedy Neighborhood Collaborative (WMKKNC) Wellness Project provides junior high students with an introduction to the experiences of mental health careers through interactive involvement. Mark Twain Junior High School continued their participation in the Wellness Project. Five (5) junior high students participated in skits, scenarios, and discussions on issues that impact their mental health such as how to handle stress at school and home, self-esteem, how mental health impacts physical health and vice verse, cyber bullying, and mental health issues in teen and pre-teens.

Highlights

WE&T was involved for the first time as a participant of the Stanislaus Regional Health Advisory Committee. This committee plans and provides input to the local high school Regional Occupational Profession (ROP) program. This could be a potential opportunity to reach more students with introducing careers in public mental health.

Josie's Place (MHSA-funded drop-in center for transition aged young adults) was a selected mental health practicum site for Davis High Health Academy students for a second year. The practicum session included an experiential stigma reduction activity "Labels are for Jars". Students stated that this was an eye opener about how their perception of mental health can be harmful and inaccurate. A panel of young adults shared their lived experience as consumers of behavioral health services as a way to provide information and inspire hope for recovery.

The Mark Twain Junior High students were both passionate and vigorous in learning what is entailed in seeking a career in mental health. They were involved in numerous outreach efforts with other junior high students and in the community regarding mental health. They actively participated at the annual mental health recovery celebration called "The Day of Hope", where they gave information about mental health to family, students, and their peers at the event. The learning experiences for the

students were to reduce stigma about mental health, celebrate recovery/wellness, and be exposed to a career in mental health.

These students also participated in the Mental Health Promotion Campaign kickoff "StanUP for Wellness". They were proud to discuss with people at the event about the myth of mental illness and gave information that would help people make sound decisions about getting help. The students participated in the Health Academy practicum rotation at Josie's Place.

Challenges

The mental health scholarship offered to the Davis High Health Academy students has not generated the expected interest. The Health Academy students tend to have their sights set on a physical health profession like Nursing when they near graduation.

Program Results Shown in RBA Framework	
• 1 BHRS program hosted 10 Health Academy students in their health practicum site rotation with 5 Mark Twain Junior High students • 6 scholarships offered @ $500 each for senior Health Academy students pursuing a career in mental/behavioral health • 5 junior high school youth volunteered at the "Day of Hope" celebration and Mental Health Promotion Campaign kickoff "Stan Up for Wellness".	**How Much?**
• 6 TAYA shared their lived experience during the Health Academy mental health practicum rotation • 1 Mental Health Clinician provided info on typical task for a mental health clinician to provide insight to a career in mental health • 100% of five (5) junior high school youth are from diverse/underserved community	**How Well?**
• The new Academy Director stated that hearing the panel share their stories gave him hope about recovery and he plans to refer future young adults that may need mental health services to Josie's Place	**Is Anyone Better Off?**
How Lives Are Changing	
L, a junior high school youth with the Wellness Project shared how much he/she enjoyed doing outreach and providing information about mental health at the "Day of Hope" and "Mental Health Promotion Campaign". L stated he/she enjoyed making connections to other individuals through these activities and had fun doing this with his/her peers. During L's participation with the Health Academy rotation at Josie's Place, he/she declared interest in a career in mental health.	

WE&T - Consumer and Family Volunteerism

Operated by Human Resources and Training Division of Behavioral Health and Recovery Services

This program specifically addresses the needs of consumers, family members, and diverse community members who wish to volunteer in the public mental health. The emphasis of MHSA value within volunteerism expands the perspective of consumer and family members in the mental health workforce. It also provides consumer and family members an opportunity to get back and give back to the workforce as part of their recovery. Efforts to creatively maintain a program that recruits, trains, and supports volunteers of all ages will be ongoing.

Volunteer opportunities continued for California Association of Social Rehabilitation Agencies (CASRA) students from Modesto Junior College, referred to as "field placements." The placements were located in BHRS programs as well as community-based organizations. To support students' success, WE&T has volunteers who work under the direct supervision of the WE&T Manager. The volunteers offer a focus to students on how they can be organized to succeed in their studies and how being an effective student is preparation for future employment as well as practical hands-on support with enrollment and registration processes. These efforts can be critical for consumers and family members who are re-entry or first time college students. The volunteers distribute an orientation/welcome packet for new students, organize distribution of the WE&T loan program information, and maintain weekly drop-in hours in the WE&T volunteer office.

Highlights

A Volunteer Liaison was contracted to ensure processes and procedures for BHRS volunteer program will be consistent for individuals who wish to volunteer at BHRS. The newly incorporated volunteer protocols opened new opportunities to volunteers such as volunteering for one-time special events. This allowed individuals interested in a day event or a special event with BHRS to volunteer with no long-term obligations. The process was much simpler with a quicker turn around to volunteers.

BHRS volunteer program continued to progress with sixty (60) volunteers during this FY11-12. Nine (9) volunteers placed in BHRS sites are CASRA students. Two exceptional CASRA graduates volunteered with WE&T to provide mentorship and support to CASRA students. They assisted with outreach to culturally diverse ethnic communities, CASRA orientation, community events, classroom presentation, and ensuring CASRA student success. They are putting their knowledge from the classroom into practice and role model the achievability of academic success even for consumer and family members.

Challenges

The adjustment from United Way to BHRS was still a challenge in 11/12. Many programs that were familiar with the way volunteerism was administered by United Way had to adjust to the changes. Programs were asked to be involved in the creation of their volunteer position(s) with writing the volunteer job descriptions and the specific requirements. The learning aspect of a new and developing process for volunteering was both challenging to volunteers and programs.

Program Results Shown in RBA Framework	
• 60 volunteers in FY11-12 • 11,331 total volunteer hours accumulated in FY11-12 • 15 total programs and agency partners participated in the volunteer survey	**How Much?**
• Total dollar value to department at $21.79 an hour equals $246,897.04 • 10 BHRS sites participated in using volunteers • 13/15 programs or agencies participated in the survey were either currently using volunteers or have used volunteers in the past	**How Well?**
• Staff from Stanislaus Recovery Center stated, "We really couldn't survive without the volunteers." • Staff from Josie's Drop in Center reported, "Without the volunteers, I think this place would be so dull. We are so grateful for them. Without them, I don't think we would be able to accomplish what we have." • Volunteer reported, "I enjoy what I do. I believe it's my calling…I feel very appreciated here. Every time I pass this place I feel bubbly in my stomach and I really love to be here." • Volunteer stated, "I love volunteering here. One of my favorite things is that I'm not just here to support the members, but they also support me."	**Is Anyone Better Off?**

How Lives Are Changing

J, a volunteer stated, "I first started volunteering because my education required me to have a certain hours of field experience to complete the requirement for getting my degree". Although J has completed the requirements and received a degree over a year ago, J has continued to volunteer for BHRS. J stated the reason for this was, "I love helping people to live the best possible life they can". J felt volunteering also helped J to realize the gifts that J had to offer such as, "My commitment to being dependable, resilient, and being deeply passionate in what I do". J stated that these gifts can be given in simple ways that help individuals in contact know "…I won't give up on them. I will go above and beyond to help them and assist them in helping themselves, encourage them to utilize their coping skills in everyday life, and to get them reliable resources."

J reflected on the experience, "I feel so blessed… the experience hasn't been one sided." J added, "…I have learned many valuable lessons…how to work on a team, how to collaborate with others in our community, and how to get things done." J stated, "I have formed relationships with peers and co-workers and have learned they have gifts to share as well." J expressed appreciation of the opportunity to volunteer and being able to make a difference in others life.

WE&T - Targeted Financial Incentives to Increase Workforce Diversity

Operated by Human Resources and Training Division of Behavioral Health and Recovery Service

The MHSA Representative Stakeholder Steering Committee recommended, as a top priority, that financial incentives be linked with an ongoing assessment of 'hard to fill or retain' positions by language, cultural requirements, consumer and/or family member lived experience, special skills or classifications.

This program provides financial incentives through educational stipends to students in master's level Social Work and Psychology program. In addition, offers financial stipends for BHRS and organizational provider staff working on a Baccalaureate degree in Psychology. The stipends and scholarships are provided for potential recruits who meet established criteria based on the assessment of 'hard to fill or retain' positions.

The MS and MSW stipends continued in this fiscal year through our existing contract with CSU, Stanislaus. BHRS awarded six (6) stipends this year and five (5) of the six (6) recipients met desirable classifications for hard to fill positions identified in the WE&T plan workforce needs assessment.

BHRS assisted in submission of 22 loan repayment applications to the Statewide Loan Repayment Program. Ten (10) were awarded in Stanislaus.

Highlights

Through the MSW and MS stipends and clinical supervision afforded by this WE&T program, five (5) individuals successfully gained employment as mental health clinicians. Job placement of these graduates into the mental health workforce validates not only individuals mastery of skills but also the intent of this effort and other WE&T programs.

Significant progress in the development of guidelines for Baccalaureate Degrees stipends was made in FY11-12.

Challenges

The downturn in the economy continues to be a challenge in this key area of workforce development. There were not many new job opportunities in the mental health workforce in FY11-12. However, there is a large pool of job applicants for clinician positions. As a result, the Workforce Development Council recommended a reduction in stipends for master's level students.

Program Results Shown in RBA Framework	
• Awarded 6 stipends: 3 MSW and 3 MS stipends, each to graduate students at CSU, Stanislaus • Stipend awards equal a total of $64,750.	**How Much?**
• 100% of field placement students did an outstanding job and were successful in completing their field placement. • 90% of stipend recipients are from diverse populations: 1 bilingual Spanish, 1 African American, 1 bilingual Arab-Muslim, and 2 with lived experience as consumer or family members	**How Well?**
• 5 MSW/MS stipend recipients were hired as full-time mental health clinicians at the following agencies: Center for Human Services, Sierra Vista, and AspiraNet.	**Is Anyone Better Off?**

How Lives Are Changing

M, a Master's of Social Work (MSW) stipend recipient reported that the mental health stipend was a determining factor for his/her pursuing a career in Public Mental Health. M stated that he/she was unsure of the direction he/she was heading even though M was in his/her master's program. M felt the outlook of getting a job was bleak as no one was hiring. The stipend helped M decide on the career path he/she would eventually take in the MSW program.

Without knowing what the future was going to be, M put his/her trusts in the stipend and believed the payback would be worth his/her time. This hope became true when M was quickly hired by a non-profit public mental health agency within three months of receiving M's MSW degree. M stated having the stipend was the difference to him/her choosing the career path to public mental health.

Prevention Early Intervention (PEI)

PEI was the third component of MHSA to be approved and funded in FY09-10. Extensive community planning that was built on lessons learned from earlier processes involved over 500 people, many of whom had not previously participated in MHSA stakeholder processes. This initial stakeholder process continues to provide a broad community network of partners that work to implement and strengthen the capacity of our community to address behavioral health issues early, promote well being, and truly develop a "help first" system.

The presence of prevention and early intervention as a separate component of the Mental Health Service Act represents the biggest change in mental health planning and funding that had occurred in twenty years. Some PEI services may not look like conventional mental health services due to their focus on improving well being and the reliance on informal networks of support rather than addressing directly unmet need for treatment of mental illness. Inclusion of PEI in the MHSA is grounded in the belief that prevention and early intervention has the greatest potential to reduce service costs including long-term mental health treatment, special education, welfare supports, and criminal justice costs, as well as decrease the disparities in accessing services for unserved and underserved populations.

PEI approaches are transformational in the way they influence restructuring of the mental health system to embrace a "help-first" orientation. It works by strengthening the capacity of the broader community to address a core set of risk factors that target initial onset of mental health problems by strengthening and improving conditions of well being and protective factors. Potential multiple negative outcomes can be dramatically reduced for all age groups. To further distinguish the intent of PEI programs, the goal is to engage persons prior to the development of serious mental illness or serious emotional disturbances or in the case of early intervention, to alleviate the need for additional mental health treatment or years of extended treatment.

Stanislaus County has eight PEI projects that include 18 programs; many of the programs have more than one contracted agency to implement the program in communities around the county. Each type of program has a unique approach that incorporates community-based interactions with service recipients that strive to include MHSA values of cultural competency, community collaboration, wellness, recovery/resiliency, client/family driven services, and an integrated experience of the service.

Three years of implementation activities has produced many good individual, community and system outcomes some of which will be described later in this report. BHRS and agency partners implementing PEI programs now have a deeper understanding of the real and potential impacts of prevention programs and extensive knowledge about what is effective for this type of service. As a result, three key program changes are begin made

Arts Resiliency & Social Connectedness, an adult-focused prevention program, is proposed for elimination in FY13/14. In 2010, BHRS sought potential contractors to implement this program by releasing a Request for Proposal (RFP). At the end of the process - no proposals were received. This was an unexpected result and input was sought from local agency partners and community arts organizations in deciding next steps. A large number of PEI programs were in early stages of implementation in 2010 and considering community input to wait and do some outreach/education, the RFP was not immediately re-released. Subsequent efforts produced no additional interest to justify release of an additional RFP in FY11-12. Additionally, in November 2011, an innovation project

intended to contribute to learning in the area of peer support through artistic expression was selected for funding. As a result, the decision was made to eliminate the PEI project and redirect the funds to other PEI programs in the Adult Resiliency and Social Connectedness Project.

Aggression Replacement Training (ART) a youth focused early intervention program is proposed for restructuring to offer a broader range of group and individual early intervention services for the target population. With the ART group model's rigid structure and staffing requirements of two facilitators, the program faced the challenge of scheduling groups to maximize staff time and resources and reach the maximum number of youth. In addition to the evidenced-based ART group model, BHRS can provide effective group services for this population based on "best practices." School and community partners have offered feedback that a broader range of groups and individual supports that focus on overall behavioral health issues would benefit and provide additional support for youth at risk for juvenile justice involvement. To effectively promote these services, BHRS will change the name of the program from "ART" to a name that accurately reflects the broader range of groups and individual services. These additional groups could be facilitated without an additional cost of a co-facilitator and offer services to a broader group of individuals within the target population. As with all PEI programs, these behavioral health groups will develop a set of performance measures to show overall impact of the intervention.

Faith/Spirituality-Based Resiliency and Social Connectedness, an adult focused prevention program is targeted for process improvement and restructuring in FY13-14. BHRS implemented the program initially without the benefit of experience or knowledge of how specialized staff knowledge would need to be for effective mobilization of diverse faith and spiritual community leaders on behavioral health issues. Originally proposed as a program with one part-time staff focusing on peer support, the first three years of implementation has revealed that the program needs a different approach to project management and administrative support that includes more time and expertise in "hands-on" administrative experience. Despite considerable enthusiasm and effort that produced some progress and successes, many of the collaborative partnerships relied on spiritual leaders and community members, who have little or no administrative support to act on strategic plans and decisions, as a result many of the groups' decisions and plans failed to materialize or produce results. With input from participating community members a decision was made to stop program activities, reevaluate administrative support needs, clarify resources available, develop a new approach and re-start in FY13-14. It is currently proposed to engage the services of a Project Manager with significant administrative experience and ability to work independently to support faith and spirituality leaders across the County in implementing various community-based strategies and projects that increase behavioral health support for their community members. As with all PEI programs, these behavioral health groups will develop a set of performance measures the show overall impact of the intervention.

Prevention Early Intervention Statewide Training, Technical Assistance and Capacity Building funds are used to assist Prevention & Early Intervention program staff and community partners to obtain technical assistance from one or more qualified contractors that have the ability to provide statewide training, as well as partnering with local community partners. These funds are included in overall PEI budget and applied to individual program budgets as training needs and opportunities are identified.

Overall PEI Highlights and Challenges

- In 2012, BHRS invested in an Outcomes Manager to assess and develop a more robust administrative and technical system to support Results Based Accountability (RBA) implementation throughout all programs. As the department implemented RBA within this new PEI system, we realized that we lacked the support structures, both administrative and technical, to advance the learning of PEI services and to produce timely reports on program performance measures. In 2013/2014, BHRS has acquired the services of an Outcomes

Support Specialist Personal Service Contract. BHRS leadership is in the process of assessing the ongoing need and fiscal sustainability of continuing additional support to PEI program performance measurement data collection and reporting.

- PEI constitutes an entirely new part of the behavioral health system, the size and depth of which has never existed in behavioral health agencies in California. The overall intent of MHSA and PEI specifically is to reduce the negative consequences of mental illness. As a good steward of this opportunity, BHRS seeks to fulfill on the intent of PEI and in doing so, we continue to seek efficient and effective ways to invest in training and development of BHRS staff and community partners who are implementing PEI programs. In Stanislaus County, most PEI programs are contracted to nonprofit and community-based organizations and therefore not centralized within BHRS. This presents the additional challenge of accurately assessing staff development needs and implementing training to address the needs. Moreover, BHRS and most of the new prevention implementers have established strengths in providing treatment and are relatively new to prevention concepts and practices. PEI services and strategies are fundamentally different than treatment services. Many PEI strategies involve actions beyond clinical settings such as community capacity building to address stigma and promote well being, resiliency-based approaches to increase protective factors and reduce risk factors with older adult and youth populations, broad school-wide behavioral health interventions that not only target youth but staff as well, and a variety of education and outreach strategies. BHRS has identified, and will pursue in FY13-14, addressing the need to invest in training in the concepts and practices of PEI for all PEI program staff.
- Community capacity-building strategies continue to generate new and creative ways for communities to address mental health and mental illness stigma at the neighborhood and community level. BHRS has enjoyed partnerships with a broad and diverse group of community leaders and residents in developing new and innovative approaches and strategies to improve well being. In 2012/2013, the department released request for proposals for community well being projects in West Modesto, Grayson, Southeast Stanislaus County, and South Modesto. Nine community groups successfully submitted proposals and were funded to implement community-based mental health and well being projects in their respective communities.

PEI Component Budget & Expenditures	
FY11/12 Total Requested MHSA Funds	**FY11/12 MHSA Funds Expended**
$5,701,178	**$3,564,748***

*Unexpended funds in the FY are due to operating reserve, salary savings, and delays in program implementation.

PEI – Community Capacity Building Initiative (CCBI)

This CCBI project responds to stakeholder input from underserved cultural populations to invest in their communities and increase overall capacity to address existing needs and disparities in mental health care and well-being focused projects. CCBI supports strategies to increase targeted communities' behavioral health capacity in the areas of (1) leadership development, (2) organizational capacity, and (3) community capacity by utilizing Asset-Based Community Development strategies and approaches. CCBI also supports the Promotores/Community Health Worker model by training and employing community behavioral health workers from targeted communities to address mental health system disparities by acting as liaisons between their communities and BHRS, and equally important to lead well being focused community projects.

Asset-Based Community Development (ABCD) works from the principle that every single person has capacities, abilities and gifts, and that the quality of an individual life depends in part on the extent to which these capacities are used, abilities expressed and gifts given. Recognizing the assets of individuals and communities is more likely to inspire positive action for change from within than an exclusive focus on needs and problems. ABCD focuses on what is present in a community rather than what is absent, requires a fresh look at marginalized communities and sees opportunities rather than problems. Asset-Based Community Development's primary goals include increasing behavioral health capacity at three levels: (1) Individual and Leadership Development, (2) Organizational Development, and (3) Communities. This program was made available to underserved communities and community leaders throughout Stanislaus County but will include two specific initiatives that promote, support, and further develop Asset-Based Community Development strategies in the Latino and faith-based communities. Utilizing ABCD strategies, BHRS will convene leaders and stakeholders within these respective communities to identify best practice approaches to increase behavioral health capacity and to promote emotional health and wellness in their respective communities. The collaborative's work and mission will come forth from an inclusive process that reaches non-traditional partners to provide support and leadership to local behavioral health Asset-Based Community Development efforts. This project integrates organizationally and programmatically with strategies being implemented as part of the Stanislaus County Alcohol and Drug Abuse Prevention Plan to insure an overall behavioral health approach.

Promotores and Community Health Workers (P/CHW) play a critical role in developing opportunities for community members to gather, belong, and exercise their leadership capacity to improve their personal well-being as well as the well-being of their community. Promotores/CHW plan and support community-led interventions that sustain their well-being, reduce "mental illness" stigma, and connect isolated individuals to a community of support. Their function is crucial within diverse, primarily Latino communities in Stanislaus County, communities that are traditionally underserved/unserved within the mental health systems. Since P/CHWs are from the communities they serve, they have a self-interest in the results of the community well-being projects. This differs from a traditional mental health services provider approach. P/CHWs use their natural connections in their communities to educate the community on behavioral health and well-being and connect community residents with each other in ways that inspire them to act on their own behalf to improve their well-being. P/CHWs are agents of change focused on creating communities of support in their neighborhoods that promote wellness.

The Community Outreach and Engagement (O&E) program was established in recognition of the special activities needed to reach diverse underserved communities that have high needs and are disproportionately unserved by traditional types of mental health services. This program's strategy is based on outreach by two racial ethnic community based organizations that provide education, depression screening, transportation services, and resource linkages for individuals and families that are reluctant to enter traditional agency services.

Each community-based organization seeks to reduce stigma and support access to more intensive service when needed. Services are culturally competent, client- and family-focused and promote recovery and resilience while maintaining respect for the beliefs and cultural practices of the individuals served. Emphasis is placed on diverse communities including, but not limited to Hispanic, African American, Southeast Asian, Native American, and Lesbian, Gay, Bisexual, and Transgender (LGBT) throughout the county.

- West Modesto King Kennedy Neighborhood Collaborative has focused on increasing outreach into neighborhood based supports that honor cultural practices by hiring individuals from the neighborhood. Several important objectives define the approach: 1) continue the community-based strategy for mental health outreach and engagement in West Modesto; 2) provide mental health depression screenings; 3) provide mental health referrals for West Modesto residents needing specialty services; 4) provide group peer support sessions for depression and substance abuse; 5) provide transportation services to residents in support of their mental health service needs; 6) continue operation of the mental health drop-in center in West Modesto; and 7) continue to increase awareness and engage youth in the neighborhood regarding mental health issues and career opportunities in mental health.
- El Concilio: Latino Behavioral Health has focused on outreach to promote and educate the community on mental health and substance abuse recovery to the underserved/unserved populations in the outer geographical areas of Stanislaus County. As a founding member of the Central Valley Promotores Network Vision y Compromiso, El Concilio continues to work closely with Promotores to educate and outreach to Latino communities about health and behavioral health in a way that honors their culture and way of life.

Highlights

Asset-Based Community Development:

- Released Request for Proposals and funded nine community behavioral health ABCD projects in West Modesto, South East Stanislaus, South Modesto, and Grayson/Wesley.
- In partnership with Modesto City Schools, Modesto Police, Stanislaus County Sheriff, and the District Attorney's Office, ABCD supported the further development of a community collaborative in South Modesto (gang injunction area). The 2011/2012 ABCD projects include strengthening relationships with elected leaders, hosting a 5K run in gang injunction area, recruiting new members, neighborhood cleanups, community-led well-being events, training, and data collection and reporting.
- Supported the further development of the Grayson Community Group, a collaborative of residents focused on improving well-being in their community primarily by increasing the number of individuals who know each other within the neighborhood. 2011/2012 ABCD projects include the development of the Neighborhood Watch Program, Door-to-Door outreach campaign, National Night Out Events, and a Community Year-End Celebration.
- Additionally, BHRS convened leaders from the Asian American Community to discuss their interest in increasing well-being in their community. BHRS initiated a community collaborative that ultimately developed into the Stanislaus Asian American Community Resource grassroots effort focused on improving well-being for the Asian American Pacific Islander (AAPI) in Stanislaus County. This group has engaged in cultural bridging efforts to strengthen relationship across all culture to increase opportunity and well-being for the AAPI including International Festival, Diversity Celebration, Tzi Chi Foundation Buddist Birthday Celebration, Mental Health Promotion Campaign, Presentation to the BHRS Cultural Competency and Oversight Committee, California Reducing Disparity Project Asian Pacific Islander Strategic Workgroup (CDRP API SPW).

Promotores/Community Health Workers:

- After the successful recruitment of individuals within their respective communities, the Promotores/CHW implemented training and project planning throughout all nine targeted communities.
- Projects included the development of peer-led support groups focused on improving well-being, support groups for mental health conditions, community-led training and conferences, community-based supports for individuals receiving mental health early intervention/treatment services, and various community-led projects focused on improving well-being and addressing stigma.
- Additionally, the projects continued to provide innovative ways to engage the Latino community in the area of behavioral health and emotional well-being.

West Modesto King Kennedy Neighborhood Collaborative (WMKKNC):

- The Drop-In-Center peer support sessions evolved during 2011-2012. Originally, the sessions were fixed 6-week group sessions with a specific beginning and end to each group. At the request of group members, the sessions shifted to an "open-entry/open-exit" framework, allowing individuals to enter and leave when they wanted. The effect of this change was to make the support session environment much deeper and more transformative for individuals needing to significantly change their lives.
- Another change this year was a substantial shift in focus to outcomes. WMKKNC developed new methods for tracking referrals and completion of referrals. Additionally, has been an ongoing process to fully automate the WMKKNC data collection and analysis.
- WMKKNC made presentations at Parolee Orientations during 2011-2012. Parolee Orientation is an event that is held about every two weeks for newly released parolees (formerly incarcerated inmates). Initially, WMKKNC was invited to make one presentation and this followed up with occasional invitations. Beginning in September 2011 WMKKNC has been included in every parolee orientation event.
- WMKKNC also expanded collaborative work with the faith-based community. In the past WMKKNC worked collaboratively with a group of local ministers but without any financial support. This year WMKKNC applied for BHRS community capacity building grants, and were awarded two grants which began in fall 2012.

El Concilio: Latino Behavioral Health & Recovery Services (LBHRS)

- Due to outreach work, an interview with Univision, and presentations at the Modesto Library on depression, parenting, and bullying targeting the Latino community, there was a high volume of calls from consumers requesting help or wanting more information.
- The partnership with Modesto Library has caused a significant increase in request for therapy. As a result, Modesto Library requested El Concilio/LBHRS to start a new support group at their site.
- A women's support group was formed. This group of women (average age is 40 yrs) needed support on various mental health topics; depression, family, and parenting. The women have gained confidence and high self-esteem after attending numerous support group sessions. They have expressed that the psycho-education provided by LBHRS has been very helpful in their lives, both as individuals and professionals.

Challenges

ABCD:

- With limited experience in issuing RFPs for broad community-based behavioral health projects and an emphasis on due diligence to ensure effective use of funds, BHRS extended the release date of the initial RFPs beyond the initial expected release date. As a result, nine projects were selected to be funded by the end of FY11-12.

- Additionally, ABCD implementation within the BHRS is an innovative approach to addressing community behavioral health, and BHRS continues to work with community partners and residents to develop and redefine performance measures to show impact and overall benefit of the project.

Promotores:

- Engaging communities and community-based organizations in the development of community led projects and initiatives that are focused on improving well-being, rather than delivering discrete sets of mental health services, continues to be a challenge. Specifically, when many community service agencies and organizations' infrastructure specifically supports delivery of discrete sets of services, working to develop a broad community initiative focused on leadership development and community action requires rethinking and restructuring of support and infrastructure. Many organizations have intake and assessment requirements for any individual the program engages. The Promotores/CHW does not engage residents as service recipients but as potential leaders and partners in the development of community projects and initiatives focused on improving well-being. This shift in action for many community partners has been challenging, and BHRS continues to engage and reengage to ensure that residents are not only engaged as service recipients but as potential partners.
- The success of these projects has been challenging as well. Specifically, many of the new projects involve additional support groups and trainings, which have increased utilization of space within the partner agencies facilities. At times, there is not enough space or the space is too small, so Promotores/CHW have begun to seek partnerships with organizations that can provide access to larger facilities.

Program Results Shown in RBA Framework	
ABCD: • 858 South Modesto residents engaged in ABCD Projects • 451 South Modesto residents attended community meetings • 35 community meetings were conducted in South Modesto • 6 projects, led by South Modesto residents, were implemented to improve well-being • 261 residents engaged in ABCD projects in Grayson • 26 community meetings were conducted in Grayson **Promotores:** • Approximately 234 Promotores were active in their communities • 232 trainings were provided by Promotores • Over 800 support sessions were provided by Promotores • Over 4,775 individuals participated in Promotores' events throughout the County **West Modesto King Kennedy Neighborhood Collaborative (WMKKNC):** • 10 Neighborhood Outreach Workers (NOW) were identified and trained • 150 individuals were supported by NOW • 681 households were contacted (1,616 duplicated) • 233 individuals screened for depression • 493 individuals attended 155 support group meetings • 51 educational/outreach presentations were given at community events • 3,054 contacts were made at community events • 84 transportation services were delivered	**How Much?**

Program Results Shown in RBA Framework	
El Concilio: Latino Behavioral Health & Recovery Services (LBHRS) • 224 contacts were made through 66 presentations about Promotores/Promotoras model • 23 Promotores were identified and trained • 15 Promotores were active • 237 contacts were made through 53 community events/activities • 103 individuals were supported by Promotores • 412 (duplicated) contacts were made through 8 peer support groups • 191 screenings and/or individual assessments were completed	
ABCD: • 71% (48/68) of South Modesto community and planning meetings were designed & facilitated by South Modesto residents, including meeting topics, questions and next steps • 15 leaders were identified in South Modesto using ABCD principles **Promotores:** • 89% (8/9) of the community lead Promotores reported increased mental health knowledge and Promotora skills • 89% (8/9) of the community lead Promotores trained at least 5 other promotores in their community **West Modesto King Kennedy Neighborhood Collaborative (WMKKNC):** • 123 individuals were referred for 145 mental health services • 100% of participants who received transportation services arrived to mental health appointments on time **El Concilio: Latino Behavioral Health & Recovery Services (LBHRS)** • 33% increase in number of people receiving one-on-one needs assessment • 20 requests were received for support groups from CBO and/or other agencies • 76 referrals were made to El Concilio from CBO and/or other agencies	**How Well?**
ABCD: • South Modesto and Grayson Community Groups defined who they are and their purpose for being • South Modesto community collaborative defined themselves: *We are a group of residents that have come together to focus on building and strengthening relationships as a way to transform the community. By coming together and supporting one another, we believe that we can move towards positive change we all desire.* **Promotores:** • 89% (8/9) of the community lead Promotores reported increased confidence • 89% (8/9) of the community lead Promotores reported increased leadership skills • 103 community projects were led/initiated by Promotores, indicating increased leadership • 35% of local network meetings were planned and co-facilitated by community Promotores, indicating increased leadership	**Is Anyone Better Off?**

Program Results Shown in RBA Framework

West Modesto King Kennedy Neighborhood Collaborative (WMKKNC):

- 59% follow-through by program participants who received referrals for mental health services

El Concilio: Latino Behavioral Health & Recovery Services (LBHRS)

- 100% of the participants increased their well-being during and/or after one-on-one therapy

How Lives Are Changing

El Concilio: Latino Behavioral Health & Recovery Services (LBHRS)

G, a participant in the Hughson support group, complained of intense shoulder pain. G had gone to the doctor's office and had received medication. However, the medication did not alleviate her pain. After regular attendance at the weekly support group G reported that her pain had decreased. G stated that she noticed feeling more relaxed after having the opportunity to share her stressors and concerns with the group at large. G then reported sleeping more comfortably, sleeping more hours, and waking up without pain. In fact, G reported that she had stopped taking the medication prescribed to her and yet her shoulder pain had not returned. G reported feeling overall happier and optimistic and she attributed it to her regular attendance.

Promotores:

These stories are examples of how Promotores are changing lives throughout the county. The stories are in the women's own words.

Ceres:

B, a Promotores shared her experience encountering a new woman participant in their Morning Coffee group for the first time. B stated, "I welcomed the group with a simple ice breaker, let's start with your name and in one word describe how you feel today". B stated," The word fine/(bien) is not allowed, it's too easy to say it….but really think how you are feeling today". When the new participant's turn came B said, "She broke down in tears and said she felt terrible, sad, mad, scared and that all she wanted to do is die..." Although, the other participants gave her a lot of immediate support she was not able to control her feelings. B had one of the other Promotoras take over the group while she gave the lady some time in private. B spoke with the woman for a while and learned she had just found out she had cancer and had not told anyone in her family. B supported her through the emotional state and when she came back to the group she apologized to the group for breaking down. B stated, "All the participants stood up and walked over to give her a hug, one by one, she cried more from being comforted by the group." B referred her to counseling but she did not qualify because she did not have insurance and couldn't pay the sliding fee. B asked her to keep coming back if she felt comfortable. B reported, "she is now attending all the groups she can and is doing much better emotionally and physically and she was able to qualify for emergency medical assistance. She now claims that the Morning Coffee group saved her life".

Newman:

D stated, "When I first became part of the Promotoras, my family was going through a phase of pain and suffering". She added, "Due to unexpected events, I became head of my household". D said, "Dancing with the promotoras made it possible for me to move aside the pain to continue to live, and I became stronger for my children". D got involved in the morning coffee group, and through the conversations she learned that others have it worse then she does. She stated, "When you see that there are harder things in life, you strengthen yourself." She said," I told myself, no more, I can come out of this!" D strongly felt the group has helped her and wish that every person under difficult situations is able to move forward like she has done. She shared, "The strength and the success

stories of other promotoras make me very happy". She said, "Living this has helped me to be strong and not let others take advantage of me, and give back to my community and family". She concluded, "The promotoras cheer me up and make me want to be a leader!"

North Modesto/Salida:
C, a coordinator at the North Modesto/Salida Family Resource Center discussed her experience working with the Promotoras in her region. She shared how impress she felt about the community Promotoras acting with leadership to sustain the activities supported by the former lead Promotoras in the area. She stated that activities continued with the Latina Wings group at Davis High School having two members stepped up to teach English to about 17 members, and the Perkins Elementary Dance Therapy group promoting physical activity and relationships among women. She stated feeling proud to have met the Promotoras and the ways they have acted as leaders to promote their health and well-being.

Oakdale:
An invitation began 10 years ago when T first came through the door for a group session. After the session, she appeared to need to talk to a friend. This was the start of this conversation and she has constantly been back every Friday since. During all these years, she has strengthened herself with the information and love shared in Familias Unidas, and through the trainings she received through the Parent Institute and our center. T has active roles in organizations such as ELAC, DELAC, and PTC. Last year, T organized a Latino Committee called Moms in Action to help improve student academic achievement as a pilot at 1 of 6 Oakdale schools. T has initiated a computer program to support children and parents to improve English proficiency for reclassification. This program has proven to work, as those students participating in the program have increased CELDT annual scores. Now, she will lead this program in all the schools of Oakdale Unified District and train school representatives

Patterson:
L stated that before she participated with the Promotoras she suffered from anxiety and was afraid to talk to other people. She stated once she was invited to join the Promotora Project, "My life has changed completely. I feel like a new woman!" She stated that she's able to recognize her moods when "I'm getting sad or depressed". She stated that this help prompted her be proactive in her emotional health by "… get out of bed, go out to my community and look at the things that my community may need support with". She stated, "I have been with the Patterson Promotora Network for over a year now, and I learn how to control the anxiety, to understand people's reactions, to talk to other women, and to dare to be myself, in front, in the middle, to be okay with myself". She said, "Now, I support the dance therapy, I speak on the microphone, I have my family supporting community events with me". L stated that she helps other women that have a similar experience to hers. She said she tells them, "don't give up, wake-up, get ready, come with us to walk, to talk, to dance, and come with us to help others". She stated that she has grown a lot personally since joining the Promotoras and believe her ongoing work will help her grow even more. She stated, "I see challenges in my community but now, I have a group of friends who are as committed to supporting ourselves and other women in our town and we are engaging other people, clubs, churches, businesses, and organizations to support us to promote mental health, and dance therapy, and to get involved and act together to decrease the needs of Patterson, CA".

Hughson/Waterford/Denair/Empire – Southeast:
C shared the struggles she had with resettling in the USA after fleeing from the uncertainty of her Country of origin. She stated that she didn't have any family here and found herself living in depression and isolation. She gained weight and found it very difficult to enjoy anything at all, including her children. She stated, "My life has changed completely…" since she became involved with the Promotoras. She stated, "I have learned new things, I learned to value myself as a woman,

Program Results Shown in RBA Framework
to go in front of a group, and not to feel alone or fearful". C has made new friends and developed new support in her life. C stated, "Through dancing, I have lost over 20 pounds, I became an instructor and I'm now certified by Zumba". She stated that now she has found what she likes to do. She stated, "…I like to serve my community, have friends, and enjoy exercising. I'm very happy now, I feel proud of the woman I've become, of what I do, and what I have accomplished". **Turlock:** L self disclosed having little patience and tolerance for anything. Although she is very talkative, she has trouble connecting with others. During the Promotoras 101 training, she learned techniques for stress relief and art to support individual well-being. Through this experience, she realized that one of her gifts is creating art. She has gained patience, and has embraced art to cope with stressful situations. The work of art has benefited her with making good choices and has supported her to be present with her family. Now she says, "I have thought of many things to end the suffering, but I came to realized that I want to be alive for me and my children. I discovered that nothing lasts forever, and I will go through this". With renew hope and energy, this promotora is now self employed, very active in supporting other promotoras in community, and carving a better future for her and her family.

PEI - Emotional Wellness Education/Community Support

The Emotional Health/Wellness Awareness and Education Project incorporates universal and selective prevention strategies. Friends Are Good Medicine is a countywide support group public information project that facilitates the expansion and development of social support networks to increase overall access to social support for at-risk individuals and families in each of the priority populations. The StanUp for Wellness campaign focus is on developing unique strategies that address specific culturally underserved populations, and help families, educators, health care providers and young people recognize mental health problems and seek or recommend appropriate services.

Programs

- **The Mental Health Promotion Campaign (MHPC):** The MHPC is a countywide multimedia campaign that helps families, educators, healthcare providers, and young people recognize mental health problems and seek or recommend appropriate services. In January 2011, BHRS and partners initiated the campaign planning process, and implementation has begun. The campaign includes mental health and wellness messages aimed at reducing stigma associated with mental health and mental health issues co-occurring with substance abuse. The goals are to increase the public's awareness of behavioral health concerns and to provide information on how to develop and maintain emotional wellness and resiliency.

- **Friends are Good Medicine Program (FGM):** FGM is designed to be a resource, providing information and support to community self-help groups that sign-up for the Friends are Good Medicine database. This program has the intent to promote community-based self-help efforts in both the general and professional community. This program provides leadership training, consultation and assistance to groups, as well as information sheets on topics of interest to self-helpers.

Highlights

Mental Health Promotion Campaign (MHPC):
In early 2012, BHRS developed the official logo and branding for the mental health promotion campaign: "StanUp for Wellness". The campaign was developed after numerous community stakeholder meetings and input insuring message effectiveness in the MHSA priority populations, as well as the broader community. The campaign was launched with an event at 10th Street Place, which included local community, county, city and social service agency leaders. The event garnered media coverage and resulted in an editorial piece and a news article in the Modesto Bee. With the development of the campaign messaging, the MHPC will now focus on developing effective marketing materials for prevention and early intervention programming as well as promoting well-being concepts broadly within the community. The MHPC has provided consultation to newly developed PEI programs, helping them identify best practice strategies and strengthen their capacity to promote their new programs and services. The MHPC developed a website that will link to various behavioral health supports that include both professional treatment services, as well as community supports. Some of the MHPC accomplishments include:

- Developed StanUp for Wellness logo and branding materials

- Coordinated StanUp for Wellness Launch event for campaign
- Developed StanUp For Wellness Campaign Website
- Developed StanUp for Wellness bus ad campaign promoting website
- Developed Friends Are Good Medicine Resource Guide and marketing materials for the Stanislaus County Fair
- Coordinated Modesto Bee Editorial Meeting and subsequent editorial on well-being
- Consulted with four prevention and early intervention programs on marketing and outreach strategies

Friends Are Good Medicine (FGM):
FGM continues to provide support and services to strengthen the capacity of the self-help and peer support group network in Stanislaus County. FGM continues to maintain the online directory of over 150 self-help/peer support groups focused on supporting the behavioral health of County residents. The support groups are convened by individuals who selflessly give up their time to support others through very difficult life challenges. FGM accesses marketing and support to strengthen the program's capacity to better serve the community. The FGM directory promotes support groups in the following areas and populations: Abuse, Addiction/Recovery, Bereavement, Disabilities, Health, LGBTQ, Life Changes & Transitions, Mental/Emotional Health, Parenting, Senior Support, Veterans, and Youth/Teen Support. FGM developed a printed directory after community stakeholders provided feedback that the online version, although helpful, should not be the primary source of the information. FGM distributed 5,000 booklets to the various groups and agencies in the following areas: nonprofit, social service agencies, law enforcement, education, faith/spirituality, community collaboratives throughout Stanislaus County, and various other organizations and groups. FGM trained over 64 community members interested in further developing their skill as facilitators or starting new peer support groups.

Challenges

Mental Health Promotion Campaign (MHPC):
There have been organizational challenges in implementation of this program's unique set of the strategies and actions. BHRS leaders learned that the internal approval processes and decisions at times take longer than anticipated and sometimes create unwanted delay of time sensitive implementation. To address this issue, BHRS evaluated decision-making responsibility and delegated it to specific individuals in an effort to be more facile in implementation of strategies. This is the first of such broad mental health promotion campaigns ever implemented by BHRS. The multiple challenges and learning that resulted is invaluable for future decisions about the cost effectiveness of marketing strategies.

Friends Are Good Medicine (FGM):
There is a growing community of Latino Spanish-speaking individuals that are starting peer support/self-help groups to support the behavioral health of their community. Many of these individuals have had some training, but could benefit from an extensive training in peer support group facilitation. To address this issue, in June 2012 FGM initiated the development of the peer support group facilitator training in Spanish. It is anticipated that the training will be provided in early 2013.

FGM received feedback from the community and social service agencies that the online directory was not ideal in reaching underserved/unserved populations who at times have limited or no internet access. FGM addressed this issue by developing a print version of the directory which will print on an annual basis. FGM faces challenges of marketing the website and print directories with more cutting edge marketing strategies and social media networking. Due to restrictions on social media within

County networks, FGM is challenged with marketing the directory other than costly radio, print and television mediums. To address this issue, BHRS allocated mental health promotion campaign funding to support FGM marketing efforts to better promote the online and print directory.

Program Results Shown in RBA Framework	
Mental Health Promotion Campaign (MHPC) • 300 individuals attended the StanUp for Wellness Kick-Off event • 4 stakeholder/advisory board meetings were held • 88 individuals, including representatives from 4 of the county's largest private companies, attended the stakeholder/advisory board meetings to provide input for this initiative **Friends Are Good Medicine (FGM)** • 161 individuals were trained in Mental Health First Aid • 64 individuals were trained in Peer Support Group Facilitator Training • 80,723 hits on the FGM website; 4,346 unique IPs (website visits)	**How Much?**
Mental Health Promotion Campaign (MHPC) • 54 community leaders provided input about the campaign, which was incorporated into the StanUp for Wellness campaign • 50% (300/600) of those invited attended the Kick-Off event • 85% (17/23) of PEI programs participated in the Kick-Off event **Friends Are Good Medicine (FGM)** • Partnerships with 22 organizations were established to provide FGM Directories to communities across the county • 100% (39/39) of the responding training attendees increased their understanding of how to facilitate peer support groups	**How Well?**
Mental Health Promotion Campaign (MHPC) • An estimated 109,303 individuals were exposed to the StanUp messages through newspapers (daily/weekly circulation) • An estimated 371,000 individuals were exposed to the StanUp messages through bus ads (monthly) **Friends Are Good Medicine (FGM)** • The following comments express how training participants have been affected by the trainings: "Thanks for bringing this training to us. It is a great tool to those of us who are working with support groups." "I found the training very helpful. I learned a lot about group facilitating that I didn't know." "It helps me a lot to understand how to help others in need." "I feel better able to co-facilitate self-help and support groups."	**Is Anyone Better Off?**

How Lives Are Changing
Mental Health Promotion Campaign (MHPC): One of the organizers of the kick-off event described the day… Great care and planning were involved in launching the StanUp campaign. Every detail/activity associated with the kick-off was designed to meet specific MHPC target audiences and goals. Elected officials spoke, PEI programs were represented, and consumers participated and brought members of their community to celebrate the importance of well-being. The participation was diverse, from Southeast Asian monks to artists from Peer Recovery Art Project. The multiple partners also helped make the event significant by publishing articles in the newspaper (*Modesto Bee* and *La Vida en el Valle*) and providing free popcorn and ice cream (Loard's Ice Cream and Brendan Theater). People from all walks of life came together to celebrate each other and support positive emotional health/well-being, and to reduce the stigma often associated with mental illness.

PEI – Adverse Childhood Experience Interventions

The programs in this project address the needs expressed by stakeholders for expanded responses to childhood traumatic experiences including child sexual abuse, early onset of serious mental disorders, and juvenile justice involvement. This project addresses the following: key community needs of the psychosocial impact of trauma; at-risk children and youth; trauma-exposed youth and their families; persons experiencing the early onset of serious mental disorders; and early involvement in the juvenile justice system.

Programs

- **Aggression Replacement Training (ART):** Aggression Replacement Training ® is a cognitive behavioral intervention program to help children and adolescents improve social skill competence and moral reasoning, better manage anger, and reduce aggressive behavior. The program specifically targets chronically aggressive children and adolescents. Developed by Arnold P. Goldstein and Barry Glick, ART® has been implemented in schools and juvenile delinquency programs across the United States and throughout the world. The program consists of 10 weeks (30) sessions of intervention training and is divided into three components --- social skills training, anger control training, and training in moral reasoning.

- **Expanded Child Sexual Abuse Prevention and Early Intervention (ECSAPEI):** BHRS has partnered with Parents United/Child Sexual Abuse Treatment Team to address the trauma associated with child sexual abuse. The expansion provides additional Spanish-speaking programming for adults who were molested as children, establishment of 24-hour/7 day a week Warm Line for individuals and families affected by child sexual abuse, expansion of peer sponsorships and the capacity to provide education about child sexual abuse to Spanish-speaking and other audiences. Peer Sponsorships is a program of volunteer families who provide support to families who have just been identified as experiencing child sexual abuse.

- **Early Psychosis Intervention:** LIFE Path is a program specifically designed to provide Early Intervention for 14 – 25 year-old Stanislaus County residents who have experienced initial symptoms of psychosis within the last year. The program provides intensive treatment for consumers, families, caregivers, and significant support persons across a spectrum of specialized services. These services are tailored to meet the unique needs of each participant and may include screening and assessment, diagnosis, individual and family counseling, Multi-Family Group, crisis and relapse prevention, education and vocational support, independent living skills support, family support education, psycho-educational workshops, outreach, medication and treatment, and recovery planning. A primary goal is to support consumers in discovering their life path potential by decreasing the disabling effects from untreated psychosis.

Highlights

Aggression Replacement Training (ART):

- The ART program continued to support youth at risk for juvenile justice involvement through creative ways of strengthening protective factors and resiliency. ART convened youth from various programs and community efforts from across the County that target underserved/unserved populations. ART focused on youth leadership development activities, as well as the planning for the Annual Youth Leadership Summit with the purpose of highlighting youth-led efforts throughout the county. These efforts focused on promoting resiliency and protective factors.
- The program partnered with the various school districts and the Gallo Center for the Arts to promote resiliency and well-being concepts through performances at both the Gallo Center and school settings. This strategy was highlighted in the last annual update as an effort to broaden the scope of the program to reach a larger number of students.
- In 2011 BHRS sponsored 10 suicide prevention performances of *Ophelia Lives* for grades 8 - 12. Performances were presented at Downey High School, Johansen High School, Modesto High School, Ceres High School, Riverbank High School, and one public performance at the Gallo Center. The focus for the public performance was to engage community partners. Approximately 3,500 students and adults were reached through these performances.
- BHRS sponsored 10 Bullying prevention performances of *The Boy Who Cried Bully* for grades K - 5. The performance was presented to approximately 10,000 students and adults at five Ceres elementary schools, three Newman elementary schools, one Modesto elementary school, and one Waterford elementary school. BHRS provided clinical and administrative support in the implementation of these projects. Clinical support focused on interventions with students who witnessed performances and had questions or mental health issues that arose during the performances.

Expanded Child Sexual Abuse Prevention and Early Intervention (ECSAPEI):

- The Speakers Bureaus include adults molested as a child and/or a parent, and offenders going classes and service organizations to speak about child sexual abuse and telling their personal stories.
- Speaking engagements addressed a total of 336 people, 10% of whom were Spanish speaking only (50% of attendees were bilingual Hispanics who opted to attend the English-speaking portion of the program).
- ECSAPEI received 213 warm line calls, almost doubling last year's calls.
- Compared to the beginning of this program, there are a greater number of parents coming in for treatment with their children. This includes both parents (Mom and Dad) which is different than in the past.
- Thirteen individuals started treatment as a result of attending the Speaking Engagements or contact through the Warm Lines.
- Since the implementation of this program, Parents United has seen substantive increases in the number of Latinos served in the treatment side of this program.

Early Psychosis Intervention: LIFE Path

- Training in how to use the Structured Interview for Psychosis Risk Syndromes (SIPS) was received in September 2012 for the LIFE Path staff. This training originates from the PRIME clinic at Yale University Medical School, Department of Psychiatry, and builds an increased awareness of mental health diagnostic differentials, furthering the ability to shorten the timeframe between the screening process, provision of assessments, and referrals to

community resource supports for consumers.

- Thirteen assessments were completed for individuals ages 14-25, focusing on family/psychosocial history and current level of functioning (mental status exam).
- The LIFE Path program reported a 100% back-to-school return rate for youth who had withdrawn from school prior to enrollment in LIFE path, but have since then been enrolled in program and actively working with the LIFE Path Team.
- LIFE Path has a presence on local college campuses and is successfully connected with CSU Stanislaus Health Center. The program has received referrals for students in need of early intervention services.
- One hundred percent of LIFE Path participants were willing to receive and take medication.
- Individuals screened, but found ineligible for program services, received appropriate referrals to other community resources.
- Of the individuals served, 75% are Hispanic/Latino or Black/African American, and 25% are Caucasian.
- 56% of community presentation attendees indicated an increase in knowledge of early signs of psychosis after attending the presentations.

Challenges

Aggression Replacement Training (ART):

- BHRS is recommending the restructuring of the Aggression Replacement Training program by offering a broader range of groups and individual early intervention services for the target population. With the ART group model's rigid structure and staffing requirements of two facilitators, the program faced the challenge of scheduling groups to maximize staff time and resources and reach the maximum number of youth. In addition to the evidenced-based ART group model, BHRS can provide effective group services for this population based on "best practices." School and community partners have offered feedback that a broader range of groups and individual supports that focuses on overall behavioral health issues would benefit and provide additional support for youth at risk for juvenile justice involvement. To effectively promote these services, BHRS will change the name of the program from "ART" to a name that accurately reflects the broader range of groups and individual services. These additional groups could be facilitated without an additional cost of a co-facilitator and offer services to a broader group of individuals within the target population. As with all PEI programs, these behavioral health groups will develop a set of performance measures that show overall impact of the intervention.

Expanded Child Sexual Abuse Prevention and Early Intervention (ECSAPEI):

- Engagement within the Hispanic community is impacted by issues of secrecy and families not wanting to talk about child sexual abuse. The program is beginning to nurture and foster a core group to return to their Hispanic community and help others access treatment.
- Speaking engagements were lower than in past years due to issues within different agencies; e.g., competing training topics, and service demands.

Early Psychosis Intervention: LIFE Path

- A critical element with early psychosis intervention programs is an in-depth education and awareness campaign to targeted individuals within service systems that serve the target population of 16 to 25 years old. This involves multiple and targeted presentations to school staff, college and university staff, faith and spirituality leaders, the business community, social service providers, etc. The challenges included limited hours for outside presentations and trainings within these service systems. For example, many school districts do not have

time to educate their teachers or administrators due to their limited staff development time, which has significantly decreased over the last few years. However, the program continued to engage and articulate the importance of this information to reach key individuals within the service system, which ultimately resulted in increased access and presentations. BHRS and the contractor continue to monitor access and the number of presentations delivered in the community since it is critical to raising awareness about the signs of the onset of early psychosis symptoms.

Program Results Shown in RBA Framework	
Aggression Replacement Training (ART) • 21 youth participated in ART Groups • 26 services providers were trained/supported in ART Group facilitation • 25 youth leaders participated in youth leadership development planning • 254 youth served at the Youth Leadership Summit • 13,500 students and adults were reached with bullying prevention and stigma reduction messages through creative arts strategies **Expanded Child Sexual Abuse Prevention and Early Intervention (ECSAPEI):** • 336 individuals attended 11 speaking engagements • 33 attendees were Spanish-speaking only • 213 calls were made to the warm line • Approximately 200 people visited 2 table presentations **Early Psychosis Prevention: LIFE Path** • 113 phone consultations were made with various members of the community, including mental health services providers, schools, consumers, consumer family members regarding information about early psychosis intervention • 204 individuals attended 31 community presentations • 61 screenings were completed to assess program eligibility • 25 multi-family group sessions were held	**How Much?**
Aggression Replacement Training (ART) • 24% (5/21) participants completed ART **Expanded Child Sexual Abuse Prevention and Early Intervention (ECSAPEI):** • 24 AMAC group meetings (6 each quarter) were held • Treatment team offered services to 505 individuals, 7 of whom were Spanish speaking only. **Early Psychosis Prevention: LIFE Path** • 98% (47/48) of the individuals who were determined ineligible for the program were successfully connected to other community resources • 100% (13/13) who were determined eligible for the program entered the program	**How Well?**

Program Results Shown in RBA Framework	
Aggression Replacement Training (ART) • 40% (2/5) youth who completed ART reported a decrease in difficult behaviors (decrease in YOQ-SR Scores) **Expanded Child Sexual Abuse Prevention and Early Intervention (ECSAPEI):** • 98% (329/336) of individuals who attended speaking engagements increased their parental knowledge of the impact of child sexual abuse as well as their knowledge of treatment and support services. • 98% (329/336) of parents who attended speaking engagements increased their knowledge of how to keep children safe from child sexual abuse. • 9 people started treatment as a result of the Speaker's Bureau • 6 people started treatment as a result of the Warm Line contact **Early Psychosis Prevention: LIFE Path** • 100% of individuals in program on meds were medication compliant • 96% of individuals in program reported decrease in relapses • 56% of attendees at community presentations demonstrated increased awareness of the early signs of psychosis • 100% of individuals in program reported family lives are stabilizing	**Is Anyone Better Off?**

PEI - Child and Youth Resiliency and Development

The Child and Youth Resiliency and Development Project addresses the needs expressed by stakeholders to focus on facilitating emotional resiliency among high-risk children and youth through mentoring, education, life skills training, peer support, and community leadership opportunities. It addresses key community needs of at-risk children, youth, and young adult populations by focusing on these priority populations: children and youth in stressed families, at risk for school failure, at risk of or experiencing juvenile justice involvement, and underserved cultural populations.

Programs

- **Leadership and Resiliency Program (LRP):** BHRS has partnered with four community-based organizations to support their youth leadership development efforts. The partnerships include:

    - Sierra Vista Child and Family Services (SVCFS)- The Bridge Community Center
    - Hughson Family Resource Center (HFRC)- Youth Connection/Hughson Youth Council
    - Center for Human Services (CHS) - Patterson Teen Center
    - Project Uplift/Leadership for the Future – West Modesto King Kennedy Neighborhood Collaborative (WMKKNC)

    LRP are school-and/or community-based programs for youth ages 14-19 that enhance internal strengths and resiliency, prevent involvement with substance abuse and violence, and help youth avoid school failure and involvement with juvenile justice. Specific activities include resiliency groups, adventure and outdoor activities, community service opportunities, conflict resolution, social skills training, and peer mentoring. Individuals who are the focus of this program are involved in its development.

- **Children are People (CAP):** CAP is a program for children of alcoholics or substance abusing parents/caregivers. CAP is a psycho-educational, problem-solving program designed to address in a small group setting, the problems of children in third through fifth grades who are exposed to family substance abuse. The program consists of 8-10 sessions. Each weekly session includes opening and closing exercises and a topic for learning/discussion that addresses a specific psychosocial concern children may encounter. The program provides training and supervision to staff and qualified volunteers at different sites within the county.

Highlights

Bridge Youth Builders- SVCFS- The Bridge Community Center:

- Nineteen at-risk Southeast Asian youth, from the West Modesto area, received guidance and training, developing their leadership skills to engage and mentor other youth in their communities.
- Over 130 at-risk Southeast Asian youth, from the West Modesto area, received opportunities to participate in a wide variety of community projects.
- Through their exposure to occupational education and college preparedness, four members of the Bridge Youth Council elected to pursue a college degree; two enrolled at Modesto Junior College (MJC), one at UC Davis, and one at UC Berkeley.

- One member of the Bridge Youth Council (now a sophomore at CSU Stanislaus) was offered a paid job with BHRS coordinating leadership training and activities for at-risk youth.
- Two thirds of individuals served reside in the culturally and geographically underserved area of West Modesto (zip code 95351).

Hughson Youth Council (HYC) - HFRC:

- In conjunction with the Hughson Community Christian Center, members of HYC volunteered their services, stuffing boxes and wrapping gifts for 430 needy Hughson families during a Christmas Basket Project.
- Last year, members of HYC replaced 7 computers and 12 monitors in the Community Media Center. This year, members of HYC applied and were awarded a grant to finish replacing the computers in the Community Media Center. Computers are now accessible to members of the community from 3-5 p.m., when the local library is closed.
- The Hughson Family Resource Center and HYC were awarded a $31,000 foundation grant to help develop alcohol/drug prevention activities, including a mentorship project in the Hughson community.
- Due to their success as the only youth led group in the Central Valley to successfully pass the Social Host Ordinance in Hughson, HYC was asked by other County Youth Councils to provide information and presentations regarding the environmental impact of underage drinking.

Lifeplan-CHS:

- The Lifeplan program includes students from Del Puerto High School, the Patterson Teen Center, and Grayson Community Center. Additionally, the program attained recognition as a school club at the Patterson high school, securing a faculty advisor. This greatly increased the capacity and integration of the program on the school campus. The program experienced difficulty in recruiting youth in the previous year, but have adjusted their programming strategy to increase utilization.
- A key component of this program is working with youth to mentor other youth, as well as creating a personal "Board of Directors." The program successfully implemented this component of the program by working with returning youth to act as mentors to mentor new participants.
- The program staff continued to provide training on the model for school staff, and most importantly community partners. The program successfully built a partnership with the Grayson community capacity building initiative focused on improving well-being for the community. The program is now focused on connecting students within the program to local community service projects within their neighborhoods.
- Ten Lifeplan groups formed during 2011-12, with 92 (unduplicated) participants who participated either as a group participant or a youth mentor. Of those participants, 87 were new, while the other 5 were returning participants.
- Lifeplan continued to strengthen youth leadership skills by utilizing past members as youth mentors in the program. This year, nine youth returned as youth mentors. Of those 9 youth, two served as youth mentors in more than one My Lifeplan Group.
- Three My Lifeplan trainings were facilitated to project staff and partners; two were provided to staff at Patterson Teen Center and one was provided to staff at Grayson Community Center.

Leadership for the Future/Project UPLIFT-WMKKNC:

- The Leadership for the Future program continued to produce impressive outcomes with the intentional strategy of peer youth mentorship. The program pairs-up high school students who can mentor elementary students focused on improving academic and youth resiliency outcomes. The program has shown success in connecting mentors with positive adult role

models. In addition, program participants have exhibited current improvements or maintained good academic performance, as well as continued to pursue higher education.

- The program continued to enjoy high levels of community leadership and commitment from the West Modesto King Kennedy Multicultural Community Collaborative and Modesto City School Leadership. In addition, adults provided mentorship support beyond the scope of this contract. The program highly leveraged the program's resources to serve not only program participants but a broader group of youth in the Project Uplift Program.
- All program participants reported either "Very Good" or "Good" relationships with adults in the program, and only one participant indicated difficulty with adult relationships outside of the program.
- Overwhelmingly, participants indicated they are more likely to continue their education and training, are more hopeful for their own future and better prepared for the future.
- Over the years, this program has had a solid track record for being able to successfully connect participants to employment opportunities. Employers include Farmer's Market & Taco Bell and Project YES (Youth Employment Services) Program run thought the Ceres School District.
- Five program participants were seniors, and all five graduated with their high school diploma. Four enrolled at Modesto Junior College (MJC). The fifth student is planning to enroll at MJC but is taking a break from school.

Children Are People (CAP):

- After initial implementation, BHRS adjusted the program design based on school partners and participant feedback that the curriculum was too stigmatizing and therefore counter productive to children's fully engaging in the program. As a result of this feedback, BHRS paused the use of the CAP curriculum, revised the approach and implemented a program with a broader, behavioral health and well-being focus. Psycho-education and skill development remain a central focus of the program, but it is now focused on well-being and resiliency approaches rather than specific information pertaining to "substance abusing parents." Additionally, students identify "what well-being means to them" and in partnership with program staff, teachers, and parents, design strategies to improve well-being for students within the classroom. The CAP program provided services at Orville Wright and Fairview Elementary schools for all fifth grade classes. The CAP groups were co-facilitated by a school staff and a BHRS Mental Health Clinician.
- The program was adjusted to strengthen the capacity of school staff and teachers that participate in the classroom sessions to continue to support students in their behavioral health with the skills developed through the course of the program.
- At both school sites, the Program enjoyed substantive partnerships and support by school administrators, teachers and students.
- Through the course of the program, students developed projects to address safety in a community park, improve healthy food options in the school cafeteria, and bullying prevention.

Challenges

Bridge Youth Builders (BYB):

- Tracking and reporting meaningful data to support RBA framework was challenging. For example, tracking unduplicated number of persons served and defining measurements has been difficult. However, the program has been working on clear and accurate definitions and a shared understanding of what the data means.

Hughson Youth Council (HYC):

- At least half of the members of HYC were high school seniors who graduated in June 2012. The remaining members were primarily from middle schools, and are less experienced at carrying out public service projects.
- When members of HYC were asked how they would improve the program, one answered that volunteer hours needed to be tracked more efficiently.
- Another member wished that schools were more involved with this program, so more students would stay away from drugs and alcohol.

Leadership for the Future/Project UPLIFT:

- The program was originally designed for ten youth mentors (high school students) who were mentoring elementary school students (grades 3 to 6). The mentoring occurred on-site at Franklin and James Marshall Elementary Schools and in association with the After-School programs. In the spring of 2011 there was a major incident in the Modesto City School District (MCS) where a teen youth worker (not in any way related to this program) took advantage of an elementary school girl. Because of this incident MCS stopped all outside program activities on school grounds. In response to this situation, beginning in 2011-12 the mentoring program shifted to Mark Twain Junior High School. In early 2012, the MCS re-authorized this program to work with the Franklin After-School Program so the program re-established mentoring with elementary school students. In FY11-12 the program worked with BHRS-PEI staff to create program modifications that resulted in a primary change of focus in the program to 13 -19 year-old youth, and a minimum goal of 100 youth to participate during the 2012-13 program year.

Children Are People (CAP):

- Staffing turnover has limited full implementation of this program to the extent that the program was not offered in the second half of the school year in FY11-12. After hiring a new program clinician the program continued in school year 12-13.

Program Results Shown in RBA Framework	
Bridge Youth Builders: • 19 members of the Bridge Youth Council were active at the end of FY2011-12 • 26 community service projects were planned and completed by the Bridge Youth Council • 117 (unduplicated) at-risk youth were mentored by the Youth Council **Hughson Youth Council (HYC):** • 114 at-risk youth were reached through community outreach and educational presentations • 21 at-risk youth participated in the Hughson Youth Council • 21 at-risk youth participated in the youth development program • 13 community projects were initiated and completed by HYC **Lifeplan:** • 10 Lifeplan groups were formed • 92 individuals participated in the Lifeplan group (unduplicated) • 34 Lifeplan outreach activities were implemented • 3 Lifeplan trainings were facilitated to project staff and community partners	**How Much?**

Program Results Shown in RBA Framework	
Leadership for the Future/Project UPLIFT: • 10 mentors (high school students primarily from Modesto High School) received training • 10 students (mixture of elementary and middle school students) from Franklin Elementary and James Marshall Elementary were mentored **Children Are People (CAP):** • 114 children participated in CAP groups and individual services • 35 individuals were trained to facilitate CAP • 3 schools/organizations implemented CAP	
Bridge Youth Builders: • 100% (19/19) of the Bridge Youth Council members reported satisfaction with program services • 100% (19/19) of the Bridge Youth Council members reported an understanding of the 40 developmental assets **Hughson Youth Council:** • 29% (6/21) at-risk youth in HYC reside in other cities/communities • 43% (9/21) at-risk youth in HYC are not Caucasian. **Lifeplan:** • 17% (9/52) of students who previously graduated from Lifeplan returned as youth mentors. • 90% (78/87) of students eligible to graduate from Lifeplan actually graduated during FY 2011-12 • 14 students indicated they have contacted a person from their Board of Directors since the conclusion of their program • 100% (20/20) of responding participants would recommend Lifeplan to a friend **Leadership for the Future/Project UPLIFT:** • 100% (21/21)* of responding participants reported that the program trained people to interact with adults in a good way • 100% (19/19) of responding participants reported having good relationships with adults in the program • 95% (19/20) of responding participants reported having frequent opportunities to participate in events that take place in the larger community • 95% (20/21)* of responding participants indicated that they learned ways that young people can take action in the community. • 95% (18/19) of responding participants indicated that young people are given opportunities to lead community-wide activities *Some participants responded more than once **Children Are People (CAP):** • 66% (23/35) of CAP facilitators reported feeling confident conducting the CAP program • 100% (35/35) of CAP facilitators were highly satisfied with the program	**How Well?**

Program Results Shown in RBA Framework	
Bridge Youth Builders (BYB): • 100% (19/19) of the Bridge Youth Council members reported increased self-efficacy • 100% (19/19) of the Bridge Youth Council members reported an understanding of the assets in improvement in leadership skills. • 100% (19/19) of the Bridge Youth Council members reported improvement in their leadership skills **Hughson Youth Council (HYC):** • 100% (15/15) of youth on HYC indicated that they have developed meaningful relationships with adults in the program and adults outside of program; feel valued by adults; and the program trained them to interact positively with adults • 100% (15/15) of youth on HYC indicated that they are more hopeful about the future • 93% (14/15) of youth on HYC indicated that they are prepared for the future • 100% (9/9) of participating youth indicated increased knowledge of adverse consequences of alcohol and other drug abuse. **Lifeplan:** • 90% (18/20) of responding Lifeplan participants reported an increase in positive self concept • 88% (21/24) of responding Lifeplan participants reported an increase in positive outlook for the future • 91% (30/33) of responding Lifeplan participants reported an increase in connectedness to their community • 96% (43/45) of responding Lifeplan participants reported increased leadership skills • 100% (18/20) of responding Lifeplan participants reported that they have used skills learned in Lifeplan since the conclusion of the program **Leadership for the Future/Project UPLIFT:** • 90% (19/21)* of responding participants reported having good relationships with adults outside of the program • 100% (21/21)* of responding participants reported feeling valued by adults • 95% (20/21)* of responding participants reported more likely to continue education or training • 100% (21/21)* of responding participants reported being more hopeful than before about their future • 95% (20/21)* of responding participants reported feeling better prepared for the future *Some participants responded more than once **Children Are People (CAP):** • 94% (107/114) of the children participants reported feeling confident about using skills and knowledge learned from the program • "I didn't have that much trust but now with the lesson I feel more safe to talk to them." – student comment about the group • "This group is helpful for me because they made me feel like a better person and part of a familia." – student comment about the group	**Is Anyone Better Off?**

How Lives Are Changing

Hughson Youth Council:
At the end of the Fiscal Year, members of the HYC were asked about their expectations when they joined the program and if those expectations were met. Of the 14 who answered this question, 13 stated that expectations were met. These were some of the individual responses:

- Being a positive asset to my community and that I get to spend time with my peers
- I enjoyed meeting new people and being part of a group that benefits the community in a positive way
- I enjoyed being involved with the community and meeting new people
- I enjoyed all the people I met and my experiences
- I enjoy helping people
- I enjoyed hanging out with friends
- Being with other youth members and getting to meet new people and helping my community

Leadership for the Future/Project UPLIFT:

"How mentoring has helped me and changed my life" by Youth Participant
During my junior year of high school, I did not have a real idea of what I was going to do with my life after high school. I knew I wanted to go to college but I didn't know how I was going to get there. My parents didn't want to or afford to pay for my schooling and I couldn't wrap my head around how I was going to earn enough money to continue my education. I may have run away from home without graduating high school because of the lack of support and guidance I was receiving at home. My mother would heckle me constantly because I didn't have a plan for life and because I didn't participate in extracurricular activities. During the spring semester, she sent me off to my first Project UPLIFT meeting, the Youth Leadership Program in west Modesto.

At Project UPLIFT the mentors taught me numerous things; from how to prepare for a job interview, leadership to knowing how to get information on colleges. I even got my first job as a mentor at Franklin Elementary because of Project UPLIFT. My mother noticed a change in me as I began to go to UPLIFT mentoring activities. She noticed I had become more active outside of school. Instead of staying home doing nothing productive with my time I was actively volunteering my time to Project UPLIFT and the community service that we do. However her concern of what I was going to do after I graduated was still an issue. I also went on college tours with Project UPLIFT to view college options as well. I did not have a good relationship with my mother or my father who lives in Denver and because of that my mother wanted me out of the house after high school and told me I better have a plan for my future. At first I went to my father for advice on my situation to which my father told me to go into military service like he had. My Dad had told me that Air Force or Navy would be best for me. He instructed me that I can get my education and be away from home as long as I follow the orders they appointed to me.

I then went to my mentor for advice regarding the military. Being a Navy Veteran himself persuaded me into looking into the Navy, but said we will go visit all branches to see which one would interest me the most. He also took me by the recruiting offices of both the Air force and the Navy. Ultimately, I decided on enlisting in the Navy and I am currently awaiting my ship out date to boot camp all thanks to my mentor's guidance and expertise as a mentor. After the Navy I plan to use the college funds I earn through my service to earn a degree in engineering. My college education will be debt free.

How Lives Are Changing
My mentor has also helped me with job interviews, speeches, and even encouraged me to fill out scholarship applications. He's helped me become more confident in myself and my future and guided me to finding my own way to success. Not only has he been a great mentor to me but also a great role model and friend as well. Luckily I had great mentors to keep me on track. **Children Are People (CAP):** A teacher of a participating class describes changes in her students' behavior after CAP: "My students seem more respectful and aware of their environment and the other students in their environment. The depth at some of the issues they talk about is much greater."

PEI - Adult Resiliency and Social Connectedness

The Adult Resiliency and Social Connectedness Project serves adults with the goal of reducing the experience of stigma and discrimination related to having a mental illness through opportunities for social support that are not based on having mental illness. The project will reduce barriers in access to early mental health interventions by addressing stigma associated with mental illness and emotional health problems. Stigma reduction strategies include expanded social support networks, culturally appropriate support, and early mental health interventions offered in non-stigmatizing settings. This includes expanding existing communities of support and enhancing linkages between communities of support.

Programs

- **In Our Own Voice (IOOV) – Anti-Stigma Program:** IOOV is a unique public education program developed by NAMI in which two trained consumer speakers share compelling personal stories about living with mental illness and achieving recovery. The program was started with a grant from Eli Lily and Company. IOOV is an opportunity for those who have struggled with mental illness to gain confidence and to share their individual experiences of recovery and transformation.

- **Faith/Spirituality-Based Resiliency and Social Connectedness:** This program facilitates, encourages, and supports faith communities and spirituality groups throughout Stanislaus County to create increased social support and social connections for adults experiencing the impact of trauma and other risk factors. These activities include a variety of support groups, study groups, outreach, social and recreational activities, and personal/peer based support. Partnerships with other PEI programs will allow faith-based organizations to provide education and information about behavioral health concerns that reduce stigma, enhance emotional wellness, and support recovery.

Highlights

In Our Own Voice (IOOV):

- Several presenters went back to college and got jobs. This program has proven to be a morale booster for them; they gained self confidence, self-esteem, and tools to find and keep jobs. Also, some have become teachers and support group leaders in the NAMI affiliate.
- NAMI joined the Modesto Chamber of Commerce this year in hopes of networking and spreading the stories to the community. The Chamber welcomed NAMI and the program intends to participate in Chamber activities.
- IOOV successfully trained six new English speakers (of all ages). One of the six IOOV speakers is a member of the LGBTQ community.

Faith/Spirituality-Based Resiliency and Social Connectedness:

- This program continued to facilitate, encourage, and support faith communities and spirituality groups throughout Stanislaus County to create increased social support and social connections for adults experiencing the impact of trauma and other risk factors.
- The program supported Recovery Modesto leaders in defining results of well-being for their community. Recovery Modesto is a collaborative of faith-based recovery and peer support groups throughout the city of Modesto. Collectively, Recovery Modesto provides peer support groups on a monthly basis to an estimated 2,000 people. BHRS's role and partnership with Recovery Modesto is to provide them technical assistance in the area of planning and

performance measurement as they work to increase the social and peer supports for their community members. Recovery Modesto leadership team identified (1) increasing the number of faith-based supports in Modesto, and (2) strengthening the capacity of faith-based peer support group leaders to provide support for individuals seeking out faith-based supports in their recovery from mental illness or alcohol and other drug substance abuse.

- The program convened the leaders from the mindfulness and Buddhist spiritual traditions to inquire of existing behavioral health supports for the mindfulness and Buddhist communities, as well as their interest in developing additional behavioral health supports for their community members. The conversation resulted in the development of trainings designed to inform the community on "mindfulness approach" to address behavioral health issues. In addition, the workgroup identified increasing the number of mindfulness/Buddhist based recovery supports for their member as a long-term goal.

Challenges

In Our Own Voice (IOOV):

- The successes of the program have also created some challenges. Since two presenters are working full-time and going to college, they are unable to travel and speak.
- One of the recent challenges is encouraging Asian peers to be involved. However, one Cambodian peer is currently trained in IOOV.

Faith/Spirituality-Based Resiliency and Social Connectedness:

- BHRS implemented the program initially without the benefit of experience or knowledge of how specialized staff knowledge would need to be for effective mobilization of diverse faith and spiritual community leaders on behavioral health issues. Originally proposed as a program with one part-time staff focusing on peer support, the first three years of implementation has revealed that the program needs a different approach to project management and administrative support that includes more time and expertise in "hands-on" administrative experience. Despite considerable enthusiasm and effort that produced some progress and successes, many of the collaborative partnerships relied on spiritual leaders and community members, who have little or no administrative support to act on strategic plans and decisions, as a result many of the groups' decisions and plans failed to materialize or produce results. With input from participating community members a decision was made to stop program activities, reevaluate administrative support needs, clarify resources available, develop a new approach and re-start in FY13-14. It is currently proposed to engage the services of a Project Manager with significant administrative experience and ability to work independently to support faith and spirituality leaders across the County in implementing various community-based strategies and projects that increase behavioral health support for their community members. As with all PEI programs, these behavioral health groups will develop a set of performance measures to show overall impact of the intervention.

Program Results Shown in RBA Framework	
In Our Own Voice (IOOV): • 1,231 individuals attended 66 presentations by IOOV speakers • 17 peers were active speakers for IOOV **Faith/Spirituality-Based Resiliency and Social Connectedness:** • 6 community leaders from the Buddhist/Mindfulness community convened to develop partnerships to increase behavioral health support for their community members	**How Much?**

Program Results Shown in RBA Framework	
• 3 trainings were developed in partnership with local community leaders for the community and service provider staff on mindfulness approaches to mental health treatment	
In Our Own Voice (IOOV): • 23% (15/66) of the presentations were given in Spanish • 18% (222/1,231) of the attendees were Spanish speakers • 90% (199/221)* of attendees reported that this was their first time hearing of NAMI and/or IOOV *First quarter reporting only **Faith/Spirituality-Based Resiliency and Social Connectedness:** • Partnerships between faith-based community leaders were strengthened	**How Well?**
In Our Own Voice (IOOV): • 98% (217/221)* of attendees reported that recovery from mental illness is possible • 80% (177/221)* of attendees reporting that mental illness is like any other physical illness • 75% (166/221)* of attendees reported that they would not mind working with someone who is mentally ill *First quarter reporting only **Faith/Spirituality-Based Resiliency and Social Connectedness:** • Faith-based recovery leaders developed a strategic plan to increase faith-based behavioral health support groups, strengthen skill sets of support group leaders, and promote faith-based recovery groups. These leaders reach an estimated 1,000 people on a monthly basis	**Is Anyone Better Off?**
How Lives Are Changing	
In Our Own Voice (IOOV): In an email to the program coordinator, one IOOV speaker stated, “Being a speaker for IOOV has been one of the most rewarding experiences of my life. It’s obvious that people want and need to be informed about mental illness and we are providing a service that truly works for myself and others.” When asked what was learned from being an IOOV presenter, one speaker wrote, “Acceptance of myself has increased tri-fold. To stand in front of 10 or 60 people and see their faces (all faces) focused on what it is like to have a mental illness is a dream come true.” The speaker also shared that the audience learned that “I am no different than they are . . . I have a medical illness. I have learned to live with my illness and am a productive person. There is hope. Definitely breaks the stigma and the audience has learned what it is like to be me.”	

PEI – Older Adult Resiliency and Social Connectedness

This project funds new programs and strategies designed to reach physically impaired and socially isolated seniors who are at higher risk of depression and suicide. The project has three types of programming that address psychosocial impacts of trauma and onset of depression, and other disorders including co-occurring disorders in older adults. All program strategies begin to address stakeholder identification of community needs related to increasing supports in the community, include all age groups, and improve access to services.

Programs

- **The Program to Encourage Active, Rewarding Lives for Seniors (PEARLS):** PEARLS is a 19-week individualized program where a PEARLS counselor visits at-risk seniors in their homes to offer help by teaching problem solving techniques and encouraging increased social and physical activities.

- **Senior Peer Counseling:** Senior Peer Counselors are trained volunteer counselors who regularly visit older adults who are having trouble overcoming difficulties or facing significant change in their lives. The Peer Counselors are seniors themselves. The volunteer counselors attend an initial training and are supervised by a professional clinician. The volunteer Counselors help connect seniors to services, help them learn to cope, and support them during difficult times. They provide counseling and support to those experiencing emotional distress due to health problems, grief, loss of a loved one, depression, anxiety or other difficulty. These peers often share similar life experiences and offer comfort and understanding. The home visits are usually weekly and open ended in duration. There is no fee for the service which is for adults 60 years of age or older.

- **Friendly Visitor:** Friendly visitor volunteers visit with lonely seniors in the community, usually two times a month, providing socialization and support to the seniors who may not otherwise have any contact with anyone else. Activities may include reading together, taking walks, playing cards, or having coffee and conversation.

- **Senior Center Without Walls (SCWW)**: is a phone-based program with offerings similar to activities you would find at a senior center. Once registered, each senior will receive a monthly calendar of events. All they have to do is call in to join in group discussion, fun games and quizzes, storytelling of travel adventures, or join a discussion on current health topics. This program offers a book club, support groups and much more.

Highlights

PEARLS:

- To improve understanding of who should be referred to the program and increasing access to the program, PEARLS partnered with the Mental Health Promotion Campaign to develop a variety of marketing materials and placed several ads in the local newspapers.
- PEARLS utilized the RBA Technical Assistance process to improve the selection of program performance measures, data collection and reporting. PEARLS expanded the data collection to include total referrals and started tracking outcomes of referrals, and surveys were developed to assess the impact of the program on participants' lives.

Senior Peer Counseling:

- There has been growth in this program, including 11 new Senior Peer Counselors and 25 newly registered seniors.

Friendly Visitor:

- There has been a good demand for the Friendly Visitor program, and consequently a wait list was established. Plans are in place to expand outreach and volunteer recruitment, and improve training and recognition to ensure volunteer retention.

Senior Center Without Walls:

- The most notable special project was in partnership with Senior Center Without Walls of Northern California. They agreed to localize the brochure by adding the Stanislaus County name and then also sent a marketing consultant to work with the program to better define and target partner agencies and potential clients.
- SCWW then conducted special training sessions with the Howard Training Center, the home delivered senior meals program, and the Catholic Charities homemaker program staff. The Senior Center Without Walls program did see an increase of referrals (6 new participants shortly afterwards).

Challenges

- Recruitment, training, and support of the volunteer counselors and friendly visitors became increasingly time-consuming, and the need for a dedicated volunteer coordinator became apparent. Although a very dynamic coordinator was successfully recruited, hired, and trained, it was short lived, and she left for a position as a Social Worker at a local hospital before the year ended. It was necessary to restart the recruitment and hiring process.
- Subcontracting with outside agencies for the PEARLS and Peer Counseling program staff impacted the ability to provide efficient and effective services. The initial reason for contracting to outside agencies was to leverage the existing network of Family Resource Centers located in rural communities throughout the County, expanding this program beyond the existing older adult service provider networks. As the program was implemented, the number of older adults engaged in this FRC network was not high enough to sustain a steady level of referrals to the program. Additionally, with the staff from multiple agencies and various levels of supervision, the program did not function efficiently and effectively.
- BHRS in partnership with Area Agency on Aging staff decided to streamline the program and implement it as a County operated program rather than continue to contract out parts of the service to a local CBO who provide mental health services. It felt that a stronger connection to the older adult service provider network and better outreach and engagement was needed. In 2012/2013, PEARLS programming will be staffed, directly supervised and managed by Aging and Veteran Services.
- In addition, the program will provide services to individuals who may not qualify for PEARLS services, but do qualify for early intervention (EI) and other supportive and referral services. Due to the PEARLS model focus on older adults that are homebound, the assessment process “screens out” individuals that would otherwise benefit from some level of early intervention or support/referral services. These individuals had mental health conditions that were either beyond or below the capacity of the program. The program will expand service and capacity to provide EI services, which are short duration, low intensity, but not treatment services. The contractor will monitor utilization in this expansion of PEARLS to assess the level of resources needed to continue such services. BHRS directed the contractor to provide

these services with the same level of funding by reallocating existing funding to these expanded services.

- The Senior Center Without Walls program has been underutilized. Efforts were made to localize the feel of the program for greater acceptance and improved utilization. This program will continue to be a partner, but will now serve as a support program for the PEARLS, Senior Peer Counseling, and Friendly Visitor Programs.

Results Shown in RBA Framework	
PEARLS: • 9 community outreach presentations were given to Older Adult service providers about PEARLS and the referral process • 60 seniors were screened for eligibility in PEARLS • 49 seniors were deemed eligible for PEARLS who took the PHQ-9 questionnaire (depression screening) • 31 seniors enrolled in PEARLS **Friendly Visitor:** • 49 volunteers actively participated in the Friendly Visitor Program • 15 new seniors registered for the Friendly Visitor Program • 57 seniors actively participated in the Friendly Visitor Program **Senior Peer Counseling:** • 11 new Senior Peer Counselors were trained • 18 Senior Peer Counselors were active • 35 seniors actively participated	**How Much?**
PEARLS: • 52% (16/31) seniors completed the program **Friendly Visitor:** • 100% (25/25) of responding program participants reported Friendly Visitor volunteers were supportive • 89% (31/35) of responding program participants reported a high level of program satisfaction **Senior Peer Counseling:** • 100% (8/8) of responding senior participants were satisfied with the program and gained benefits from the program	**How Well?**
PEARLS: • 100% (17/17) of responding program participants indicated the program provided them with useful tools and strategies for use in every day life **Friendly Visitor** • 92% (23/25) of responding program participants reported the program made a difference in their lives	**Is Anyone Better Off?**

Results Shown in RBA Framework

Senior Peer Counseling:

- 94% (17/18) of responding program participants reported Senior Peer Counseling made a difference in their lives
- 100% (10/10) of responding program participants reported Senior Peer Counseling provided them with useful tools and strategies for use in every day life

How Lives Are Changing

PEARLS:
V is a 94 year-old widow who was referred to PEARLS due to changes in her health, complex family issues, and problems with access to services. V initially reported symptoms of depression such as decreased interest in activities, problems with sleep, poor diet/appetite, and intermittent suicidal ideation. V also suffered from severe macular degeneration, lost her driver's license, and stopped teaching as a result. She lives in senior housing and has a limited support system.

Through participation in PEARLS, V was able to effectively identify needs and wants, and the resources to assist her in accessing the community once again. V has developed more friendships and now is participating in community activities once again.

Friendly Visitor:
M is an 86-year old disabled adult. He has a degenerative spinal cord disease which resulted in several fused vertebrae and limited mobility of his head and neck. He is highly educated individual who worked in a profession that requires highly technical skills and knowledge. He never married, has no children, and lives alone. He was "adopted" 2 years ago by a Friendly Visitor volunteer "Tom" who continues to visit him every 1-2 weeks. Some of their favorite activities are playing backgammon and listening to opera together. They simply enjoy one another's company and have built a true friendship.

Senior Peer Counseling:
G is an 81 year-old, divorced, female who was referred for services. She was referred due to changes in her health (recent diagnosis of Alzheimer's, loss of Communicative Activities of Daily Living (CADL), and has a son who has severe issues with alcohol addiction). G felt overwhelmed with "everyday tasks."

Through Peer Counseling, G was able to learn healthy boundaries with her son, obtain resources to assist with ADLs, and access needed community based supports. G participates in ALANON, Curves, sees friends more often, and is dating again.

PEI – Health/Behavioral Health Integration

Health/Behavioral Health Integration Project is the result of a collaborative planning process conducted in Stanislaus County and involving diverse stakeholders throughout the county. Stanislaus County BHRS conducted focus groups dedicated to identifying needs, strategies, and best ways to implement services. The PEI Planning Team, in collaboration with community-based organizations and other partners, conducted twenty-five stakeholder focus groups in the nine towns in Stanislaus County. Four community-based organizations serving diverse cultural communities also independently conducted targeted focus groups and submitted reports offering a more in-depth perspective on emotional health within the ethnic/cultural communities they serve. Communities engaged by these organizations include: Hispanic, African American, Southeast Asian, and Lesbian, Gay, Bisexual, Transgender, Questioning (LGBTQ). A specific focus group was conducted with healthcare providers throughout the county. Additionally, healthcare providers participated in many of the community focus groups held throughout the county. Other stakeholders gave input supporting the idea that primary healthcare settings are desirable in that they are frequently used, generally accessible, and considered non-stigmatizing service settings for behavioral health early intervention services to be delivered. Stakeholders also suggested that there is a neighborhood connection between primary care clinics, faith-based organizations and schools that will interact to strengthen access. Placing behavioral health prevention and early intervention strategies in these non-stigmatizing settings will ensure that community capacity will be expanded during implementation of the PEI Plan. These non-traditional settings will increase access by culturally underserved populations and allow for linkages to traditional mental health settings when stepped-up service is necessary.

This project expands on an effective model of behavioral health integration with primary care that is currently used in selected community health centers within Stanislaus County. The project will fund behavioral health clinicians and psychiatric consultation in primary care health clinics serving primarily underserved cultural communities. The project interfaces with several other projects in the PEI plan to ensure continuity of care to older adults, children/youth, and adults who are at risk of depression and suicide due to untreated behavioral health issues.

The project is one program implemented by two contractors, Golden Valley Healthcare and Stanislaus County Health Services Agency, at numerous primary care sites throughout the county to address identified needs related to increasing supports in the community, to include all age groups, and improve access to services. To do so, it expands on an effective model of behavioral health integration that is currently used in selected community health centers within Stanislaus County. Clinicians and psychiatrists are embedded in six primary care health centers throughout the county.

Program Sites:

Hughson	Hughson Medical Office
Ceres	Ceres Medical Office
Turlock	Golden Valley Health Center
Newman	Golden Valley Health Center
Patterson	Golden Valley Health Center
West Modesto	Golden Valley Health Center

Highlights

The program continued to successfully expand access for individuals with no previous contact with the mental health system. Both contract partners also continued to serve high percentages of Latino, Spanish-speaking individuals as well as the rural population. With limited mental health services in rural areas of the county, such as Southeast and West Stanislaus County, these integrated behavioral health services provide critical services to the targeted populations in the rural communities of Stanislaus County. After an initial evaluation of the program showing patient improvements in depressive symptoms, the county and contract service providers have entered discussions on additional performance measures such as the impact of behavioral health improvement on physical health outcomes.

Challenges

As part of the RBA plan for this project, the contractors were required to administer a Patient Health Questionnaire 9 (PHQ9) at every visit to show incremental increases/decreases in depressive symptoms. Although the contractors successfully implemented the PHQ9 in the first year of the project, one contractor reported that the tool had become intrusive in the therapeutic process and requested a moratorium on its use. The County agreed with the contractor on the intrusiveness of the tool and agreed to work with the contractor to develop/implement an alternative performance measurement tool for the FY 2012/2013.

Program Results Shown in RBA Framework	
• 1,840 Stanislaus County residents received behavioral health services in a primary care setting • 372 participants received 1,180 visits/encounters at two sites*	**How Much?**
• 55% of patients were Hispanic, a target population for this project • 27% of patients' primary language was Spanish • 61% overall retention rate (3 or more visits)*	**How Well?**
• 83% of patients who received behavioral health services through this project did not have any previous contact with Stanislaus County BHRS • 117 patients received at least two sessions for depression; 36% of those patients showed improvement from one visit to the next.* *data from one organization not available	**Is Anyone Better Off?**

PEI – School - Behavioral Health Integration

School-Behavioral Health Integration Project is an early intervention project, with selective prevention elements that serve at-risk children, youth, educational professionals, and parents. The early intervention focus is on preventing school failure and other psychosocial problems resulting from early onset of mental illness, trauma and family stress. The project consists of a range of multi-faceted activities including embedding a mental health clinician within a school setting to provide behavioral health consultation, substance abuse problem identification, screening and referral, support for educational professionals and parents, screening, and early interventions for behavioral and emotional problems of students. This project is based on elements from a variety of successful program models including school-based mental health consultation, student assistance programs, classroom-based mental health education and intervention programs, and in-service programs for school professionals.

Programs

Student Assistance and School-based Consultation Program:
BHRS has partnered with two community based organizations to implement this program.

- Nurtured Heart Program – Center for Human Services in Patterson Unified School District (NHA): NHA is designed to change the school culture of Apricot Valley and Las Palmas Elementary Schools to one that engages the positive and strengthens the inner wealth of its students. The goal of the Nurtured Heart Program is to build the capacity of each school to enhance the emotional resiliency of their students through the school-wide implementation of the Nurtured Heart Approach. The NHA is a system of relationships where all energy and attention is directed to what is going right, and little or no energy is given toward negative behaviors or choices. The program unites students, teachers, and parents in their efforts to build a more positive school community.
- Creating Lasting Student Success (CLaSS) – Sierra Vista Child and Family Services in Modesto City Schools: CLaSS is a prevention and early intervention model that strives to see students succeed in the home, at school, and in the community. It is built upon strength-based and evidenced-based practices that have proven results. CLaSS seeks to work with children who are considered “at risk” for behavioral issues that lead to problems at school and in the home. CLaSS consultants are trained to work with children, their families and teachers by helping them develop action plans that everyone can follow. The focus is on helping children succeed.

Parents and Teachers as Allies (PTAA):

- NAMI-operated Parents and Teachers as Allies Education Program helps families and school professionals identify the key warning signs of early-onset mental illnesses in children and adolescents in our schools. It focuses on the specific, age-related symptoms of mental illnesses in youth. PTAA emphasizes that families and school professionals are natural allies in working to ensure that youth with early-onset mental illnesses receive timely and appropriate treatment.

Highlights

Nurtured Heart:

- The Nurtured Heart Program continued to be a highlighted prevention program in Stanislaus County. The program focuses not only on interventions with children, but with staff as well, reinforcing positive discipline across the campus. The school staff has been highly receptive and has talked very positively about the impact of the support they received through the program.
- The program now has a certified Nurtured Heart Approach Advanced Trainer, which allows for greater flexibility and in-depth training and support for school staff in the implementation of the model.
- The contractor continued to provide a high level of services with no complaints from the community or program participants.
- The program continued the commitment to evaluating and assessing if the program is making a difference by surveying students, parents and teachers. The evaluation allows the program to monitor changes in emotional health and wellbeing, as well as internalization of Nurtured Heart Values.

Creating Lasting Student Success (CLaSS):

- Mental Health Consultants served on the SARB committee for Modesto City Schools (MCS). While many of the children that are attending SARB go to schools outside of the campuses being served, participation in SARB has assisted in providing a venue to present school-based integration services to other MCS leadership and staff.
- It appears that more teachers and staff took part in the program and entered as willing participants as opposed to feeling coerced by their superiors. Teachers have enjoyed the services they received and biases that may have been assumed in the beginning of the program have been disappearing.
- Most of the parent education classes were conducted in Spanish to reach the 64% Hispanic/Latino population served.

Parents and Teachers as Allies (PTAA):

- The program staff presented to over 267 staff members and parents in Stanislaus County in Denair, Hughson, Empire, and Modesto.
- The program was asked to present to the school SARB Board.
- The nurses at Modesto Junior College (MJC) asked the program to present, indicating that they get so many young people coming to them who are in need of help for mental problems. The result of this request is that there will be a NAMI presence and office space available at MJC.
- A different outreach effort to the Hispanic communities was initiated at James Marshall and Alberta Martone Elementary School. Short presentations were given at those schools, with great responses from the parents. Parents requested that PTAA host a support group, but the program doesn't have the resources to do so yet.

Challenges

Nurtured Heart:

- A key component of this program is teachers and school administrators attending training and consult session to strengthen their capacity to implement program interventions within their

classroom and campus. To accomplish this, the program provides funding and support for substitutes that allow the teachers to take time away from the classroom. Over this last year, school administration has had challenges in securing substitutes, which has decreased the amount of training and consultation hours. In addition, the Las Palmas Elementary School has had a change in leadership. As with all school-based programs, a change in school leadership creates challenges as program staff and new school officials build their relationships and develop a shared understanding of the program outcomes and intention. Despite these challenges, school partners and contractor continued a steadfast commitment to implementing the model and have continued to work through these issues.

- The program continued to work with an Organizational Consultant to develop and analyze surveys and tools to measure the outcomes of the program.

Creating Lasting Student Success (CLaSS):

- Four staff members were offered opportunities with school districts. Staff turnover impeded the program's ability to collect, track, and monitor programmatic data throughout the year.

Parents and Teachers as Allies (PTAA):

- The program has been limited in providing the training to schools staff and administrators due to time constraints. Many schools have a limited number of hours for staff development. The lack of access to the school staff for the required hours of trainings has led to NAMI develop a condensed version of a mental health education program. Since PTAA is a national program that requires adherence to the specified model, BHRS has asked the contractor to develop a presentation that fits within the time limits of schools and to provide training to a broader group of individuals such as parent groups, college student, etc. Additionally, BHRS and NAMI will monitor the program outcomes for any further adjustments.
- The program reached out to the Westside communities, visiting churches, family resource centers and Promotores groups to spread the word about NAMI and its programs. A family class in Patterson started in October but there was a low turnout. PTAA has been connecting to people in the community, meeting with the church officials and having discussions with the Westside Collaborative members about how more interest can be generated.
- The program has been challenged in recruiting bilingual presenters to meet the needs of the communities. One bilingual teacher was trained, but additional work needs to be done. In response to this challenge, the program hired a part-time assistant to work on the issue.

Program Results Shown in RBA Framework	
Nurtured Heart • 1,415 students participated in Nurtured Heart program • 4,134 Nurtured Heart student contacts • 87 teacher/staff participated in Nurtured Heart trainings • 384 teacher/staff contacts through Nurtured Heart trainings • 119 Nurtured Heart parent contacts through trainings • 82 in-class, age appropriate skill building presentations to students • 22 meetings (Greatness Groups) with students requiring more intensive relationship building **Creating Lasting Student Success (CLaSS):** • 108 staff/teachers received mental health consultations	**How Much?**

Program Results Shown in RBA Framework	
• 179 students participated in CLaSS • 240 parents participated in CLaSS • 476 classroom group presentations were given • 29 community events were held on school campuses **Parents and Teachers as Allies (PTAA):** • 176 parents/teachers attended 9 educational presentations	
Nurtured Heart • 59% (10/17) of responding parents reported knowledge of Nurtured Heart values • 73% (27/37) of responding teachers indicated a commitment to Nurtured Heart values **Creating Lasting Student Success (CLaSS):** • 100% (49/49) of responding parents reported positive response to services • 92% (108/118) of responding students reported positive response to services • 100% (53/53) of responding teachers/staff reported positive response to services **Parents and Teachers as Allies (PTAA):** • 80% (120/150) of responding attendees reported increased knowledge identifying the keys to early recognition and treatment of mental illnesses in children/adolescents • 86% (18/21) of responding parents/teachers expressing satisfaction with training and would recommend program to other school professionals	**How Well?**
Nurtured Heart • 47% (8/17) of responding parents reported school connectedness • 87% (33/38) of responding teachers did <u>not</u> report on-the-job stress related to student behavior • A parent stated that the Approach helper her be more patient with her children, and another shared that he is able to feel connected to his son after using the Approach at home. **Creating Lasting Student Success (CLaSS):** • 277 fewer incidences of suspensions expulsions, or office referrals (from all three schools) • 25% reduction in number of Disciplinary Dispositions compared to the previous school year (2010-11) for all three schools • 48% reduction in number of Disciplinary Dispositions since the inception of the program (2009-10 school year) for all three schools • 97% (111/114) participating students do not enter formal Mental Health services **Parents and Teachers as Allies (PTAA):** • One elementary school attendee commented, “Thank you for all information and	**Is Anyone Better Off?**

Program Results Shown in RBA Framework

for sharing your stories; touching, moving insightful."

- After a presentation at Teachers College of San Joaquin, an attendee shared, "It is wonderful to have a connection to help families get resource. Thank you to the presenters for sharing their personal experiences. It really made the information real and meaningful. And gave a sense of importance to the issues they discussed."

How Lives Are Changing

Nurtured Heart

- A participating second grade teacher said that she can see her student faces light up when she is using Nurtured Heart in her classroom. She stated that they really perk up and sit up taller. She also shared that she feels less on edge at the end of her work day now that she is using the Nurtured Heart Approach.
- A participating Kindergarten teacher stated that her students are more responsive to her during transition times in class now that she is using the Approach.
- A participating fifth grade teacher shared that she feels teachers are helping keep each other accountable simply by using the Nurtured Heart Approach. She stated that when other teachers overhear a teacher using the Approach it reminds them to use it. She definitely thinks it has encouraged a positive school culture.
- A participating third grade teacher stated that she is able to manage her classroom more efficiently now that she is not taking children's behavior personally, a skill taught through the Nurtured Heart Approach.

Creating Lasting Student Success (CLaSS):

- A child at one elementary school entered the program at the beginning of the year with an average of 7 physical altercations during the week. This child was considered so disruptive that he was placed behind a screen in order to separate him from the rest of the class. It was assumed that he would reach the limit of suspensions and would be transferred to another campus within the year. The Mental Health Consultant worked effectively with the teacher and provided training and encouragement in the use of effective praise. The same consultant also worked with the child on basic social skills in how to get along with others and control impulses to get angry. The result is that this child was able to earn Student of the month honors for the month of January.
- The Mental Health Consultant at another elementary school was called to perform a home visit for a difficult child that was re-entering regular education after having been in several residential placements in another county. She was reuniting with parents who were able to regain custody after having completed court mandated programs to ensure their ability to effectively provide for the child's basic needs. This child was given to truancy and disrespectful behavior in the class. Her testing indicated that she was at grade level and was capable of performing well. Through work with the teacher and child, this student is now attending class regularly and has not received any disciplinary action within the past month. While work is ongoing, the initial results appear promising.

Technological Needs Projects (TN)

The overarching goal of technological needs projects is to support modernization of information systems and increase consumer/family empowerment by providing the tools for secure access to health and wellness information. These projects will result in improvements in the quality of care, operational efficiency, coordination of care, and cost effectiveness.

Stanislaus has four projects in various stages of implementation, 1) Electronic Health Record and 2) Consumer Family Access to Computing Resources, 3) Electronic Data Warehouse, and 4) Electronic Document Imaging. Service recipients, family members, and contract organizations were and continue to be involved in ongoing processes related to development, planning, and implementation of projects.

Electronic Health Record System (a.k.a. Anasazi) implementation is a massive endeavor that reaches to every part of BHRS' service system. All support areas (such as billing) are affected and all face-to-face contacts between service recipients and providers are touched by this new method of keeping health records confidential and accessible. In FY11-12, the department and contract services providers "went live" with the Practice Management and Progress Notes components of the Electronic Health Record, which involved training over 280 staff on the system. The previous information management system ("Insyst") is now used only for activity prior to 2012. Preparation for the next phases of implementation is underway. These phases include electronic assessment and treatment planning, e-prescribing and Managed Care operations.

Consumer Family Access to Computing Resources Project is providing computers, printers, and access to the Internet for service recipients in service locations throughout the county since December 2010. Two Technicians were hired and trained in FY11-12, and rollout of devices continued. The Technicians are providing support to consumers and family members through the use of technology including assisting in job search, resume creation, and basic computer skill instruction and assistance. Based on input from consumers and programs (e.g., the Youth Advisory Council at Josie's Place), additional computer and networking resources were provided in various locations in the community, and services were adjusted to better serve the identified needs.

Electronic Data Warehouse is a project aimed at developing and deploying a robust infrastructure for extracting data from the Electronic Health Record, for the purpose of managing and reporting on that data. In FY11-12, scoping of hardware and software was completed and some data began to be extracted from the Electronic Health Record.

Electronic Document Imaging is a project aimed at transferring the existing warehouse of paper medical records to more readily accessible electronic files. In FY11-12, hardware and software for the project requirements were developed and limited testing began on scanning hardware.

In the FY12-13 MHSA Plan Update and stakeholder planning process, an expansion was recommended to extend the functionality of the Electronic Health Record System Project by purchasing electronic signature pads and mobile devices. This expansion, effective February 2013, will allow Electronic Health Record entries from remote locations, a necessary step to advancing the use of electronic records in the behavioral health service system.

Project Budget & Expenditures	
FY11/12 Total Requested MHSA Funds	**FY11/12 MHSA Funds Expended**
$2,123,671	**$970,337***

*Unexpended funds in the FY are due to operating reserve, salary savings, and delays in equipment purchases due to bid processes.

Highlights

"Go-live" of Anasazi Practice Management and Progress Notes was completed (from a systems perspective) in January, 2012. Staff that provides direct client services completed training to understand the features provided by Anasazi for managing medical charting and usage of electronic health records. Regular EHR newsletters and "Lunch and Learn" sessions were also conducted to help keep staff informed about the system.

Rather than hiring consultants to manage the training of end-users, BHRS and contract service providers were selected to perform the role of "SuperUser." Employing a "Train the Trainer" approach, these SuperUsers then took on the task of training all required staff on the system.
All required staff were able to become proficient in Anasazi. While the department had set aside contingency funds against an expectation of reduced revenues related to lost productivity during implementation, there was not a significant revenue decrease realized.

Technicians for Consumer Family Access to Computing Resources have begun assisting consumers and family members with tasks such as personal email accounts, filling out student applications, and filing for educational financial aid on the computers and via access provided as a part of this project.

Challenges

There are uncertainties about the claiming and reporting of healthcare services due to the impact of healthcare reform, increased State and Federal mandates, and evolving standards. Changes in standards have also been challenging such as HIPAA 5010 implementation, which requires new changes to software, systems, and procedures for providers to bill Medicare for services provided. The implementation of the tenth revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) will require the confrontation of code changes, new policies, and guidelines for practices. Healthcare reform and its "Meaningful Use" requirements will continue to be a challenge. Integration and interoperability of Health and Mental Health systems is a stated objective of Healthcare reform. In addition, BHRS will need to continue to comply with the Health Insurance Portability and Accountability Act and the Code of Federal Relations Title 42, Part 2 privacy and security mandates, which is the focus of our endeavors in utilizing these MHSA funds. No matter which direction technological changes drive us we must remain mindful that the customers are the focus of our endeavors.

Program Results Shown in RBA Framework	
• 288 staff were trained in Anasazi Practice Management • 221 staff were trained in Anasazi Progress Notes • 16 Practice Management and 12 Progress Note SuperUsers were trained • Newsletters were created monthly • Lunch and Learns were conducted monthly.	**How Much?**
• Only 4% of staff attended Anasazi training more than once prior to going Live in system, attesting to the efficacy of the training • 100% of required staff went Live in Anasazi in FY11-12 • Revenues related to service delivery were not significantly impacted. • All trainings were conducted by SuperUsers.	**How Well?**
• SuperUsers continue to provide support in their departments as resident experts on the system; improving each System of Care's ability to support itself. • Unfortunately, satisfaction surveys focused on Anasazi EHR training were not conducted during training. This will be rectified for future sessions.	**Is Anyone Better Off?**
How Lives Are Changing	
The Implementation of the Anasazi system was anticipated to be a challenging effort that would require leadership and determination on the part of many people. An example of this type of implementation challenge is to identify "SuperUsers" who are willing and able to learn quickly to assist with working out challenges for general users throughout the system. "SuperUsers" can be anyone who will use the system in their work; e.g. administrative clerks, accountants, mental health clinicians. Because the role of "SuperUsers" is so critical, leadership and passion for the process is vital. BHRS is fortunate to have had a number of people who self-identified and took on the role of "SuperUsers" with enthusiasm. The commitment by the "SuperUsers" afforded BHRS with the infrastructure to "go-live" with Anasazi including the training and support of over 280 staff. Thanks to these "SuperUsers" who stepped-up, the department is better off with all required staff now using the electronic health record.	

Innovation (INN)

The primary goal of MHSA innovation projects is learning and contributing to practice in the mental health and behavioral health. Services may be delivered as a means to achieve the learning object proposed but Innovation funds may not be used to sustain the service after the learning project is completed.

Innovation funding is unique and intended for projects that will focus on and demonstrate ways to increase access to underserved groups, increase the quality of services including better outcomes, promote interagency collaboration, and increase access to services. Additionally, innovation projects are expected to contribute to learning in the mental health field by introducing new approaches, making a change to an existing mental health practice or introducing a new application of a promising community-driven approach that has been successful in a non-mental health context.

Innovation projects are developed through input from community planning processes and are reflective of the unmet need identified by inclusive and diverse stakeholder input. Project ideas typically begin with identification of dilemmas, some of which are long-standing, in the behavioral health system. Innovation funding makes it possible to try out new approaches, gather data, define and measure the success of the new approach or practice without taking funds away from other necessary services.

Since January 2010, Stanislaus County has conducted two rounds of community planning for innovation funding that resulted in establishment of 10 new projects. The first round of planning resulted in one project with learning goals related to stakeholder and agency partner participation in understanding public funding processes and how community may contribute to decision-making. The project is entitled: Evolving a Community-Owned Behavioral Health System of Supports and Services. Concluding in FY12-13, the final report, starting on page 126, is included in this annual update.

The second round of planning began with the BHRS leadership team's intention to bring out ideas for projects in behavioral health that are unique to efforts in our county commitment to community capacity building and advancement of non-stigmatizing early intervention approaches. The process began with stakeholder input in the spring of 2010. Input was solicited to identify areas that we (BHRS and our community) could significantly move forward our learning in behavioral health. By identifying these areas named "learning edges" the second round of projects was achieved in Stanislaus County.

To ensure broad community participation, educational workshops were conducted throughout the County in preparation for the Request for Proposal process that ultimately resulted in selection and funding of nine (9) new Innovation projects. These nine community-based projects were approved in August 2011 and began implementation in FY11-12. Projects are operated by six unique community-based organizations and one county agency. Progress reports on each project are included in this annual update starting on page 134.

Planning and preparation for a 3rd Round of Innovation Projects was conducted in FY12-13 and resulted in two (2) new projects proposed to begin in FY13-14. The projects; Stanislaus County Wisdom Transformation Initiative and Garden Gate Innovative Respite are included starting on page 159 and 172 respectively. These new projects are subject to prior approval by the MHSOAC prior to implementation.

Focused planning for future Innovation projects is anticipated to begin no later than FY15-16. Contributing elements to the next innovation projects will include, but not be limited to: 1) lessons learned from earlier projects, 2) funds available, and 3) emergence of new opportunities to advance learning identified through community input, 4) health care reform and other legislative influences on the behavioral health care system.

INN Budget & Expenditures	
FY11/12 Total Request MHSA Funds	**FY 11/12 MHSA Funds Expended**
$846,247	**$556,848***

*Unexpended funds in the FY are due to operating reserve, salary and other cost savings, and delays in implementation.

INN01 - Evolving a Community-Owned Behavioral Health System of Supports and Services

FINAL REPORT

This report is based on the instructions from MHSOAC:

Each county must provide the MHSOAC a final report upon completion of the project. The final report may be included in the County's annual update or its integrated Three-Year Plan, whichever is due during the year the project is completed; the county does not have to provide a separate report. The Final Innovation Report will be posted on the MHSOAC website from which others can learn about the project and its findings.

Issue Addressed

Stanislaus County Behavioral Health system, like all service systems in California face an adaptive dilemma of rapidly declining revenues, steadily increasing costs, and rapidly increasing need. We describe this dilemma as adaptive because we believe we cannot resolve these challenges *and* improve behavioral health outcomes through traditional strategies for managing budget shortfalls.

This innovation project, operated by BHRS, was designed to achieve a high level of stakeholder engagement that would develop and deepen as the project was implemented. BHRS would learn as would stakeholder participants what is needed to design processes that enable community and county partners to join BHRS leaders in developing an integrated, financially sustainable behavioral health system committed to results.

The project was intended to build upon our work over the past five years to expand the Department's role from providing services to individuals who meet eligibility critieria, to implementing multiple strategies to increase the capacity of communities to promote the behavioral health and emotional well-being of their members independent of services.

Description of Project

The description includes the purpose(s) and expected outcome.

Focused on promoting interagency (and community) collaboration, this 3 year project (FY10-11, FY11-12 & FY12-13) was designed to explore new approaches to stakeholder processes that would impact the following areas:

1. Governance and organizational processes and procedures
2. Educational efforts for service providers, community leaders, and other traditional and non-traditional stakeholders
3. Planning processes, and policy and system development processes

The processes were designed and implemented for stakeholder engagement and collaborative decision-making related to BHRS budgets constituted a new practice or approach. Instead of reviewing the Alcohol and Other Drugs (AOD) budget and identifying cuts, we took the approach to identify what services and programs to fund.

This effort began by creating an expansive stakeholder process to build consensus among community and countywide stakeholders about how to address the emerging budget shortfalls across both the mental health and the alcohol and other drug (AOD) budgets, and how to leverage all available resources to improve behavioral health outcomes across the county.

It was understood that any recommendations that emerge from a stakeholder budget process must be consistent with regulatory and statutory requirements governing County budgets, as well as the Department's (and others') ability to implement and manage the proposed changes. The processes designed through this project were grounded in these requirements and understandings. The intention was not to relinquish BHRS statutory and regulatory authority; rather, the intention was to help BHRS leaders and partners build shared understanding and ownership of the BHRS budget, and the array of other community, private, and county resources available to improve residents' behavioral health and emotional well-being. We believe such shared understanding and ownership are essential if we are to fashion long-term collaborative responses to the adaptive dilemma we now face as a behavioral health system.

Analysis of the Effectiveness of Project

The analysis is from data collected and the perspective of project participants. It includes at least the following information:

- **Any changes or modifications made during implementation**
- **How it affected those who used it**

Approved in September 2010, implementation began in FY10-11 with a significant amount of preparation prior to starting stakeholder meetings in November 2010. Part of the learning objective involved developing effective ways to inform stakeholders of the complexities of numerous funding streams at BHRS, regulations for use of categorical funds, flexible funds, and contingency planning required in public agencies.

The initial phase of the project addressed preparation for and design of stakeholder processes to achieve essential revisions to the Community Services and Supports (CSS) plan. The CSS plan revision process involved preliminary education about public mental health funding streams as well as revisions to the already approved CSS plan. The learning project began in earnest with the AOD budget meetings in October 2010.

Participating stakeholder groups included people in recovery, family members, community leaders, faith-based leaders, non-profit providers, private sector providers of behavioral health services, BHRS staff members, union members, BHRS Senior Leadership Team (SLT) members, senior leaders from other county agencies, representatives from the County CEO's office, representatives from the Advisory Board on Substance Abuse Programs (ABSAP) and the Mental Health Board, and others.

Each stakeholder group selected delegates and alternates to represent them in this process. In addition to these delegates and alternates, a number of organizations were invited to participate in the process but could not or chose not to do so. These organizations included: Doctors Medical Center; Emanuel Medical Center; Memorial Center Hospital; the City of Modesto; Oak Valley Hospital; the Parole Office; and the Promotoras. A number of observers attended and participated in the open conversations and small group efforts, including senior leaders and staff members from BHRS, Health Services Agency staff members, the Living Center, Valley Recovery Resources, and others. Eight (8) meetings were held between November 30, 2010 and March 2, 2011 and one final closure meeting in September 2011. Average attendance at these sessions was well over 60 people including delegates, alternates, and observers.

Everyone who participated in this process came to understand the impact that the projected budget cuts would have on individuals and families who struggle with alcohol and other drug issues. There would be fewer services and supports in a system that has suffered repeated budget cuts over the past several years. These cuts mean that a significant number of people, many in crisis, will likely not be able to get services that would help.

All participants agree that the process has generated far better recommendations than would have emerged had the process not taken place. Moreover, the process revealed an array of community-based, faith-based, private sector, and other supports and services beyond those funded by BHRS. The process also made visible the passion and commitment of BHRS staff and the many community and other partners who support people that suffer with addictions and other alcohol and drug-related issues.

Following these early sessions, delegates worked to develop principles to guide their deliberations. They then reviewed cost and service level scenarios for various programs, and worked through small and large group processes to develop multiple iterations of their recommendations. After several rounds of deliberations, delegates engaged in a series of conversations to understand where they had agreement and where they had divergence. Ultimately, delegates approved by consensus the set of recommendations that were sent to the BHRS Senior Leadership Team members who formally decided what to recommend to the County CEO and Board of Supervisors.

What was Learned

This innovation project was designed with three (3) phases to be accomplished. The first phase of learning began in October 2010 with BHRS Alcohol and Other Drug (AOD) budget. This first effort allowed us to test various process designs aimed at educating community members and stakeholders about budget and program design issues within the realities of regulatory requirements and revenue constraints. The first lessons learned report was produced after the AOD budget process was complete.

What follows is a bullet point summary of the Lessons Learned from the AOD Stakeholder process.

The purpose for this analysis is threefold:

1. To provide a focus for the planning team's reflections for further refining the next stakeholder process,

2. To document the lessons learned from the first year of the project and

3. To offer information to others who may seek to replicate this type of project and demonstrate additional learning focused on promoting interagency (and community) collaboration related to governance and organizational processes and procedures, educational efforts for service providers, community leaders, and other stakeholders in planning processes, and policy and system development processes.

The data for this summary emerged from feedback forms completed by participants at the end of each delegates meeting, assessment forms completed by participants during the final meeting of the process, and notes taken during de-briefing meetings with BHRS staff. The data is organized into three sections: Continue, Start, and Stop. The *continue* section includes recommendations for what practices and orientations in the first process should be continued in the next process. The *start* section includes recommendations for what practices and orientations should be started in the next process that were not part of the first process. The *stop or change* section includes recommendations

for what practices and orientations should not be continued, or should be changed, from the first process in the next process.

CONTINUE: Continue these things from the first process into the next process	
Practice • Experience	**Details**
1. Stakeholder Education	• The AOD stakeholder process proceeded through five stages: orientation, education, deliberation, decision-making, and process assessment. • The orientation and education phases focused on: the outline of the stakeholder process; the role of delegates, alternates, and observers; an explanation of the AOD budget, including the particular parts of the budget affected by the reduction; the array of programs funded in the AOD budget that potentially would be affected by the reductions; and private sector, faith-based, and community resources available to support people struggling with AOD issues. • Participants consistently reported high levels of understanding of the content presented. As the process moved from education to deliberation to decision-making, participants reported feeling confident in their ability to address effectively the issues before them.
2. Sense of Community and Genuine Engagement	• Participants reported experiencing high degrees of trust, safety, and mutual respect in the process. • Many participants commented on the positive impact of SLT member participation in the process. SLT members' engagement was a critical success factor. Had the SLT members not participated, the process may not have been perceived as authentic. Moreover, without this engagement SLT members may not have fully understood the "why" behind the stakeholder recommendations.
3. SLT and staff's willingness to embody and reinforce leadership development	• Participants' feedback was taken seriously to make changes to key processes as needed. We also discovered that as the group encountered a *learning edge* that could not be planned for ahead of time, it was important to role model the spirit of not knowing and mutual learning but without unraveling key agreements achieved to date with the stakeholders or undermining their confidence in the process. • The staff planning and de-briefing meetings enabled the process to be modified as needed in a timely manner.
4. Processes for achieving consensus and collective learning	• Participants' feedback described the process as successfully helping them to achieve collective learning and develop consensus recommendations. • Process tools and concepts mentioned included: small group table dialogue, scallop principle, gradients of agreement, not-knowing and non-attachment, the way questions were facilitated and the repeated opportunities for clarification and feedback.
5. Processes and structures that foster focused conversation	• Many participants attributed the positive results to a clear, disciplined process and structure that allowed the group to remain focused on task. • Facilitation points identified included: use of microphone runners, clear power point slides, informative handouts, keeping cross-talk to a minimum, forming sub-groups to work on details, recapping

	last meeting at start of a meeting (though some participants wanted this practice to be reduced over time), clarification after each section by providing context for how each element or piece of work fit into the whole, feedback forms at the end of each meeting, use of name tags with affiliation, and formalization of roles: delegates, alternates, observers.
6. Dedicated staff for managing logistics	• Many participants offered enthusiastic appreciation for BHRS staff who helped with meeting logistics.

START: Consider starting these things in the next process that were not done (or not done as much) during the first process	
Practice • Experience	**Details**
1. Stakeholder accountability to constituency groups	• Reinforce the role of 2-way communication between delegates and their constituency. • Develop structures and processes to facilitate this communication process between delegates and their constituencies: e.g. 1-page summary documents, asking delegates to report out their conversations with their constituencies, making on-line resources available, providing more time in between meetings
2. Develop a pool of staff and community facilitators	• These facilitators can be a local resource to support workgroup meetings and small group dialogues within the large group process.
3. Stakeholder representation	• Increase outreach to invite more participation by people who receive services, community leaders, including leaders from underserved communities, private providers, and others. • Consider providing support for transportation. • Be open to providing child care if requested by participants. • Announce meetings well in advance to encourage participation. • Do more to bring front-line staff along in this process. They may not see the process as relevant to their day-to-day responsibilities.
4. Clarification of staff members' role in the process	• Several staff members reported feeling confused and divided in their loyalty when an issue emerged that also affected them personally (e.g. a staff member who was also a member of a community, a faith-based organization, or self-help group). Explore this issue with staff members and provide appropriate clarification.
5. Data development agenda for budgets and programs	• Work to document known funding restrictions before stakeholder meetings • Work to develop (or improve existing) program performance data where possible. Note: many programs are currently not required to report outcome data. As BHRS moves to implement Results-based Accountability across all programs, this data will become increasingly available. BHRS will share what is available in each subsequent stakeholder process.

6. Implementation issues	• Be more explicit about implementation steps that will follow budget approval—e.g. how stakeholders can participate in planning meetings regarding implementation of recommendations. • Identify and communicate about long-term issues that may need to be addressed outside of the stakeholder budget process—e.g., budget changes could result in reduction of services to mono-lingual clients, if so, what structures can be created to address this system issue?
7. Leadership development	• Increase the integration of leadership development modules into the process to: • Support SLT members in planning for and presenting content and process without overwhelming participants or unraveling the process. • Help delegates feel more comfortable with emergent issues that cannot be planned-for ahead of time e.g., restrictions on Substance Abuse Prevention and Treatment (SAPT) funding. • Explore creating a *3rd side process* to help participants see the whole when divergence arises, and to become aware of more of the data as it arises through the deliberations. This is based on the work of Bill Ury, co-author of *Getting to Yes,* and involves a small group of people acting as formal observers when substantial divergence arises in the process. These observers are invited at strategic intervals to offer reflections to the group designed to help delegates see patterns of action and opportunities for convergence.
8. Meeting logistics	Participant feedback and staff debriefing notes included the following suggestions: • Use a brighter projector and larger fonts • Have at least 2 microphone with runners • Encourage people to sit at different tables from session to session • Create a more accessible on-line resources—e.g., budget tutorials, summary of key concepts and terms, short meeting summaries—and actively promote these resources • Consider a more central meeting location, or rotating locations

STOP OR CHANGE: Consider not doing these things in the next process	
Item	**Description**
1. Change the length and/or timing of meetings	• Some participants suggested scheduling the meetings to end at 8:00 or 8:30 p.m.; others requested exploring options for holding the meetings during the day.
2. Number of BHRS staff as delegates	• Some participants commented on the large number of BHRS staff who were formal delegates. Others felt given the complexity of issues, and the impact on Department programs, the number of BHRS staff participating was critical. The interest going forward is to ensure that delegates reflect the diversity of perspectives needed for effective deliberations.
3. Food	• Participant feedback regularly included comments related to the food being served. Participants appreciated having meals served, particularly given the length of the meetings. Some people expressed displeasure with one of the meal providers. Participants regularly expressed appreciation when we varied the food provider—e.g., with

	certain retail meal sources, doing so added complexity to the meeting preparations.

Recommend this Project to Others?

Recommend whether the project would be recommended for others to replicate, including any lessons learned in implementation, with a comment about its cost effectiveness

This project was proposed as a three-year effort:

1. During the first year of the project, the proposal was to develop the design for the stakeholder process, and begin limited tests of this design focused on essential revisions to our Community Services and Supports (CSS) and the FY 2011-12 AOD budgets. These first efforts will allow us to test various process designs aimed at educating community members and stakeholders about budget and program design issues within the realities of regulatory requirements and revenue constraints. At the end of the first year, we will produced our first lessons learned document.
2. During the second year, we proposed to fully implement the stakeholder process, focused on the entire FY 2012-13 BHRS budget, including the MHSA, core mental health, co-occurring and AOD budgets. At the end of the second year, we planned to assess the process, make revisions, and prepare for the third year. A lessons learned document was proposed.
3. During the third year, we proposed to implement a revised stakeholder process focused on the FY 2013-14 mental health and AOD budgets. At the end of this process, we proposed to assess the project and decide whether to continue the effort without Innovation funding. A final lessons learned document was proposed.

The first year of this project was considered to be a successful learning experience. A direct expression of the commitments to fiscal sustainability and community capacity-building, this project explored how to develop deeper shared ownership of the department's budget among community stakeholders—including people who receive services, family members, and community leaders—and how to engage stakeholders as partners in addressing the consequences of budget shortfalls. It allowed BHRS to test various process designs aimed at educating community members and stakeholders about budget and program design issues within the realities of regulatory requirements and revenue constraints; a significant amount of detailed information and data. It also tested the amount of BHRS staff resources necessary to conduct extensive presentation of a vast and complex amount of information about how government funding works and program service data.

The experience of implementing the AOD budget phase revealed the passion and commitment of BHRS staff and the many community and other partners who support people who suffer with addictions and other behavioral health/alcohol and drug-related issues.

The final meeting to conclude the AOD budget process phase was convened in September 2011 ten (10) months after the process began in November 2010. At the end, all participants agreed that the process generated far better recommendations than would have emerged had the process not taken place. Moreover, the process revealed an array of community-based, faith-based, private sector, and other supports and services beyond those funded by BHRS.

The success of the project to that point, led the BHRS leadership team to consider the learning that had occurred and deliberate the cost/benefit of continuing. Consensus was achieved that three key elements needed to be developed before the process would move to the broader and even more detailed scope of all BHRS budgets. Three key elements were the focus of developed: 1) More organizational work needed to happen to better support the next iteration of the process, 2) Changes

at the state budget process would need to be better resolved and 3) Statewide changes in MHSA statute/guidelines would need to be better resolved.

Ultimately, BHRS leadership made the decision to end the project early at the same time acknowledging that the project successfully demonstrated how community partners and department leaders had discerned and acted together to responsibly steward the behavioral health system in the midst of profound challenges.

In FY11-12, energies began to be directed toward launching an extensive and ongoing organizational effort to transform the county's behavioral health services system. Four commitments define this transformation effort: a commitment to results; a commitment to community capacity-building; a commitment to fiscal sustainability; and a commitment to leadership development. Taken together, these four commitments and related practices are called the Wisdom Transformation framework.

Continue the Project Under a Different Funding Source?

Whether the project will be continued under a different funding source:

- **If not, why not?**
- **If yes, what is the source for new, ongoing funding?**

The project as developed and approved is not proposed to continue under other funding however, many of the lessons learned will be incorporated into future organizational processes and interagency collaborations in the future.

Key lessons learned for other organizations seeking to further learning in this arena:

- The project added value to the behavioral health system, revealing an array of community-based, faith-based, private sector, and other supports and services beyond those funded by BHRS. Additionally, stakeholders and BHRS leaders worked to better integrate and leverage these supports and services to mitigate the impact of the budget cuts.
- This was an excellent process that was very time- and energy-intensive for staff and participants alike. The specter of doing such a project for the entire behavioral health budget was believed to be overwhelming to current resources.
- This process pushed the organization for near absolute budget clarity and transparency – for this process to be effective the will to work for the clarity and transparency has to really be a "given" in values to the organization and to the county. The process can so easily go sideways without good information and the willingness to be transparent.
- The volatile and ever-changing funding structure and other influences such as, Realignment and Health Care Reform make this kind of budget process even more complex but arguably even more important in terms of having community ownership and buy-in of how public services are delivered.
- A key lesson learned was that if community members and partner providers were invited, resourced, and supported over time, they are more than willing to participate and take ownership of shared problems and high quality solutions.

Materials Developed to Communicate Lessons Learned and Project Results

A description or links to any reports, manuals, CDs or DVDs or videos, or other materials that have been developed and will be used to communicate lessons learned and project results

This report will be posted at www.stanislausmhsa.com. No other reports, manuals, or materials were developed.

Arts for Freedom (INN-02)

Operated by Peer Recovery Arts Project

Arts for Freedom project is 3 year project operated by Peer Recovery Arts Project focused on increasing quality of services, including better outcomes for individuals of all ages.

The project has a mission to learn and demonstrate how an emphasis on what people *can* do rather than what they *cannot* do through artistic expression will reduce stigma so that people can be identified as something other than their illness or diagnosis.

The learning goals of Arts for Freedom are intended to ask the following question: Would building a welcoming and inclusive community that provides opportunity for those with a mental illness to step away from and not *be* their illness while working (and learning) side by side with others, increase self-esteem, promote recovery, reduce stigma, and contribute to healthier and more productive members of the community who are therefore less dependent on the mental health services system?

Arts for Freedom will be based in a conveniently located, small, multipurpose facility that serves as office, free public art gallery, art consignment shop, classroom, meeting space, clearinghouse for participants to volunteer for and be connected with city- and county-wide projects, and general gathering area for consumers, family members and other community members.

The project will help support and accelerate county-wide transformation by connecting people receiving services to community-based supports.

Highlights

This project was one of nine community-based innovation projects begun in Stanislaus County in FY11-12. Approval of projects occurred in August and the first phase of implementation was for BHRS to develop provider contracts with the organizations who would be implementing the projects. Once contracts were established, Initial start-up activities began immediately and continued through-out the first 6 months of each project. Evaluation tools for measurement of learning objects were developed and refined during start-up phase of the project.

Arts for Freedom was contracted and funded to begin November 1, 2011. Implementation activities through June 30, 2012 are reported in this annual update.

Many aspects of this fledgling organization were developed and a location was identified in a downtown Modesto for office and art gallery space. Immediately the project began to schedule events, attract artists and develop positive working relationships with other downtown merchants. Participation in Arts for Freedom events includes an ethnically diverse population of individuals of all ages, genders and self-identified mental health consumers and family members of mental health consumers. Over 1500 artists, volunteers and other participants attended events and engaged with the project in the first six (6) months.

Early learning of start-up phase includes but not limited to:

- The gallery attracts consumers and family members from all regions of the county, all age groups for the purpose of viewing, showing and creating art.

- Downtown merchants warmly welcomed the Arts for Freedom project and consider it a business that adds value to the downtown environment
- Project management and Board members had a sharp learning curve with budgeting, payroll and other operational features of the project

Challenges

Innovation presents a challenge, as a unique part of the Mental Health Services Act, to keep the focus on learning. Typically, in behavioral health programs, the focus is on services. This focus presented its own challenges for each new innovation project.

Additional challenges are unique to each project and are due to circumstances, need for infrastructure, staff and development of evaluation approaches. Taking the time initially to ensure that projects are appropriately set-up to learn was found to be a critical part of long term success.

Arts for Freedom's early challenges included but were not limited to:

- Cleaning and remodeling of gallery space was more costly than anticipated.
- Organizational and program start-up was more time and effort consuming than anticipated
- Cost of Worker's Compensation to this start-up organization was more costly than anticipated.

Each challenge was met and overcome by the commitment of the Board of Directors, Executive Director, staff and numerous volunteers who devoted extra time and effort.

Program Results Shown in RBA Framework	
• 1 Chamber of Commerce Ribbon cutting ceremony • 1,517 individuals participated in Arts for Freedom activities • 2 art supporting organizations used the gallery for events • First community gathering/event was conducted during which 200 bowls were painted at Empty Bowls Benefit for Second Harvest Food Bank • 6 art classes offered to various ages • 25 merchants and organizations established relationship • 150 artists signed up to exhibit art in the gallery • 75 artists exhibited art in the gallery • 11 artists sold art through the gallery	**How Much?**
• 50% of artists (75/150) who signed up to exhibit art have had exhibits • 15% of artists (11/75) showing art also sold art	**How Well?**
• Not enough implementation time or data collected to measure yet	**Is Anyone Better Off?**

How Lives are Changing

The Arts for Freedom Program's first fundraiser was kicked off February 24, 2012, to benefit 48 local artists. This project encourages friends, family and community members to sponsor a known artist or an artist whose name is selected from the fundraising bulletin board, at the 1222 J Street gallery in Modesto. There are four age groups of artists you may sponsor: Child/Youth (ages 1-13), Youth (ages 14-22), Adult (ages 23-58), and Older Adult (age 59 & up).

On May 21, 2012, seven members of the community service-oriented youth group, Community Youth Connections (CYC), met with Founder and CEO of the Peer Recovery Art Project Gallery/Arts for Freedom, and a representative of Stanislaus County Family Court. The youth group is working with the Modesto Court House to revamp their Dependency Waiting Room and make it more teen friendly. With the goal of making the waiting room a more beautiful, friendly space for youth, they will be partnering with youth artists and the innovation project to create an inspirational mural for the room, as well as creating a space in the room to display art created by youth.

Beth & Joanna - Friends in Recovery (INN-03)

Operated by National Alliance for Mental Illness

Beth and Joanna – Friends in Recovery Project is a 3 year project operated by National Alliance for Mental Illness (NAMI) and focused on increasing quality of services including better outcomes for consumers of mental health services.

This project uses a model borrowed from other disciplines in which two individuals are paired in a mentor/mentee relationship. Mentees are individuals who have mental illness and/or co-occurring substance issues, are isolated and need/seek support. Pals or mentors are someone who is successfully utilizing recovery practices related to their mental illness and/or co-occurring substance issues.

This project will seek to demonstrate that peer support can be effective when offered in the community and parallel to treatment as a short term mentor/mentee relationship. Two essential outcomes are at the center of this demonstration project: 1) that this mentoring approach enhances recovery in ways that can be documented, and 2) which elements of the program such as particular dimensions of the mentoring relationship, training, and support for the mentoring relationship, etc. made the difference and therefore should be sustained.

The project will help support and accelerate county-wide transformation by connecting people receiving services to community-based supports.

Highlights

This project was one of nine community-based innovation projects begun in Stanislaus County in FY11-12. Approval of projects occurred in August and the first phase of implementation was for BHRS to develop provider contracts with the organizations who would be implementing the projects. Once contracts were established, Initial start-up activities began immediately and continued through-out the first 6 months of each project. Evaluation tools for measurement of learning objects were developed and refined during start-up phase of the project.

Beth and Joanna-Friends in Recovery Project was contracted and funded to begin November 15, 2011. Implementation activities through June 30, 2012 are reported in this annual update.

As a small local non-profit organization, NAMI – Stanislaus traditionally has run on a significant amount of volunteer energy with little overhead expense and has along history of resourceful grass roots dedication. Selection of their Innovation project proposal brought start-up that, though anticipated, were challenging.

Start-up activities included development of new intake procedures and curriculum, scheduling of initial screening sessions, orientation workshops, and recruitment of volunteers. Organizational start up activities involved refinement of bookkeeping software to meet cost report requirements, as well as, understanding contractual requirements related to program activity reporting requirements with a focus on evaluation of learning.
Early learning of start-up phase includes but not limited to:

- Intake and screening is critical to determining the comfort level for participation of mentors

- Successful mentor/mentee relationships start best when the mentee participated in the choice of mentor
- Mentors may be act as advocates of mentees in some situations that are challenging to the mentee
- Mentors may need ongoing support and training

Challenges

Innovation presents a challenge, as a unique part of the Mental Health Services Act, to keep the focus on learning. Typically, in behavioral health programs, the focus is on services. This focus presented its own challenges for each new innovation project.

Additional challenges are unique to each project and are due to circumstances, need for infrastructure, staff and development of evaluation approaches. Taking the time initially to ensure that projects are appropriately set-up to learn was found to be a critical part of long term success.

Beth and Joanna Project's early challenges included but were not limited to:

- Organizational and program start-up activities were challenging to this small organization
- A skilled evaluator's input is needed to assist in development of surveys.
- Issues related to trust to be addressed in matching mentors/mentees

Program Results Shown in RBA Framework	
• 1 Project Coordinator identified • 1 Consultant Evaluator identified • 1 intake form developed • 4 Orientation Workshops conducted • 22 individuals attended the orientation workshops • 5 Mentors recruited and trained • 3 group social events were held with mentor/mentee pairs • 1 Survey developed to focus on "recovery experience"	**How Much?**
• Not enough implementation time or data collected to measure yet	**How Well?**
• Not enough implementation time or data collected to measure yet	**Is Anyone Better Off?**
How Lives Are Changing	
Innovation projects, by their nature, offer opportunities for learning at many levels; staff, participants, and community. Self- determination and recovery orientation are at the heart of this mentoring project. Early-on participants in the Friends in Recovery Project gave significant input that shaped how the project would develop and be implemented. Mentors and mentees contributed their input and lived experience perspectives on issues such as boundaries, safety, and accountability: e.g. how to match mentors and mentees, whether mentors/mentees should attend workshops together, how much advocacy is appropriate for a mentor to offer to mentees and what mentors should do if the mentee has a crisis.	

Building Connections for Troubled Youth (INN-04)

Operated by Ceres Partnership for Health Families/Center for Human Services

Building Support Systems for Troubled Youth Project is 2 year project operated by Ceres Partnership for Healthy Families and focused on increasing the quality of service and creating better outcomes for troubled youth through a family resource center-based mentoring program that integrates school, community, and family support systems to increase developmental assets in troubled youth ages 7-11 yrs. The project has a secondary focus on promotion of interagency collaboration to increase quality of service and better outcomes.

This project collaboration will seek to learn and demonstrate new approaches to supporting families with pre-adolescent aged youth who are experiencing behavioral struggles are at risk for higher incidences of involvement in substance abuse and other health/mental health compromising risk behaviors but not necessarily able to access the traditional mental health service system – nor do they necessarily need it. The community-based family resource center will take the lead and coordinate project activity, local school administrators will assist in identifying at-risk youth, share the use of school facilities and allow the use of teacher and/or administrator staff time to participate and local businesses partners will provide incentives and services to participating children and families. If proven effective, the project could be replicated in other communities in Stanislaus County.

By focus on building developmental assets early the project can demonstrate ways for youth to avoid lifelong involvement with publicly funded systems.

The project will help support and accelerate county-wide transformation by addressing the learning priority of improving the well-being of children.

Highlights

This project was one of nine community-based innovation projects begun in Stanislaus County in FY11-12. Approval of projects occurred in August and the first phase of implementation was for BHRS to develop provider contracts with the organizations who would be implementing the projects. Once contracts were established, Initial start-up activities began immediately and continued through-out the first 6 months of each project. Evaluation tools for measurement of learning objects were developed and refined during start-up phase of the project.

Center for Human Services on behalf of Ceres Partnership for Health Families was contracted and funded to begin Building Support Systems for Troubled Youth Project on November 1, 2011. Implementation activities through June 30, 2012 are reported in this annual update.

This unique project is implemented by a Family Resource Center that is a widely known and deeply trusted resource in the Ceres community. As implementation began and presentations in schools were welcomed the project adopted the name of “Youth Guide Program”.

Community agency partners received information about the project to assist with referrals of youth into the program, as well as, for the program to refer youth and families with additional treatment needs that are identified. Partners include but are not limited to: Ceres Unified School District, Ceres

Fire Department, Ceres Police Department, Center for Human Services, Sierra Vista Child and Family Services, and Recovery Services when drug and alcohol treatment issues are present in the family.

Challenges

Innovation presents a challenge, as a unique part of the Mental Health Services Act, to keep the focus on learning. Typically, in behavioral health programs, the focus is on services. This focus presented its own challenges for each new innovation project as well as with BHRS staff.

Certain challenges are unique to each project and are due to circumstances, need for infrastructure, staff and development of evaluation approaches. Taking the time initially to ensure that projects are appropriately set-up to learn was found to be a critical part of long term success.

Youth Guide Project's early challenges included but were not limited to:

- The end of school year occurred 6 months into start-up. Project efforts were directed toward partner agency education, community support and preparation for the next school year.

Very few issues occurred in the implementation processes that were considered a significant challenge. School, community and agency support for the project was aligned and early implementation was seamless.

Program Results Shown in RBA Framework	
• 1 Project Coordinator identified • 2 Project Mentor staff identified • 1 Volunteer Mentor identified • 1 Project Manager identified • 1 Project Evaluator identified • 1 student assessment tool developed and piloted • 1 family strength based assessment tool developed and piloted • 1 contact tracking form developed • 1 parent education curriculum identified • 15 referrals received from schools • 3 youth began participation • 12 family members began participation	**How Much?**
• Not enough implementation time or data collected to measure yet	**How Well?**
• Not enough implementation time or data collected to measure yet	**Is Anyone Better Off?**

How Lives Are Changing

"C" is a seven year old male living in a single parent home with 3 siblings. Many emotional and behavioral issues were present in school for "C" and he was referred to the Youth Guide Project by his elementary school.

Following initial information gathering with school, parents and grandparents the Youth Guide Mentor provided one-on-one sessions showing age appropriate videos, provided positive reinforcements, individual training, modeling, and verbal prompting for social and behavioral concerns. The typically twelve week curriculum went at a slower pace to allow for custody issues to be resolved. Once "C" and his siblings were in a more stable living environment, he began to feel and demonstrate the benefits of consistent mentoring.

Prior to participating in the Youth Guide Project "C" was in the Principal's office at least twice a week for behavioral issues. After the first month grandparents and school staff reported behavioral changes for the better and by the end of the second month "C" had not been sent to the Principal's office for one entire month. At the end of the school year, Youth Guide Project mentoring was planned to continue over summer in preparation for the next school year.

INN – Civility School Learning Project (INN-05)

Operated by Center for Human Services in partnership with Keyes Unified School District

Choosing Civility Learning Project is a 2 year project operated by Center for Human Services (CHS) and focuses on a new approach to increasing quality of services including better outcomes by creating ownership of "social culture" in a school environment.

.

Implementation partner Keyes Union School District will site the project at Keyes Elementary and Spratling Middle School where students, classroom teachers, parents, and campus staff will participate through campus-wide introduction of civility activities and strategies.

The project seeks to contribute to practices that will have a positive impact on school campus culture, increase children's developmental assets and strength-based social connections, engage parents and improve their constructive communication with the school personnel, increase teacher/school personnel productivity and develop positive partnerships on behalf of children, and the impact on mental, behavioral and emotional wellness for students, teachers and school staff

The project will help support and accelerate county-wide transformation by addressing the learning priority of improving the well-being of children.

Highlights

This project was one of nine community-based innovation projects begun in Stanislaus County in FY11-12. Approval of projects occurred in August and the first phase of implementation was for BHRS to develop provider contracts with the organizations who would be implementing the projects. Once contracts were established, Initial start-up activities began immediately and continued through-out the first 6 months of each project. Evaluation tools for measurement of learning objects were developed and refined during start-up phase of the project.

CHS was contracted and funded to begin Choosing Civility Learning Project on November 1, 2011. Implementation through June 30, 2012 is reported in this annual update. This project is operational during the school year and with no time to spare the "kick off" event was planned for and accomplished on November 10, 2011. District Administration and School Board support of this project was evident from the beginning when they agreed to cancel school for 1 day in order for a robust attendance to be achieved. The kick-off event engaged 90 school staff and 1 School District Board member in a full day of interactive learning and enthusiastic team building. Focused conversations were facilitated with school staff to assess the current climate of civility and commitment levels for future participation. The Choosing Civility Project Coordinator and other staff discussed the premise of the learning project and the learning goals that were proposed. One hundred (100) copies of the book, *Choosing Civility: The Twenty Five Rules of Considerate Conduct* were distributed and a "task force" of staff and parent volunteers was established at the conclusion of the Project Kick-Off day.

Start-up activities related to engaging school staff were conducted and included a discussion of the 40 Developmental Assets with exploration of how the Development Assets could be incorporated into behavioral health and emotional wellness for students. Attendance by project staff at the elementary

school teacher/staff meeting was helpful in responding to questions as well as giving update on the progress of the Choose Civility Learning Project.
Project staff, adapting to differences in school cultures, met with middle school teachers and staff at lunch to respond to questions and update them as a group on the progress of the Choose Civility Learning Project.

Start –up activities related to evaluation of learning objectives began with identification of Program and Organization Consultant, Dr. Jamie McCreary, as project evaluator. With her guidance the survey questions were focused to assess four main areas: School Capacity to Promote and Shift Culture, Civility, Positive Interactions and Mental-Behavioral-Emotional Wellness.

Early learning of start-up phase includes but not limited to:

- Learning that Parent kick-off night suggested that parent participation would be a challenging
- Learning there was a sharp contrast of enthusiasm by some and resistance by others among parents, teachers, school staff for the project

Challenges

Innovation presents a challenge, as a unique part of the Mental Health Services Act, to keep the focus on learning. Typically, in behavioral health programs, the focus is on services. This focus presented its own challenges for each new innovation project as well as with BHRS staff.

Certain challenges are unique to each project and are due to circumstances, need for infrastructure, staff and development of evaluation approaches. Taking the time initially to ensure that projects are appropriately set-up to learn was believed to be a critical part of long term success.

Choosing Civility Project's early challenges included but not limited to:

- Initial baseline survey of staff resulted in revision of the survey to enhance validity
- Some trust issues were discovered to exist between parents and teachers
- Staff resistance to adding curriculum to the school day already crowded with teaching related to academic requirements

Program Results Shown in RBA Framework	
• 1 Choosing Civility Learning Program Coordinator identified • 1 Choosing Civility Learning Project Manager identified • 1 Project Evaluator identified • 1 meeting with school district administrators and staff to discuss opportunities, purpose and intent of the Choosing Civility Learning Project • 1 "Project Kick-Off" day was conducted on Thursday, November 10th • 90 school district staff and 1 school board member participated in the activities of the day • 1 Project Parent Night was hosted at Keyes Elementary • 1 School District Board of Trustee Meeting was attended by project staff to inform and answer board members questions about the Choosing Civility Learning Project • 6 focused conversations were facilitated; 4 with school staff, 2 with parents, one of which was in Spanish • 1 Baseline survey completed with school staff • 64 civility themed classroom presentations were given to students at both Keyes Elementary and Spratling Middle schools facilitated by project staff	**How Much?**
• Not enough implementation time or data collected to measure yet	**How Well?**
• Not enough implementation time or data collected to measure yet	**Is Anyone Better Off?**

How Lives are Changing

The overarching success story for this project is the immeasurable commitment by the School Board and District Superintendant's office to be partners in this innovative project.

That spirit was expressed in the creative idea of an individual teacher who embraced the goals of the Choosing Civility Learning Project and became an "early adopter" of innovative strategies. The activity was named "Chain Reaction of Kindness" adopted from the Rachel's Challenge Curriculum being used by Choosing Civility Learning Project.

The teacher started a paper chain in which students could write statement of kindness to another student e.g. "David is friendly to me". The paper makes a link in the chain and as students add links the chain grows. As the chain grew the teacher reported it as a successful practice that could continue and parents were able to view samples of the project at Back to School Night. The "Chain of Kindness" serves as a reminder to all that choosing civility and kindness is possible.

Connecting Youth to Social Supports (INN-06)

Operated by Sierra Vista Child and Family Services

Connecting Youth to Community Supports Project is a 2 year project operated by Sierra Vista Child and Family Services (SVCFS) and focused on increasing quality of services including better outcomes with secondary focus of promoting interagency collaboration incorporating recovery and resiliency based approaches and de-stigmatizing community-based activities into treatment, and connecting youth to community based activities that may reduce length of time and intensity of treatment.

Youth who are currently receiving services are recruited to participate in the project. They may be receiving services from Sierra Vista Child and Family Services, the Drop in Center Family Resource Center (FRC), the North Modesto/Salida Family Resource Center, the Hughson Family Resource Center, and the Bridge in West Modesto. Mental Health Clinicians will assist youth in identifying activities they are curious about, interested in, and passionate about. Community Support Specialists, based at FRC or other partner agency, will assist to connect the youth to the desired activity and monitor participation in the activity. The clinician monitors progress toward recovery including length of time and intensity of treatment.

The project seeks to contribute to practice by learning how to assist mental health clinicians in thinking about incorporating community-based activities into treatment may reduce the length of time and intensity of treatment for youth and their families.

The project will help support and accelerate county-wide transformation by connecting people receiving services to community-based supports and service providers to become more facile in linking their clients to information and support for more holistic approaches to well-being.

Highlights

This project was one of nine community-based innovation projects begun in Stanislaus County in FY11-12. Approval of projects occurred in August and the first phase of implementation was for BHRS to develop provider contracts with the organizations who would be implementing the projects. Once contracts were established, Initial start-up activities began immediately and continued through-out the first 6 months of each project. Evaluation tools for measurement of learning objects were developed and refined during start-up phase of the project.

SVCFS was contracted and funded to begin Connecting Youth to Community Supports Project on November 15, 2011. Implementation activities through June 30, 2012 are reported in this annual update.

Key start up activities included outreach to 216 businesses and organizations throughout the County who might agree to offer lessons and other recreational opportunities at low cost or no cost to youth participants in the project. Youth interests were varied and included: music, dance, bowling, horseback riding, sports (e.g. boxing, soccer and martial arts), arts and crafts, fashion.
A fundraising event was also held to ensure activities could be paid for when low or no cost was not possible.

Development of a process of screening and assessing youth referred to the program was critical. A number of issues would need to be addressed before youth could begin to participate in community-based activities; e.g. parent understanding and willingness to support youth participation in activities that are not traditional office based services, and for parents to sign a Hold Harmless Agreement giving permission for their child to participate in the identified activity. Overall it was found that youth and their caregivers had great interest and enthusiasm for the opportunity to participate in community based activities as an enhancement to traditional treatment.

Evaluation tools began to be developed, tested and refined to track progress toward learning objectives. Evaluation for this project is conducted by SVCFS Quality Assurance Department.

Challenges

Innovation presents a challenge, as a unique part of the Mental Health Services Act, to keep the focus on learning. Typically, in behavioral health programs, the focus is on services. This focus presented its own challenges for each new innovation project as well as with BHRS staff.

Certain challenges are unique to each project and are due to circumstances, need for infrastructure, staff and development of evaluation approaches. Taking the time initially to ensure that projects are appropriately set-up to learn was found to be a critical part of long term success.

Connecting Youth Project's early challenges included but were not limited to:

- Unanticipated need for a release of liability from parents was addressed
- Need for additional fundraising to ensure all types of activities could be offered to youth
- Learned that participation is stronger during school year
- Transportation to and from activities can be challenging

Program Results Shown in RBA Framework	
• 1 project manager identified • 2 Community Support Specialists identified • 1 evaluation team identified, refined and finalized • 1 pre- and post-participation youth survey tool developed and refined • 1 pre-and post-participation parent survey tool developed and refined • 1 clinician/community support specialist survey tool in development • 1 fundraiser conducted • 40 referrals received into the program • 14 youth were screened into the program • 22 community based organizations agreed to offer low or no cost activities	**How Much?**
• Not enough implementation time or data collected to measure yet	**How Well?**

• Not enough implementation time or data collected to measure yet	**Is Anyone Better Off?**

How Live Are Changing

"S" an adolescent female was having trouble with friends and was being bullied at school. She identified an interest in horses that is held by many adolescent females but never fulfilled. A local equine facility contributed low cost lessons to "S" and she is really enjoying the experience of grooming and riding the horse. She reports feeling more confident in herself and having better social interactions at school.

"P" is in 3rd grade and not going to school when he started to receive mental health services. He and his parents were interested in participating in the Connecting Youth Project as an adjunct to therapy. "P" was very angry, had a hard time listening to direction from others, and controlling impulses to physically strike-out when angry. Through the innovation project he has been involved in flag football for about a month and states that he is enjoying it. His therapist reported that he is using his impulse control tools while participating in football. One of the techniques he uses is a self-imposed time-out (walk away from the anger provoking encounter) instead of resisting the impulse to strike-out and get physical.

Families in the Park (INN-07)

Operated by West Modesto King Kennedy Neighborhood Collaborative

Families in the Park Project is a 3 year project operated by West Modesto King Kennedy Neighborhood Collaborative (WMKKNC) and focused on increasing access to underserved groups through an innovative approach in a culturally specific way of outreaching to young African-American families who spend their days in West Modesto's Mellis Park. Locating the project in the untypical and accessible location of the familiar neighborhood park is the first step in a culturally specific approach as the park is a place where families feel relaxed and comfortable.

Mental health problems that contribute to lack of success in school (and later life) can be directly linked to lack of preparation for school, lack of effective parental support to attend school regularly and ongoing lack of internal resources (developmental assets) during the school years. It is anticipated that a significant number of parents/guardians and some children who will participate in the project will be identified as having mental health/behavioral needs that contribute to this problem throughout the lifespan.

This project seeks to contribute to learning by introducing a specific change in an existing mental health approach using culturally specific outreach and engagement methods to create relationship with African-American families with pre-school children that are unserved and experience significant barriers to connecting with needed mental health services and school readiness preparation.

The project will help support and accelerate county-wide transformation by improving the well-being of children.

Highlights

This project was one of nine community-based innovation projects begun in Stanislaus County in FY11-12. Approval of projects occurred in August and the first phase of implementation was for BHRS to develop provider contracts with the organizations who would be implementing the projects. Once contracts were established, Initial start-up activities began immediately and continued through-out the first 6 months of each project. Evaluation tools for measurement of learning objects were developed and refined during start-up phase of the project.

WMKKNC was contracted and funded to begin Families in the Park Project on November 15, 2011. Implementation through June 30, 2012 is reported in this annual update.

During the first six months 6 families and 10 children entered the program to participate as start-up activities unfolded around Christmas time. Key staff came on board with bi-lingual Spanish skills and experience working with pre-school children and as a recreational aid in City park/recreation programs.

Key partner meetings with Modesto City Schools and City of Modesto Parks and Recreation Department were convened to provide a briefing on the innovation project goals and negotiate a memorandum of understanding for program collaboration to occur.

Initial training of project staff was conducted in a number of topics and the Project Lead and the Project Evaluator obtained "train-the-trainer" certification in the use of 40 Development Assets.

Early learning of start-up phase includes but not limited to:

- Family emergencies are a fairly frequent occurrence and can effect participation
- Original idea of parent and children needed to be expanded to include other family members who are primary care givers of children.

Challenges

Innovation presents a challenge, as a unique part of the Mental Health Services Act, to keep the focus on learning. Typically, in behavioral health programs, the focus is on services. This focus presented its own challenges for each new innovation project as well as with BHRS staff.

Certain challenges are unique to each project and are due to circumstances, need for infrastructure, staff and development of evaluation approaches. Taking the time initially to ensure that projects are appropriately set-up to learn was found to be a critical part of long term success.

Families in the Park Project's early challenges included but were not limited to:

- The project began in November when weather typically prevents or dramatically reduces families spending time in the park. An adaptation to include activities inside the center overall came the issue.
- Creative challenge in how to implement the 40 Developmental Assets in a way that is family-friendly, engaging and fun was overcome by simplifying the assets and creating a poster for each child.

Program Results Shown in RBA Framework	
• 1 program coordinator indentified • 1 program staff identified • 1 program evaluator identified • 1 participant feedback survey was developed for continuous quality improvements • 7 adults referred to the project • 9 children referred to the project • 11 families participating in FY11-12	**How Much?**
• Not enough implementation time or data collected to measure yet	**How Well?**
• Not enough implementation time or data collected to measure yet	**Is Anyone Better Off?**

How Lives Are Changing

Early successes were seen in several children who reached developmental milestones since joining the program. One very special student's story demonstrates the power of the program to prepare children for school and encourage parent support. This story highlights two key results 1) the participation of the mother and 2) the transformation in the child.

"W" is a child who was born with some developmental delays. When "W" and her family first came to the program, the she would not leave the mother's side. There was virtually no interaction with the other children or the program facilitators. This was typical for "W" and family reported that she child seldom spoke, even at home.

"W's" mother was persistent and diligent in attending the program with her child and little by little, small changes began to be seen in her social behavior. As her confidence increased, "W" began to sit with the other children for story time and flash cards. She began to have short conversations with the facilitator about the alphabets and shapes and started to participate in other learning games and activities.

At the last meeting, "W" stood in front of the other children and parents to tell a story about a giraffe she had made during Arts and Crafts! Words cannot describe the joy and pride that shown on both the mother and her child's face. The smiles flashed for the duration of the class as other participants cheered her on. The entire group was proud and grew from the accomplishment of one shy little girl.

Innovation Integrations (INN-08)

Operated by Stanislaus County Health Services Agency in partnership with NAMI and WMKKNC

Integration Innovations Project is a 2 year project operated by Stanislaus County Health Services Agency and focused on increasing the quality of services including better outcomes, for adult and older adult individuals of all cultures, and ethnicities who receive medical and psychiatric care in a primary care clinic setting.

Stanislaus County needs a project like this to increase the quality of services offered to medically high-risk populations, including uninsured and underinsured individuals who have psychiatric illnesses and/or substance abuse issues co-occurring with chronic disease such as diabetes and hypertension. Access to peer supports is not currently included in primary care service delivery and has the potential to achieve better outcomes for overall well-being including health and mental health.

This project will help support and accelerate county-wide transformation by connecting people receiving services to community-based supports and expanding treatment options for people struggling with both substance abuse and mental illness.

Highlights

This project was one of nine community-based innovation projects begun in Stanislaus County in FY11-12. Approval of projects occurred in August and the first phase of implementation was for BHRS to develop provider contracts with the organizations who would be implementing the projects. Once contracts were established, Initial start-up activities began immediately and continued through-out the first 6 months of each project. Evaluation tools for measurement of learning objects were developed and refined during start-up phase of the project.

Health Services Agency was contracted and funded to begin December 1, 2011. Implementation activities through June 30, 2012 are reported in this annual update.

The primary focus of the first six months was identification of a program evaluator, program coordinator and physicians. Additional activities included: identification, selection and refinement of appropriate evaluation and assessment tools, screening of participants, training for clinic staff and development of working relationships with community-based organizations partners. The program was re-named “Savvy Self-Care Project” and the first cohort of participants began in September 2012.

Program Coordinator established communication with the BHRS program that serves a similar population to avoid duplication of services to individuals and continuity of care purposes.

A 12 week psycho educational curriculum was identified, based on the Galveston Model, for use with participants. Additional groups to be offered were identified with input from first cohort of participants and included topics such as: pain management, issues related to past sexual abuse, depression, issues with alcohol and other drugs, grief and recovery support. Participants were strongly encouraged to identify and bring a support person to the 12 week educational group meetings.

Early learning of start-up phase includes but not limited to:

- Mental health wellness issues should be front and center from the beginning

Challenges

Innovation presents a challenge, as a unique part of the Mental Health Services Act, to keep the focus on learning. Typically, in behavioral health programs, the focus is on services. This focus presented its own challenges for each new innovation project.

Additional challenges are unique to each project and are due to circumstances, need for infrastructure, staff and development of evaluation approaches. Taking the time initially to ensure that projects are appropriately set-up to learn was found to be a critical part of long term success.

Early challenges included but were not limited to:

- Physicians and Residents are extremely busy and scheduling potential participants has been challenging
- Peer groups are new to the primary care clinic environment and are challenging to incorporate as an approach
- Initial loss of key staff (program coordinator) was an unexpected challenge
- Participants have transportation issues which contributes to inconsistent attendance

Program Results Shown in RBA Framework	
• 1 Project evaluator identified • 1 Project Coordinator identified • 22 individuals were assessed for participation in the project • 19 individuals were accepted for participation in the project • 9 individuals completed pre and post program surveys • 1 patient curriculum identified for project	**How Much?**
• Not enough implementation time or data collected to measure yet	**How Well?**
• Not enough implementation time or data collected to measure yet	**Is Anyone Better Off?**

How Lives Are Changing

Innovation projects are demonstration projects dedicated to learning. Typically, learning (and successes) occur at many levels; staff, participants, and community.

Innovation Integrations Project was proposed to exist within a very busy primary care clinic. Many obvious challenges to quick implementation were anticipated and worked through.

Three things happened that can be considered organizational successes: 1) Doctors and Residents were excited about having the program in-house, 2) twenty-one (21) individuals were quickly identified as possible participants for the Savvy Self-Care Project and 3) the first cohort of participants started the 12 week curriculum in the second quarter of early implementation.

Many individual success stories are expected as the project continues.

INN – Promoting Community Wellness through Nature (INN-09)

Operated by Tuolumne River Trust

Promoting Community Wellness through Nature- and Neighborhood-Driven Therapies Project is a 2 year project operated by Tuolumne River Trust (TRT) focused on a community-based approach that proposes to increase access to underserved groups through a combination of family-oriented outdoor programming and capacity for resident-led neighborhood improvements as "therapies" to address wellness issues in the Airport Neighborhood. A series of community-driven and resident-led activities (therapies) will be used to address environmental and social barriers to mental wellness in the neighborhood on 3 levels:

- Individual – strengthening developmental assets in children
- Family – strengthening leadership skills and social competency
- Community – increasing resident engagement and community connectedness

Traditional approaches to addressing mental wellness issues tend to focus on treating the patient and the symptom without dealing with the physical conditions that often contribute to illness. Yet research tells us that environment, both where we live and how we perceive our surroundings, plays an important role in our overall health.

The project has a mission to learn what methods change a community's attitude toward and connection with its natural and urban environments as well as come to embrace the important role nature has in the overall increase in health and vitality of its residents.

The project will help support and accelerate county-wide transformation by connecting people receiving services to community-based supports and improving the well-being of children.

Highlights

This project was one of nine community-based innovation projects begun in Stanislaus County in FY11-12. Approval of projects occurred in August and the first phase of implementation was for BHRS to develop provider contracts with the organizations who would be implementing the projects. Once contracts were established, Initial start-up activities began immediately and continued through-out the first 6 months of each project. Evaluation tools for measurement of learning objects were developed and refined during start-up phase of the project.

TRT was contracted and funded to begin Promoting Community Wellness through Nature- and Neighborhood-Driven Therapies Project on November 15, 2011. Implementation activities conducted through June 30, 2012 are reported in this annual update.

TRT staff began with outreach to Orville Wright Elementary School administrators, staff and parents to inform them of the project and goals involved in connecting well being to activities in nature. Initial efforts with informational flyers, phone calls, one information meeting and "word-of-mouth" around the neighborhood was successful in starting things off. The first session of Get Up 'N Go After School Program included 20 children (3rd-6th grade) participating initially.

The Charlas Communitarias (Community Chats) began and gained momentum each month and residents of the Airport Neighborhood have met not only monthly but at times of projects such as the Christmas Party, the Community Carnival, Youth Soccer League and the pilot sidewalk project, on a bi-weekly basis to ensure that adequate planning and coordination is occurring for these neighborhood events.

Airport Neighborhood Collaborative meetings began in January 2012 and continued monthly with the goal of providing stakeholders in the community to meet and discuss upcoming projects and community engagement opportunities. Stakeholders living outside the neighborhood meet with stakeholders living inside the neighborhood to plan events such as Love Modesto Sidewalk Project in which 30 neighborhood families participated on April 28, 2012.

Challenges

Innovation presents a challenge, as a unique part of the Mental Health Services Act, to keep the focus on learning. Typically, in behavioral health programs, the focus is on services. This focus presented its own challenges for each new innovation project as well as with BHRS staff.

Certain challenges are unique to each project and are due to circumstances, need for infrastructure, staff and development of evaluation approaches. Taking the time initially to ensure that projects are appropriately set-up to learn was found to be a critical part of long term success.

Promoting Community Wellness through Nature Project's early challenges included but was not limited to:

- Efforts to get a neighborhood soccer league going were challenged by existing baseball league participation by youth/families outside the neighborhood
- Community Center construction was delayed
- Family emergencies are a fairly frequent occurrence and can effect participation by youth and adults

Program Results Shown in RBA Framework	
• 1 Community Outreach Coordinator identified • 1 Director of Outreach Education identified • 1 Recreation Coordinator identified • 1 Project Evaluator identified • 1 youth survey was developed and refined • 1 adult survey was developed and refined • 1 general information meeting was conducted • 20 children participated in the first after school recreation program • 15 youth participated in the Tuolumne River Adventure Club • 3 articles in local newspaper to educate public and promote the project mission • 5 Airport Neighborhood Collaborative monthly meetings were held • 30 Airport Neighborhood families participated in Love Modesto Sidewalk Project	**How Much?**
• Not enough implementation time or data collected to measure yet	**How Well?**

♦ Not enough implementation time or data collected to measure yet	**Is Anyone Better Off?**

How Lives Are Changing

Innovation projects offer opportunities for learning at many levels; staff, participants, and community. The nature day hikes along the river are intended to open youths' eyes and awareness to the wonders of the river park right outside their doors while also teaching them how to enjoy it safely. River safety and helping youth feel comfortable in the Park are top priorities of the innovation project learning objectives. The program design was based in a classic environmental education model using hands-on interactive activities to introduce youth to the natural surroundings. This approach includes a strong emphasis on participant compliance and interest in the "facts" e.g. what type of animals live in this type of tree.

Early on, it became clear that the approach would need to be modified. Project staff had to "give up" what they know about how outdoor education is delivered and shift to an approach that initially emphasized the "experience of nature".

The general rowdiness during nature walks were seen as youth finding it hard to relax, be present and express how they feel. Connection to nature and sense of well being are at the heart of this project and while it would be easier to teach the youth what kind of a tree they are sitting under, staff are focused on helping youth experience and express that wonderful feeling of relaxing into the coolness of its shade and the sense of health and wellbeing that comes from it.

Revolution (INN-10)

Operated by Center for Human Services

Revolution Project is 2 year project operated by Center for Human Services (CHS) and focused on promoting interagency and community collaboration.

Revolution Project seeks to engage adults who own businesses or have other civic leadership roles to learn what it takes to resolve existing conflicts with youth from nearby schools and build partnerships that transform mental health in the rural, underserved Westside community of Patterson. It is expected that increasing youths' high expectations and opportunities for meaningful participation will lower the incidence of involvement in substance abuse and other health/mental health compromising risk behaviors as well as increase youths' resilience, mental and emotional wellness, and academic success.

This innovative project seeks to attract the interest of youth and adults from diverse cultures and ethnic groups throughout Stanislaus County and create a new model for youth leadership in civic-minded roles as a way to improve the emotional and mental wellness of youth through strengthened relationships.

The project will help support and accelerate county-wide transformation by improving the well-being of youth.

Highlights

This project was one of nine community-based innovation projects begun in Stanislaus County in FY11-12. Approval of projects occurred in August and the first phase of implementation was for BHRS to develop provider contracts with the organizations who would be implementing the projects. Once contracts were established, Initial start-up activities began immediately and continued through-out the first 6 months of each project. Evaluation tools for measurement of learning objects were developed and refined during start-up phase of the projects.

CHS was contracted and funded to begin Revolution Project on November 1, 2011. Implementation through June 30, 2012 is reported in this annual update.

Many aspects of this project were developed out a genuine need in the community of Patterson to resolve conflict between business owners and local teens. As the project began the initial challenge of finding a location for the teen center was mediated by the City of Patterson. The city Department of Parks and Recreation stepped up to assist with finding a location that was agreeable to all parties and well located for teen participation. As soon as the Teen Center was opened in February 2012, the project began to schedule events, attract teens and develop positive working relationships with other downtown merchants. Participation in Revolution Project events includes an ethnically diverse population of youth, their families and other adults. Youth may be self-identified as mental health consumers. Over 500 youth and adults and volunteers attended events and engaged with the project in the first six (6) months.

Start –up activities related to evaluation of learning objectives began with identification of Program and Organization Consultant, Dr. Jamie McCreary as project evaluator.

Early learning of start-up phase includes but not limited to:

- The teen center attracted many more teens initially than anticipated.

Business owners were more willing than anticipated to accept the teen center as a constructive element in Patterson.

Challenges

Innovation presents a challenge, as a unique part of the Mental Health Services Act, to keep the focus on learning. Typically, in behavioral health programs, the focus is on services. This focus presented its own challenges for each new innovation project as well as with BHRS staff.

Certain challenges are unique to each project and are due to circumstances, need for infrastructure, staff and development of evaluation approaches. Taking the time initially to ensure that projects are appropriately set-up to learn was found to be a critical part of long term success.

Revolution Project's early challenges included but were not limited to:

- Initial resistance among neighboring merchants to having a teen center nearby
- Robust participation at the Teen Center caused space issues

Program Results Shown in RBA Framework	
• 1 Teen Center Coordinator identified • 1 Revolution Project Manager identified • 1 Project Evaluator identified • 1 grand opening of Teen Center in February 2012 • 600 hotdogs served at grand opening • 460 youth (unduplicated count) participated at the Teen Center first six months • 6 events conducted with youth and adult participants • 1 Youth Action Commission established • 1 Executive Youth Action Commission established • 1 adult survey tool developed and piloted • 1 teen survey tool developed and piloted	**How Much?**
• Not enough implementation time or data collected to measure yet	**How Well?**
• Not enough implementation time or data collected to measure yet	**Is Anyone Better Off?**

How Lives Are Changing

The primary focus of the Revolution Project is to build community assets that support positive youth development including mental and emotional wellness in Patterson. A learning component of this project is to find ways to get community members more involved and connected with local youth by volunteering their time. In May 2012 the Teen Center held Project Prom. Project Prom provides beautiful new and gently used prom dresses for Patterson girls. On this event gifts, dresses, shoes and accessories were gathered and donated from local businesses, community members and college sororities. Also, local hair stylists provided free services to the girls while seniors offered their time and material for dress alterations. Without a doubt, this event promoted community collaboration and connected local youth with adults. The adults that volunteered at this event experienced a positive sense of purpose by "giving back" and sharing their time and talents.

The following quote is from a senior that assisted in the Project Prom event.
"It was a pleasure and thank you for allowing me to participate in such a needed event. I could tell the girls were thrilled and I sure wish there had been something like this when I was in school - I sure could have used it."

New: Innovation Work Plan Narrative

Date: April 24, 2013

County: Stanislaus County
Work Plan #: SCINN-11
Work Plan Name: Stanislaus County Wisdom Transformation Initiative

Primary Purpose of Proposed Innovation Project

___ Increase Access to Underserved Groups
___ Increase the Quality of Services, including Better Outcomes
_X_ Promote Interagency and Community Collaboration
___ Increase Access to Services

Project Description

This project will support a collaborative transformation and learning effort among six non-profit and community-based organizations in Stanislaus County. The largest non-profit and community-based contractors with BHRS, these organizations provide behavioral health services and supports to some of the county's most vulnerable individuals and families. The purpose of this project is to help each organization better respond to the adaptive dilemma confronting the county behavioral health system, and to facilitate a deeper level of collaboration among the six organizations and between the organizations and BHRS. Over time, this project will improve outcomes for people receiving services and supports through the behavioral health system.

Why this Project • Why Now

Even with the infusion of Mental Health Services Act (MHSA) funding, the county's overall mental health budget has contracted over the past eight years, dramatically so in the past several years. Even greater reductions have occurred in the county's alcohol and other drug (AOD) budget. These budget reductions have led to dramatic declines in the numbers of people receiving behavioral health treatment services across the county.

At the same time, the number of people struggling with behavioral health issues in the county is increasing significantly, caused in part by families and individuals struggling with the fallout from the recession, including the housing downturn and high unemployment, and veterans returning home from Iraq and Afghanistan. Health care reform will soon compound this reality by dramatically increasing the numbers of people who can qualify for behavioral health services.

These challenges have affected both programs that are directly operated by the Behavioral Health and Recovery Services Department (BHRS) and programs and services delivered by the department's many community partners as well. BHRS partners are reporting dramatically increasing numbers of people seeking outpatient and other services, often significantly beyond contract maximums, who are presenting ever more severe symptoms and conditions.

We describe this reality as an adaptive dilemma because neither BHRS, nor its community partners, can resolve these challenges and improve behavioral health outcomes through traditional strategies for managing budget shortfalls. A qualitatively different response is needed.

Four years ago BHRS began to develop a qualitatively different response. BHRS staff and our partners have worked for years to provide the highest quality services and supports for the people we serve. Given the stark reality of the adaptive dilemma, however, the department's Senior Leadership Team concluded that delivering high quality services to fewer and fewer people was not enough. The department had to act to improve and expand behavioral health and wellbeing for the county's most vulnerable individuals and families, even as it pursued fiscally sustainable responses to the adaptive dilemma.

To achieve these twin aims of fiscal responsibility and improved behavioral health and wellbeing, the Senior Leadership Team launched an extensive and ongoing effort to transform the county's behavioral health services system. Four commitments define this transformation effort: a commitment to results; a commitment to community capacity-building; a commitment to fiscal sustainability; and a commitment to leadership development. Taken together, these four commitments and related practices are called the Wisdom Transformation framework.

Over the last several years, BHRS has trained senior leadership team members and program managers and coordinators in what these commitments mean, and in practices that can help staff and programs embody these commitments to improve the emotional and behavioral health of the people they serve. Just recently the department conducted a department-wide staff survey that will become part of an on-going learning and reflection process to assess the progress of the transformation effort.

In 2010, BHRS began its first Innovation project as part of this system-wide transformation effort. In this project—entitled Evolving a Community-Owned Behavioral Health System of Supports and Services—BHRS invited community stakeholders to join with department leaders to address a dramatic shortfall in the AOD budget. A direct expression of the commitments to fiscal sustainability and community capacity-building, this project explored how to develop deeper shared ownership of the department's budget among community stakeholders—including people who receive services, family members, and community leaders—and how to engage stakeholders as partners in addressing the consequences of budget shortfalls.

The first Innovation project was a remarkable success. First, community stakeholders and department leaders reached consensus on a set of recommendations for how to absorb the budget shortfall—recommendations that were ultimately approved by the Board of Supervisors. Second, and more importantly, the process revealed an array of community-based, faith-based, private sector, and other supports and services beyond those funded by BHRS. Stakeholders and BHRS leaders worked to better integrate and leverage these supports and services to mitigate the impact of the budget cuts. The project demonstrated how community partners and department leaders could discern and act together to responsibly steward the behavioral health system in the midst of profound challenges.

This newly proposed Innovation project—the Wisdom Transformation Initiative—builds upon the success of the first Innovation Project. In this project, six of the largest community-based partners of BHRS will translate and integrate the Wisdom Transformation framework into their cultures and day-to-day operations to help them improve and sustain positive behavioral health outcomes for the people they serve.

Why these Partners

The six community-based organizations participating in this project include: Aspiranet, Center for Human Services, Sierra Vista Child and Family Services, Telecare, Turning Point, and West Modesto King Kennedy Neighborhood Collaborative. Together, these six organizations represent the largest non-profit and community-based contractors with BHRS. They provide behavioral health support to many of the county's most vulnerable individuals and families, through family resource centers, neighborhood- and school-based service sites, multi-lingual services, and other community-based efforts.

Each organization has already demonstrated an abiding commitment to the Wisdom Transformation framework. Staff members have participated in voluntary training sessions introducing some of the framework's core concepts and practices. Most of the organizations have begun to implement Results-based Accountability (RBA) processes consistent with the commitment to results, particularly in those programs funded through the county's MHSA plans.

For the last year, leaders from the six organizations have participated in a voluntary learning collaborative to explore how to better adapt the Wisdom Transformation framework to support their work in county. Their conversations revealed an array of challenges that magnify the impact of the adaptive dilemma on efforts by community-based organizations to serve people suffering from or at risk of mental illness.

With increasing demands for services and diminishing public resources, providers must learn how to better leverage community-based, non-clinical resources whenever possible. To effect such change requires staff and others to develop new skill sets. For example, leaders and managers must become better adept at designing and implementing processes to engage line staff, people who receive services, family members, community leaders, and others in learning conversations about how to improve outcomes and create new approaches to complex community realities. Such processes require very different skills than, for example, the skills required to ensure compliance with Medi-Cal regulations and other quality assurance issues.

Moreover, within the six partner organizations, as well as within BHRS, many senior leaders and managers are approaching retirement age, while many younger staff members are reporting higher levels of stress and low morale. Learning how to effectively address these organizational realities is essential for community-based organizations to improve outcomes for the people they serve.

The more leaders from the six organizations engaged with each other, the more they discovered common interests and challenges, and the more committed they became to exploring how the Wisdom Transformation framework could help them improve emotional and behavioral health outcomes despite current fiscal challenges. All six organizations are enthusiastic about the proposal and have pledged the necessary staff time and support to ensure success.

What We Will Do

At the beginning of the initiative, each organization will develop a plan for how to adopt the Wisdom Transformation framework to improve the programs and services it provides for people suffering from or at risk of mental illness. Each plan will delineate:

- The results the organization intends to achieve through the adoption of the framework, including progress on outcomes, program and service improvements, and others.
- How the organization will assess progress over the two years.
- What the organization will do to effect the results it seeks, including how it will engage people who receive services, family members, and community leaders as well as staff members and others in its efforts.
- How the organization will tell the story of this initiative to staff, people who receive services, family members, and other stakeholders.

Some specific ways organizations may adapt the framework include:

- A commitment to results: Making outcome data more timely and accessible, and fostering learning conversations among staff members, people who receive services, family members, and community leaders about how to improve and sustain positive outcomes over time

- A commitment to community capacity-building: Building strategic partnerships with leaders in communities served by an organization, and helping these leaders develop strategies for improving the behavioral health and wellbeing of community members independent of the services they receive. While intensive services require a high level of professional training and competence, long-term recovery, prevention, and wellbeing require a "strong village" — relationships with people who provide on-going love, inspiration, acceptance, and practical supports.

- A commitment to fiscal sustainability: Creating strategies to promote behavioral health and wellbeing that leverage an array of available resources beyond those of the lead organization, including community-based, faith-based, peer support, and/or other non-professional resources.

- A commitment to leadership development: Creating internal processes and practices that strengthen the wellbeing of staff members and volunteers, and that encourage all staff and volunteers to exercise leadership in support of the organization's efforts to promote behavioral health and wellbeing.

Organizations will receive an array of supports to help them implement their plans over the course of the project, including:

- Consultation support: Each organization will receive significant hours of support from the consultants who created and supported the implementation of the Wisdom Transformation framework within BHRS. Examples of how organizations may use this time include training on the framework for specific audiences or the entire organization, group and 1-1 coaching, and process design and facilitation.

- Webinars: Staff members, people receiving services, family members, and others from participating organizations will engage in a series of webinars throughout the project to reinforce the fundamentals of the framework and engage emerging implementation questions. Anyone from participating organizations will be able to attend the webinars.

- Small grants: Each organization will receive two $5,000 grants to support its efforts in the initiative, one in each of the first two years of the initiative. An organization will receive the first grant upon developing its plan for how it will work to adopt the Wisdom Transformation

framework. It will receive the second grant upon submitting a progress report at the beginning of the second year of the initiative. Examples of how organizations may choose to use these grants include: small stipends or incentives to enable participation by people who receive services, family members, and/or community members; overtime or other expenses to permit staff to participate; and others.

- Peer Ally training: Participating organizations and BHRS will each identify two or more people who will receive intensive training, coaching, and support to become "in-house experts" on the Wisdom Transformation framework. Peer Allies can include managers, staff, or volunteers. This group of Peer Allies will become a peer learning community through the course of the initiative.

- Inter-organizational transformation summits: Two day-long transformation summits will be held during the project, helping participants better understand and adapt the Wisdom Transformation framework, and to share with each other successes, lessons learned, and emerging questions.

- Support for the Leadership Learning Collaborative: Leaders from the six organizations will meet throughout the project, sharing emerging lessons and challenges, providing guidance about how to improve the project over time, and developing plans for sustaining the effort beyond the Innovation Project.

- Additional resources: Organizations will have access to a variety of on-line resources, including papers, slides, videos, peer conversations, and others.

Embracing MHSA Principles and Values

We will implement this project in ways that are consistent with the general standards and core values of the Mental Health Services Act and Title 9, CCR, section 3320, including the values of community collaboration; creating integrated service experiences; promoting wellness, recovery, and resiliency; creating a consumer- and family-driven mental health system; and creating a culturally competent system of care.

First, all of the participating organizations have a long history of collaboration, and a sustained commitment to decrease competition for, and increase the effective use of, scarce behavioral health resources. The deeper level of collaboration we seek to cultivate is possible only because of this history.

Second, all of the organizations, together with BHRS, have a long history of developing integrated service responses to needs and challenges in the communities we serve. Health care reform makes this commitment even more imperative and is one of the dimensions of the adaptive dilemma that has called forth this initiative.

Third, the six organizations serve a diverse array of communities and individuals across the county, including historically underserved racial, ethnic, cultural, and linguistic communities. They provide services and supports, both traditional and non-traditional, to individuals and families in their preferred languages and in both clinical and non-clinical, community-based locations. Moreover, staff and board members from the six organizations include people from traditionally under-served communities, as well as family members and people who have received services.

As transformation efforts gain traction, we expect the participating organizations, both individually and collectively, to improve existing services, and create new services and supports, that are more integrated, and that better leverage community-based resources to promote emotional health and wellbeing. These innovative services and supports will evolve through partnerships and learning conversations among staff members, people who receive services, family members, and leaders from the diverse communities served by the organizations. These efforts will build upon and extend the networks of community relationships that have emerged through the community capacity-building efforts funded through the BHRS PEI plan over the past several years.

Finally, the multiple learning and assessment processes created through this initiative will engage people who receive services, family-members, community members and volunteers as well as staff members of the participating organizations.

Contribution to Learning

Describe how the Innovation Project is expected to contribute to learning. Innovation affects an aspect of mental health practices or assesses a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges.

A New Approach to Improving Services and Outcomes

Consistent with Innovation guidelines, this project explores new approaches to collaboration and system transformation that will impact:

- Organizational practices, processes, and procedures;
- Educational efforts for service providers, including nontraditional mental health practitioners;
- Outreach, capacity building, and community development; and
- System development.

John Ott, J.D., and Rose Pinard, Ph.D., consultants to BHRS for the last six years and co-founders of the Center for Collective Wisdom (centerforcollectivewisdom.org), are the co-creators of the Wisdom Transformation framework. This framework is a culmination of original research, and more than thirty years of work in communities and organizations across the country and beyond. The framework builds upon a number of disciplines and change frameworks, including organizational development, community building, community organizing, organizational learning, results-based accountability, dialogue, personal inquiry, and many others. The framework also integrates lessons learned through learning collaborative on community capacity-building, designed and facilitated by Ott and Pinard and funded by the California Institute for Mental Health between 2007-11.

BHRS is the first behavioral health department to adapt the framework to support an entire organization. This project will represent the first time community-based organizations will apply the framework, both individually and collectively, to promote recovery and behavioral health and wellbeing for individuals living with a serious mental illness, those at risk of developing a mental illness, and their family members.

The Learning Questions

Through this project, we will assess whether the adoption of the Wisdom Transformation framework by participating organizations increases their capacity to:

- Improve outcomes for people suffering from or at risk of mental illness;
- Create a stronger and more positive internal environment for staff, board members, and others connected to the organization so they can better support the people they serve;
- Learn to adapt better to the current policy and fiscal chaos buffeting the behavioral system; and
- Cultivate more effective collaboration among each other and with BHRS.

Through our efforts to address these overarching questions, we also expect to learn much about:

- How to help community-based organizations—each with different missions, cultures, and histories—successfully adapt the Wisdom Transformation framework within their particular programs and services;
- How to build effective learning communities among staff members, community leaders, family members, and people who receive services; and
- Whether cross-organizational learning communities and Peer Allies are promising strategies for sustaining long-term transformation efforts.

Over the course of the three-year project, we will develop annual lessons learned documents and other products to document the tangible benefits, emerging challenges, and deepening learning by project participants.

Expected Benefits

We hold a hypothesis that if we are successful through this project, we will lay the foundation for significant benefits and system improvements associated with each of the four commitments. For example, as organizations strengthen their *commitment to results*, we expect to witness concrete improvements in program outcomes, and increased satisfaction with services from the people who receive them and their families. These improvements may emerge through existing outcome measures or may require organizations to develop new measures as part of this initiative. We also expect to experience more frequent and impactful program innovations emerging from learning conversations among staff, community leaders, people receiving services, and family members.

We anticipate that successful *community capacity-building* strategies will become an effective response to the issue of flow. Demand for services far exceeds the system's capacity to provide them. Given declining resources, one way to expand access to services is by helping individuals flow through the system, receiving less intensive services over time while receiving more resources from natural communities of support. A focus on flow does not mean that we create assembly-line services; of course we will continue to provide the highest level of care possible. While participating organizations provide people with traditional behavioral health services, however, staff will increase their efforts to help people they serve to connect or reconnect with natural communities of support, communities they can rely upon as professional services decrease in intensity and ultimately end. The better organizations become at supporting this successful transition, the greater the potential for us to increase the numbers of people we serve—an important commitment always and particularly now in the face of diminishing resources.

Multiple organizations embracing a *commitment to fiscal sustainability* should produce stronger and more extensive connections with community-based, faith-based, peer support, and/or other non-professional resources to help people suffering from or at risk of serious mental illness, and help organizations weather the vagaries of public revenues. As organizations work to embody *a*

commitment to leadership development, they should experience a greater capacity to manage the internal stresses and transitions that can leach our capacity to provide high quality and sustainable care to the people we serve. For example, organizations may develop formal succession and leadership development plans, or design and implement a staff development curriculum.

The bottom line: we believe that, as participating organizations join with BHRS in embodying the Wisdom Transformation framework, the system as a whole can become more resilient, innovative, and capable of contributing significantly to the behavioral health and wellbeing of greater numbers of people across the county.

Timeline

Outline the timeframe within which the Innovation project will operate, including communication results and lessons learned.

1. This project is a three-year effort, beginning in July 2013 and concluding on or before June 30, 2016.

2. During **FY 2013-14**, we will:

    a. Evolve the Transformation framework developed for BHRS so that it is more appropriate for non-profit and community-based organizations.

    b. Develop and begin implementing the initiative-wide learning and assessment framework that will help the learning partners and BHRS assess the progress of the initiative over time.

    c. Work with each organization to develop and begin implementing a two-year plan for how to integrate the Wisdom Transformation framework in support of its behavioral health services and supports. Each plan will identify:
        (1) The results each organization will work to achieve through applying the Wisdom Transformation framework to its work providing behavioral health services and supports to individuals with serious mental illness, those at risk of mental illness, and their families.
        (2) How each organization will assess progress, including data sources.
        (3) How each organization will use the resources available to it through the initiative, including consulting hours, the small grants, and others—to support its efforts to integrate the Wisdom Transformation framework in support of its services and supports.
        (4) How each organization will engage people who receive services, family members, and community leaders as well as staff members and others.
        (5) How each organization will tell the story of its transformation process to staff, board members, people who receive services, family members, and other stakeholders.

    d. Provide $5,000 grants and consultation support to each organization once it has finalized its two-year plan.

    e. Design and implement the first series of webinars to amplify the learning about the Wisdom Transformation framework among staff, volunteers, and others from the partner organizations and BHRS.

    f. Organize the first Wisdom Transformation summit for staff and volunteers of the six partner organizations and BHRS to promote peer learning and support.

g. Develop the Peer Ally curriculum to support the development of "in-house experts" for each partner organization and BHRS.

h. Recruit and begin supporting the emergence of a learning community among 20 Peer Allies from the partner organizations and BHRS, including providing two one-day trainings to Peer Allies in how to embody the Wisdom Transformation framework within their respective organizations.

i. Convene regular meetings of leaders from the six partner organizations and BHRS to assess the progress of the initiative, cultivate lessons learned, and make adjustments to the design and timeline as needed.

j. Complete first lessons learned report and adjusted work plan for year 2.

3. During **FY 2014-15**, we will:

a. Continue working with each organization to integrate the Wisdom Transformation framework to strengthen its behavioral health services and supports, including providing on-going consultation support and an additional $5,000 grant.

b. Continue to support the development of Peer Allies within each of the partner organizations and BHRS, including
(1) Organizing three day-long training and learning sessions for all Peer Allies; and
(2) Providing intensive 1-1 coaching for each ally to help him/her deepen the skills and interior commitments needed to succeed in the role.

c. Design and implement the second series of webinars to amplify the peer learning and teaching about the Wisdom Transformation framework among staff from the partner organizations and BRHS. Peer Allies will likely play an increasing role in designing and supporting these webinars.

d. Organize the second Transformation summit for staff of the six partner organizations and BHRS to promote peer learning and support. Peer Allies and leaders from the six partner organizations and BHRS will play substantial roles within this second summit.

e. Continue to convene regular meetings of leaders from the six partner organizations and BHRS to assess the progress of the initiative, cultivate lessons learned, and make adjustments to the design and timeline as needed.

f. Complete lessons learned report and adjusted work plan for year 3.

4. During FY **2015-16**, we will:

a. Continue to support the development of Peer Allies within each of the partner organizations and BHRS through three half-day webinars.

b. Continue to convene regular meetings of leaders from the six partner organizations and BHRS to focus on sustaining the work of integrating and evolving the Wisdom Transformation framework beyond the life of the initiative.

c. Complete the data collection and analysis from the initiative-wide learning and assessment process.

d. Complete all final lessons learned and other reports for the initiative.

Plan to Evaluate and Project Measurement

Describe the plan to evaluate whether/how Innovative Project has proven to be successful, including a) expected outcomes of Innovation, b) how and at what frequency outcomes will be measured, c) how outcomes relate to Innovation's primary purpose, d) how county will assess which elements of Innovation contributed to positive outcomes, and e) how, if the county chooses to continue it, the project work plan shall transition to another category of funding, as appropriate.

As outlined in the Contribution to Learning section above, this project is designed to assess whether the adoption of the Wisdom Transformation framework by participating organizations increases their capacity to:

- Improve outcomes for people suffering from or at risk of mental illness;
- Create a stronger and more positive internal environment for staff, board members, and others connected to the organization;
- Learn to adapt better to the current policy and fiscal chaos buffeting the behavioral system; and
- Cultivate more effective collaboration among each other and with BHRS.

We will pursue multiple strategies to answer these questions and assess the overall impact of the project, including whether we are beginning to see evidence of the anticipated benefits—e.g., improved outcomes, increased consumer and family satisfaction, increased flow, a wider array of non-professional resources available to support people in recovery, and others. Some of the learning and assessment processes and data that will guide our discernment include the following.

1. Each partner organization will develop its own data sources and process for assessing the impact of the initiative on its work in the world. These processes will result in one or more products documenting the intra-organizational impact of the initiative, products that will be shared among the partner organizations, BHRS leaders, MHSA representative stakeholders, and others as appropriate. Such products will of course build upon and incorporate outcome measures and data sources already employed by the organizations, including client outcome measures, customer and family satisfaction surveys, and others.

2. The Center for Collective Wisdom will contract with Applied Survey Research (appliedsurveyresearch.org) to develop an initiative-wide learning and assessment protocol that will include surveys, key informant interviews, and focus groups from participants, people receiving services, family members, and others across the six partner organizations and within BHRS. Data from this process will be shared regularly with leaders from the six partner organizations and BHRS to guide our assessment of the emerging impact of the initiative, and how we want to evolve it over time.

3. Every major inter-organizational event—including webinars, summits, Peer Ally trainings, and others—will invite participants to offer written feedback sharing what they learned, what worked well, and what could be improved. Summaries of this feedback will be shared with participants and others as data about what is unfolding and what can be improved over time.

4. We will produce multiple written reports assessing the progress and lessons learned during the initiative, incorporating data from all of the sources identified above. These reports (and other written and visual products we develop) will document the tangible benefits, emerging challenges, and deepening learning by organization leaders, Peer Allies, BHRS leaders and staff members, people who receive services, family members, MHSA representative stakeholders, and others as appropriate.

These various forms of measurement will help us discern the answers to the learning questions detailed in the Contribution to Learning Section above. The data from these processes will also help leaders from participating organizations and BHRS discern how best to sustain and extend the transformation effort beyond the Innovation project.

Total and annual budget logically related to Innovation goals and timeline:

Project INN 11 Stanislaus County Wisdom Transformation Initiative is a three year project with a total cost of $844,445.

Year 1 - $352,073
Year 2 - $410,838
Year 3 - $81,535

This budget is based on estimated expenses for consultants, salaries for technical and administrative support, and project expenses such as video, printing and other meeting supplies that will allow for the engagement of many community-based partners in a broad-based effort to promote the Department's four aspects of long term change: community capacity, fiscal sustainability, leadership and result accountability.

Leveraging Resources (if applicable)
Provide a list of resources expected to be leveraged, if applicable.

Participating organizations will invest substantial staff time to support this project, and a variety of resources to support intra-and inter-organizational learning sessions, including technology resources, supplies, meeting space, and others. Additional resources are likely to be contributed in support of promising collaborative strategies to promote behavioral health and wellbeing that emerge through the implementation of the project.

The initiative will also leverage the networks of community relationships that have emerged through the community capacity-building efforts funded through MHSA efforts over the past several years, and deepen the already strong intention, within BHRS and its many partners, to eradicate stigma and promote behavioral health and wellbeing throughout Stanislaus County.

EXHIBIT F

Innovation Projected Revenues and Expenditures

County: Stanislaus

Fiscal Year: 2013/14

Work Plan #: 11

Work Plan Name: Wisdom Transformation Initiative

New Work Plan ☑

Expansion ☐

Months of Operation: 07/13-06/14
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/ CBO	Total
A. Expenditures				
1. Personnel Expenditures			190,823	$190,823
2. Operating Expenditures			46,100	$46,100
3. Non-recurring expenditures			35,000	$35,000
4. Training Consultant Contracts			80,150	$80,150
5. Work Plan Management			0	$0
6. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$352,073**	**$352,073**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$0**	**$0**	**$352,073**	**$352,073**

Prepared by: Jessica Tucker

Date: 4/11/2013

Telephone Number: 209-525-6020

Stanislaus County Wisdom Transformation Initiative
Budget Narrative

Narrative for FY 2013-14

1. **Personnel Expenditures $190,823**

These expenditures include:

a. Over 650 hours of time from John Ott, J.D. and Rose Pinard, Ph.D., co-founders of the Center for Collective Wisdom (C4CW). Ott and Pinard will take the lead on all aspects of the initiative, including providing consultation with participating organizations; designing and facilitating the webinars; designing and facilitating the Transformation Summit; designing and facilitating the trainings for Peer Allies; designing and facilitating meetings of the Leadership Collaborative; providing training and supervision to the locally-based consultant; overseeing the learning and assessment process; and other responsibilities.

b. Over 200 hours from C4CW's Engagement Ally, who will be responsible for building the online infrastructure to support the webinars, coordinating all logistics associated with the Transformation Summit; all logistics associated with the Peer Ally trainings; and related responsibilities.

c. Support from C4CW personnel and contractors to provide support to the overall initiative, including managing communications systems, transformation grant allocations, contract monitoring and administrative responsibilities associated with the project.

2. **Operating Expenditures $46,100**

These expenditures include:

a. $5,000 grants for each of the six participating organizations to support their work adapting the Wisdom Transformation framework to support their particular programs and services.

b. Meeting, printing, and video expenses for the Transformation Summit, webinars, and Peer Ally trainings. We will videotape many of these session and upload as online learning resources for participants and others.

3. Non-recurring expenditures $35,000

These expenditures include the first year of a three-year contract with Applied Survey Research to design and implement the overall initiative learning and assessment plan.

4. **Training Consultant Contracts $80,150**

These expenditures include over 450 hours from a locally based consultant who will be trained and supervised by Ott and Pinard to become expert in the Wisdom Transformation framework. The intention is for this local consultant (former BHRS Director Denise Hunt) to become an ongoing resource and support for the effort beyond the life of the Innovation Project. Hunt's responsibilities in this first year will include shadowing Ott and Pinard in many of their consultation session with local organizations; helping to design and support the Transformation Summit; helping to design and participate in the Peer Ally trainings; helping to facilitate and support the Leadership Collaborative, and others.

New: Innovation Work Plan Narrative

Date: April 24, 2013

County: Stanislaus
Work Plan #12:
Work Plan Name: Garden Gate Innovative Respite Project

Primary Purpose of Proposed Innovation Project
_____ Increased Access to Underserved Groups
__X__ Increase the Quality of Services, including Better Outcomes
_____ Promote Interagency Collaboration
_____ Increase Access to Services

Project Description

The Alternative Respite Project is a consumer and family centered approach to providing short-term crisis respite housing and peer support for individuals and their families who are at-risk for psychiatric hospitalization. The primary purpose of increasing quality of services, including outcomes was selected as the focus, though all primary purposes will be addressed if the innovation is successful.

The project will support and accelerate the local county-wide transformation by advancing learning on the following issues: expanding options for people struggling with co-occurring issues of substance abuse and mental illness and connecting people to community based supports.

Why this Project – Why Now

Context for this project is based in Behavioral Health and Recovery Services' long-standing commitment to incorporating peer and family member support in and around mental health and drug and alcohol services. Since 1998, Wellness Recovery Center has been a leader locally and statewide in the practice of placing recovery-based peer support parallel to traditional services. In all systems of care, behavioral health programs exist that include elements of recovery/wellness/resiliency-focused peer support. Since 2008, MHSA funded Prevention and Early Intervention (PEI) projects have taken community-based supports to a new level through community capacity building. Community is defined as "a group of people who know each other well enough that they can act together and support each other". Beginning in FY09-10 BHRS adopted an approach with MHSA Innovation to learn new and effective methods of engaging and coordinating community as a response to the adaptive dilemma of shrinking resources and growing need for behavioral health services. BHRS currently has innovation projects that are largely focused on expanding the capacity of agencies and communities to expand support for individual and families. Stigma reduction and wellness promotion are central themes in all these efforts.

There is a current unmet service need in access and crisis response that is resulting in an increase in first-time psychiatric hospitalization. We believe, and have heard from a cohort of counties, that this is a statewide phenomenon. Reasons for this phenomenon are unclear, though many believe the downturn in the economy, increased unemployment, veterans returning from combat and families that are more stressed than ever are contributing factors.

Currently, in Stanislaus County, there are a number of individuals that are not connecting with outpatient services or community peer support and who are being psychiatrically hospitalized; sometimes repeatedly. Annually in fiscal years (FY) 08-09, 09-10, 10-11 an average of 1600 days of hospitalization occurred. In FY11-12 there was a 25% increase to over 2100 hospital days at an average cost per day is $1031.00. Additionally, for those individuals who were not engaged in service or supports, over the same period of time, the number of hospital re-admissions within 30 days of discharge increased from 50 to 140, an increase of 64%.

We believe individuals are not connecting to services for many reasons, but the most commonly occurring are: some simply don't want services or don't know how to access services when they are available, some don't know what's available, some do not meet criteria for services, some are connected to service programs but are unengaged or experiencing hopelessness about services helping. The burgeoning unmet need and sky rocketing cost of psychiatric hospitalization has led Stanislaus County to the conclusion that a viable innovative alternative to psychiatric hospitalization is necessary and timely.

There are many parts of the issue that would merit the attention of this learning opportunity. BHRS and our local partners have learned over the years that recovery from mental illness and substance abuse is possible and happens for individuals of all ages. We believe there are many paths to recovery and though many individuals are connecting to community-based peer support many are still not finding their way to peer support. Successful efforts to infuse recovery and resiliency into the system have not turned the corner on what reliably connects individuals to community based support. Now is the time to addressing in an innovation project the question: "Can we move outside the paradigm of thinking that there are only two choices for people in a mental health crisis: "treatment vs. no treatment" to include community-based peer support as a real and viable alternative?"

A significant dilemma to be addressed is the presence of a "culture" that exists in the community. One of the collective beliefs held by this culture was best stated by a leader and user of peer support when he said the following: "word on the street is that if you have a mental health crisis go to the hospital". This belief is shared and practiced by individuals in a crisis, law enforcement, medical professionals, family members and behavioral health providers. Sometimes the right approach to certain issues can only be treated within a psychiatric hospital environment however sometimes peer support is sufficient to avoid worsening of the situation. Peer support is defined as "individuals who share their "Gifts" with one another in ways that give hope, direction and social connection"

What We Will Do

The issues to be addressed by the innovation are:

A. Ineffective or nonexistent supports for individuals experiencing a mental health crisis (and/or co-occurring substance use problems) to the extent that the vulnerable individual seeks psychiatric hospitalization as a remedy
B. Individuals in a mental health crisis often feel isolated, alone and vulnerable which makes it hard to reach out for support
C. Repeat hospital admissions for individuals who are not connected to community supports or service programs
D. Individuals and their families who are experiencing a mental health crisis often feel isolated, alone and don't know where to go except to the psychiatric hospital
E. Families of individuals with mental illness don't have enough, if any, support from other families and as a result feel helpless, ineffective and angry at the "system" for failing their mentally ill family member

F. Families don't have enough opportunities to learn self-care and receive support from other families members who have "been there and done that"
G. Soaring cost of psychiatric hospitalization that is diminishing resources in the behavioral health system
H. Uncoordinated outreach and peer support efforts between agencies and community-based programs

Garden Gate Respite Center, successfully operated by Turning Point Community Programs (TPCP) since 2006, is an MHSA – CSS funded Outreach and Engagement service that will be the physical base for this project. The Respite Center at Garden Gate will be expanded from 5 to 10 beds in order to serve as a stronger alternative to hospitalization.

The Respite Center is already known in the community as a safe, comfortable environment for individuals who are homeless and appear to be mentally ill. Help is provided to over 400 individuals annually, most are homeless individuals who stay an average of 2.5 days so that they get off the streets and connect to needed resources within the community. Not a treatment program, Garden Gate Respite Center serves as an engagement program that provides a safe haven with a philosophy of "moving toward wellness". GGRC often is a first point of contact for individuals who need mental health treatment, access to medical care and other services. For some individuals simply deciding to trust enough to accept respite care is a challenge. Steps toward wellness begin from the first day in respite as GGRC staff will begin to refer individuals to the service needed and encourage them to make calls to reconnect with family or other support systems. For those who are already connected to mental health services, calls are made to existing service providers.

Behavioral health providers and law enforcement are the most frequent referral sources.
The handicapped accessible center is open 24 hours a day, 7 days a week with two (2) staff awake and on-duty at all times. An individual's length of stay is evaluated on a daily basis and tailored to the individual's needs. The target population consists of adults, 18 years of age or older, with a mental illness who do not meet Welfare and Institutions Code 5150 criteria and are: homeless or at risk for homelessness; transient; or at risk for victimization and/or incarceration. Many of those served have a co-occurring substance abuse disorder with mental illness.

Target Population:
Adults (25-59 years), older adults (60+ years) and transition age young adults(18-25 years) who experience a mental health crisis, and do not receive outpatient services, except during a crisis, and may frequently and repeatedly be admitted to a psychiatric hospital. Some individuals in the target population do receive outpatient services but the connection with services can be strengthened by community-based peer support.

Embracing MHSA Values

The Alternative Respite Project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, Section 3320. The project approach is grounded in the following specific principles and values:

- A housing-first approach which will assist individuals to avoid psychiatric hospitalization and connect to community supports
- Services are voluntary
- Services are to be offered in the preferred language of the individual in crisis and their family members

- Project approaches are designed to reduce the risk of harm associated with certain behaviors such as drug and or alcohol abuse
- Participation in the service is driven by the participant's own goals, cultural values and interests; this value applies to consumers and family members
- Natural support systems grounded in the participant's own culture and available in specific cultural communities will be engaged to strengthen community support offered to individuals and their families; e.g. agencies serving diverse communities will participate in the collaborative workgroup that seeks to develop and strengthen peer support.
- Project approaches will include training for individuals with lived experience, family members, parents, caregivers and others in the following areas: providing outreach and engagement as well as skills to assist others in accessing community resources
- Wellness and recovery approach that includes physical health, mental health, and substance abuse needs, as well as transportation, follow –up, encouragement, engagement and emphasizing the inherent resiliency of individuals.
- Participating agencies and other key partners will participate in start-up workgroup and collaborate in ongoing efforts to ensure progress toward expected outcomes.
- Outcomes data will be collected and analyzed in order to inform learning, innovation of existing practices and system change. In particular there is interest in whether this project is a sustainable and cost effective approach to significantly reducing psychiatric hospital admits and related costs to the system.

Contribution to Learning

Describe how the Innovation Project is expected to contribute to learning. Innovation affects an aspect of mental health practices or assesses a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges.

Consistent with Innovation guidelines, given by past and present state agencies, this project explores making a change to an existing mental health system. Changes include practice/approach in behavioral health system outreach, capacity building, and community development by offering and encouraging peer support and community connection to individuals with mental illness and co-occurring substance abuse with mental illness as an alternative to hospitalization. The approach includes offering and encouraging family to family member support for families of the individual with mental illness.

The Learning Questions

The overarching questions that we will explore through this project include:

1. Can a "culture" shift occur in the community?
    a. Creating better alignment between need and support available
    b. Creating a more effective way of supporting individuals and families that experience the negative consequences of mental illness?

2. Can this project approach allow individuals to step away from their illness, increase self esteem, promote recovery, reduce stigma and contribute to healthier, happier and more productive members of the community who are less dependent on the behavioral health service system in a crisis?

3. Can we assist people to avoid the trauma of psychiatric hospitalization by offering community based peer support paired with short term respite care?

4. Can we learn a new cost effective approach to significantly reduce psychiatric hospital admits and possibly other related costs to the behavioral health and related systems; such as emergency rooms and jails?

Through our efforts to address the overarching questions, we expect to learn a great deal about how to connect individuals to community supports effectively, and produce better outcomes. Specifically, we will seek to learn from these questions:

5. Does offering a safe and trusting short-term living environment to individuals in a mental health crisis provide sufficient basis for them to connect with inclusive and welcoming community based support?

6. Does offering a safe and trusting short-term living environment to individuals in a mental health crisis provide sufficient basis for their family members to connect with inclusive and welcoming community based support?

7. Can we move outside the paradigm of thinking that there are only two choices for people in mental health crisis: “treatment vs. no treatment”?

8. Can we move outside the paradigm of “treatment vs. no treatment” to assist people in avoiding the trauma and isolation of no support?

9. Respite approaches are known to be successful, will the following differentiation between this project and existing practices help move us outside the paradigm of “treatment vs. no treatment” as the primary alternatives?

    a. A collaborative workgroup will coordinate efforts to ensure adherence to the proposed learning approaches to integrating: culturally specific, community-based peer support and family support.

Timeline

Outline the timeframe within which the Innovation project will operate, including communication results and lessons learned.

Implementation/completion dates: July 1, 2013 – June 30, 2016

This project is a three year effort, beginning in July 2013 and concluding on or before June 30, 2016.

During FY2013-14:

a. Start-up activities will begin immediately following OAC approval and establishment of an expanded service contract between BHRS and the provider. The provider will recruit, hire, and train staff for the expanded Respite. Services are anticipated to be operational no later than September 2013.
b. During the first 3 months, a workgroup composed of individuals with lived experience as mental health consumers, family members of individuals with mental illness, behavioral health service providers, community-based providers of diverse outreach and prevention services , evaluation specialists, the provider of respite services as well as others to be identified will convene to refine the approach. When the approach is developed, it will be implemented for the first year.
c. During the first 3 – 5 months, evaluation instruments will be developed and/or identified for use during the study phase. Additionally, during this time, a method and

timeframe for reviewing data will be developed, adjustments made as needed, and other administration/operational issues related to the service approach conducted.

During FY 14-15:
Continue all services and evaluation activities through this first full year. Adjust evaluation approach and measurement tools as needed for continued effectiveness and study of the proposed learning questions. Changes may be made to the project as the ongoing results are known.

During FY 15-16:
Continue services and evaluation activities into the final year of the learning project. Begin to formulate approach to the final learning report. Begin to evaluate learning and long term outcomes to confirm establishment of best practices and methods of successfully integrating learning into wider practice. Evaluate alternative funding options for continuation of Respite Expansion that includes effective new practices should they emerge.

Detail Timeline for MHSA Innovation Project – Innovative Respite Project at Garden Gate	
7/13 –10/13	♦ Recruit, hire and train staff for the project that are knowledgeable and enthusiastic about the innovation project ♦ Identify key partners/peer support organizations that are knowledgeable of the role of persons with live experience and their families in linking adults with psychiatric disabilities to a variety of tradition and non-traditional community-based resources. ♦ Convene an implementation workgroup composed of individuals with lived experience as mental health consumers, family members of individuals with mental illness, behavioral health service providers, community-based providers of diverse outreach and prevention services, evaluation specialists, the provider of respite services as well as others to be identified later to meet as needed during early implementation and no less than quarterly in on-going implementation ♦ Identify a BHRS Project Point person for monitoring implementation including budget and focus on approach to learning,
7/13 –11/13	♦ Identify appropriate survey tools or develop original survey tools for use during the implementation and study phase of the project ♦ Use a quality management approach to project monitoring to ensure that outcomes are linked to specific elements of the project
10/13 – 6/16	♦ Implementation and study phase – monitor progress toward intermediate and long term goals ♦ Innovation Workgroup to meet no less than quarterly to ensure focus on learning and collaboration is substantive
7/14 - 6/15	♦ Ongoing assessment and analysis of data and outcomes, adjust approach, continue project into final year.
7/15 – 6/16	♦ Conclude learning project, final assessment and analysis of data and outcomes, assess merit of continuing with alternative funding source, produce final learning report, communicate results and lessons learned.

Defining and Measuring Success:

Describe the plan to evaluate whether/how Innovative Project has proven to be successful.

Issue	Related Learning Question	Expected Outcome	Performance Measure	Measurement Frequency/ Methodology	Measurement Tool/Data Source
A. Ineffective or nonexistent supports for individuals experiencing a mental health crisis (and/or co-occurring substance use problems) to the extent that the vulnerable individual seeks psychiatric hospitalization as a remedy	#3	a) Decrease in the number of hospital days of respite population b) Hospitalization avoidance of respite population	a) # and % change in hospital days of respite population b) % of respite population not hospitalized within 30 days	a) Aggregate # of hospital days 1 year prior to respite support compared to aggregate # of hospital days 1 year post respite support b) monthly, quarterly, annually	a) Anasazi b) Anasazi
B. Individuals in a mental health crisis often feel isolated, alone and vulnerable which makes it hard to reach out for support	#1	Respite population will reach out for support	# and % of respite population who reach out for support	Reaching out for support is defined as "taking action to connect and/or gain support." The contractor will collect and record data for every participant	Contractor records of actions taken to connect and/or gain support
C. Repeat hospital admissions for individuals who are not connected to community supports or service programs	#3,4	Decrease in hospital readmissions for respite population	# and % of respite population who are readmitted to the hospital within 30 days and within 1 year	Monthly, quarterly, annually	Anasazi
D. Individuals and their families who are experiencing a mental health crisis often feel isolated, alone and don't know where to go except to the psychiatric hospital	#5,6,7	See Outcomes for Issue "A"	See Performance Measures for Issue "A"	See Frequency / Methodology for Issue "A"	See Tool/Source for Issue "A"
E. Families of individuals with mental illness don't have enough, if any, support from other families and as a result feel helpless, ineffective and angry at the "system" for failing their mentally ill family member	#6,7	Families will gain support from peer families and be empowered and hopeful	a) # and % of families who connect with peer families b) # and % of families who are satisfied with peer connection	a) Contractor will collect and record data for every family. "Connect" is defined as making contact at least 1 time. b) Survey will be used to collect satisfaction data after peer connection occurs	a) Contractor records of connections b) Survey
F. Families don't have enough opportunities to learn self-care and receive support from other families members who have "been there and done that"	#6,7	Families will gain support and learn self-care from peer families	# and % families who feel supported and have learned self-care from peer families	Survey will be used to collect self-reported data	a) Survey

Issue	Related Learning Question	Expected Outcome	Performance Measure	Measurement Frequency/ Methodology	Measurement Tool/Data Source
G. Soaring cost of psychiatric hospitalization that is diminishing resources in the behavioral health system	#4	Hospitalization days of the respite population will decrease, and in turn decrease the cost of hospitalization for this population	a) Cost of post respite hospital days (see Issue "A") compared to cost of pre respite hospital days b) Cost of hospitalization days avoided with respite support	a) Hospitalization cost data will be used for the respite population b) Hospitalization cost data will be used to calculate the cost that would be incurred if the respite population was hospitalized	a) Anasazi and accounting records b) Anasazi and accounting records
H. Uncoordinated outreach and peer support efforts between agencies and community-based programs	#1, #3, #9	The integration of peer support is developed and strengthened	a) % of those receiving respite and also receiving peer support b) % of diverse stakeholders participating in the workgroup c) % of workgroup members indicating progress toward expected outcomes	a) Not less than quarterly meetings	a) Workgroup sign-in sheets b) Workgroup notes c) Brief Attitudinal Scale administered at the end of the workgroup meeting to measure goals.

Total and annual budget logically related to Innovation goals and proposed timeline

Garden Gate Innovative Respite is a three year project with a total cost of $1,650,352.

Year 1 Total Proposed Expenditures: $560,429
Year 2 Total Proposed Expenditures: $534,282
Year 1 Total Proposed Expenditures: $555,641

This budget is based on estimated salary costs for treatment and management staff, operating expenses for household supplies, office supplies, utilities, insurance, other start-up costs, and client support expenditures for member recreation to allow for the expansion of respite services to address the critical need in 24/7 secure mental health services.

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

None identified.

EXHIBIT F
Innovation Projected Revenues and Expenditures

County: Stanislaus
Fiscal Year: 2013/14

Work Plan #: 12
Work Plan Name: Garden Gate Alternative Respite

New Work Plan ☑
Expansion ☐

Months of Operation: 07/13-06/14
MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/ CBO	Total
A. Expenditures				
1. Personnel Expenditures			420,013	$420,013
2. Operating Expenditures			116,769	$68,763
3. Non-recurring expenditures			23,647	$23,647
4. Training Consultant Contracts			0	$0
5. Work Plan Management			0	$0
6. Total Proposed Work Plan Expenditures	**$0**	**$0**	**$560,429**	**$560,429**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$0**	**$0**	**$560,429**	**$560,429**

Prepared by: Jessica Tucker
Date: 4/11/2013

Telephone Number: 209-525-6020

Garden Gate Innovative Respite
Budget Narrative for the 3 years July 1, 2013 through June 30, 2016

1 Personnel: $420,013

Personnel

.2 FTE Director of Adult Services - $21,730 ($52.24 per hour 416 hours)

This position and hours will be utilized to [provide ongoing supervision for the fiscal and clinical integrity of the program, as well as examine systemic issues related to daily operations. Continue to assist in keeping learning objectives and opportunities as focus for project. Ensure that community integration and resources are maximized for participants. Has experience locating and linking adults with psychiatric disabilities to generic community-based resources. Also has experience collaborating with generic community-based resources in combating stigma and fostering well-being in a recovery-oriented manner. Director of Adult Services will participate on the implementation workgroup with agencies that provide peer support and/or organizations that are knowledgeable of the role of persons with live experience and their families in linking adults with psychiatric disabilities to generic community-based resources.

.3 FTE Program Director - $20,754 ($33.26 per hour 624 hours)

The Program Director works closely with the Clinical Director to provide direction and supervision to the Respite staff in maximizing necessary skill sets for this specific Innovation Project. Motivational Interviewing Skills, Harm Reduction Techniques, exploring participant's interests, hobbies, and desires for increased community involvement and peer related activities. This position will orchestrate much effort in collaborative relationships with community providers, events, activities, peer-based services and supports. Has experience locating and linking adults with psychiatric disabilities to generic community-based resources. Also has experience collaborating with generic community-based resources in combating stigma and fostering well-being in a recovery-oriented manner. Program Director will participate on the implementation workgroup with agencies that provide peer support and/or organizations that are knowledgeable of the role of persons with live experience and their families in linking adults with psychiatric disabilities to generic community-based resources.

1 FTE Clinical Director - $63,752 ($30.65 per hour 2,080 hours)

The Clinical Director will provide consistent direction and support under the supervision of the Program Director to maintain a high degree of clinical expertise as well as the utilization of best practice techniques mentioned above; M.I., H.R. With the increase in beds and participants, we will want to establish a best practice for assessments, interaction skills, alignment with peer navigators, and support and guidance for the Housing Specialist as it relates to the garden gate apartments. Candidate must have experience locating and linking adults with psychiatric disabilities to generic community-based resources. Also, candidate must have experience collaborating with generic community-based resources in combating stigma and fostering well-being in a recovery-oriented manner. Clinical Director will participate on the implementation workgroup with agencies that provide peer support and/or organizations that are knowledgeable of the role of persons with live experience and their families in linking adults with psychiatric disabilities to generic community-based resources.

1 FTE Certified Alcohol & Drug Counselor - $49, 525 ($23.81 per hour 2,080 hours)

One of the purposes of this project is to learn what is possible in the way we engage and assist individuals who have dual recovery issues. Having a drug & alcohol certified specialist will allows us to have specific expertise in addressing the systemic growing concern for co-morbidity as it relates to recidivism. Providing treatment assessments and linkage to services, as well as utilize harm reduction techniques for those who can't or won't abstain from drinking and/or using will be critical to our mission in examining the impact of alternative respite care in regard to minimizing the high costs of acute psychiatric hospitalization. Candidate must have experience locating and linking adults with psychiatric disabilities to generic community-based resources that does endorse harm reduction. Also, candidate must have experience collaborating with generic community-based resources in combating stigma and fostering well-being in a recovery-oriented manner. Certified Alcohol & Drug Counselor will participate on the implementation workgroup with agencies that provide peer support and/or organizations that are knowledgeable of the role of persons with live experience and their families in linking adults with psychiatric disabilities to generic community-based resources.

1.4 FTE Personal Service Coordinator II - $48,164 ($16.54 per hour 2,912 hours)

The PSC is a case management position that will bring more skill sets to the existing staff, under the supervision of the Clinical Supervisor. The Alternative Respite Project will require much more that a safe and trusting environment as well as observation and interactions. PSCs will have the necessary skill sets to provide daily interaction, referrals, and engagement techniques to support our over-arching goal of seeing what is possible by maximizing collective efforts to reconnect people to their natural and community supports to help them towards greater independence. Candidate must have experience locating and linking adults with psychiatric disabilities to generic community-based resources or utilizing the aforementioned resources and endorse harm reduction. Also, candidate must have experience collaborating with or using generic community-based resources in combating stigma and fostering well-being in a recovery-oriented manner. Personal Service Coordinator II will inform the implementation workgroup.

1.4 FTE Housing Specialist - $47,291 ($16.24 per hour 2,912 hours)

The Housing Specialist develops relationships with various landlords, property managers, etc. in order to secure master leases to provide housing to members and is responsible for ensuring that all such housing is maintained appropriately. Responsible for seeing that housing, when vacated, is appropriately cleaned, repaired, etc. in order to be ready for the next client tenant. Responsible for tracking, accepting and managing all rents and other expenses associated with housing and leases.

1.3 FTE On-call $28,000 because the program is operated 24/7 we make substantial use of standby employees. This ensures that there will always be personnel available.

Benefits and Taxes - $140,797 includes all required payroll taxes, 5% retirement contribution, health benefit @$0 to $5,820 per year depending on employee, vacation/holiday calculated at 2% of salary, worker compensation insurance, SUI, and FICA/MediCare.

Year 2 is $420,013 and Year 3 includes Cost of Living Adjustment (COLAs) $436,814

2 Operating: $41,600

Medical supplies and pharmaceuticals - $600 on occasion immediate needs will necessitate prescription drugs or minor medical treatment.

Food - $11,055 is based upon 5 residents, 365 days per year or $6.06 per day. This calculation is based upon experience gathered from two respite homes operated currently.

Household supplies, - $8,172 minor but necessary things to run a home including dishes and silverware, cookware, cleaning supplies, paper goods, and other items. It also includes minor equipment, and window coverings and linen.

Equipment rental, repair and maintenance, software license support - $482 copier lease, computer software license costs, and maintenance contract on the copier.

Facility repair & maintenance - $315 – day to day upkeep will be performed by the residents but occasional repairs will need to be made and charged under this line item.

Utilities- $5,875 are estimated based upon the current respite home located in Modesto

Telephone - $7,514 is estimated based upon the current respite home costs and include both cell phone and land line costs.

Insurance - $2,909 contractually required coverage such as liability, damages, etc. It does not include any of the payroll related insurance such as worker compensation.

Employee mileage - $912 is estimated at $.50 per mile, 152 miles per month.

Office expenses - $3,766 office supplies such as paper, copier supplies, desk utensils, and other items required for the office administration of the program.

Years 2 and 3 include $41,600 and $43,252.

3 Non-recurring Expenditures: $23,647

Computer and communications equipment - $3,442 PC with peripherals, phones, licenses, data lines and installation.

Furnishings and fixtures - $13,105 bedroom and sitting room furniture, TV and DVD, 2 security cameras, washer, dryer, refrigerator and kitchen furniture, and other miscellaneous furnishings and items needed to begin services.

Training and orientation - $7,100 training in Evidence Based Practices, Trauma Informed Care, Housing First, Harm Reduction, and Case Management Housing Services. Also includes, pre-opening costs for employee orientation and basic training in areas such as Good Neighbor Policies and administrative requirements.

4 Allocated Expense: $71,653

Indirect Administrative - $71,653 is the individual program's share of the costs incurred to provide administrative services. The executive, accounting, and human resources departments are housed in a centralized location. All the costs associated with these services are gathered into a single cost center and allocated to both general and restricted funds based upon salaries.

As part of indirect administrative is the employee who tracks program outcomes. We estimate she will spend an average of 3 hours per week on Garden Gate Innovation Respite.

Years 2 and 3 include $71,653 and 74,519.

5 Client Support Expense: $3,516

Member recreation/socialization - $1,016 is part of the healing process reengagement within a social environment.

Transitional Housing - $2,500 - is part of the process to change the environment that contributed to the client's need for program services. Many are or were homeless at the time of admission. Ensuring that upon discharge the client is admitted to secure housing is an essential part of the program. These costs may include deposits or residential one-time costs.

Years 2 and 3 include $3,516 and $3,556

Stanislaus County Behavioral Health & Recovery Services
30-Day Public Comment Form

Mail completed forms to: 800 Scenic Drive, Modesto, CA 95350
Fax completed forms to: 209-525-6291
E-mail completed forms to: cyang@stanbhrs.org
More information: www.stanislausmhsa.com, 209-525-6247

Mental Health Services Act (MHSA)
MHSA Annual Update FY2013-14

30-Day Comment Period:
April 24, 2013 – May 23, 2013

PERSONAL INFORMATION (optional)

Name: _____ Agency/Organization: _____

Phone Number: _____ Email address:_____

Mailing address: _____

MY ROLE IN THE MENTAL HEALTH COMMUNITY (check all that apply)

__ Consumer/Service Recipient
__ Family Member
__ Education
__ Social Services
__ Service Provider
__ Law Enforcement/Criminal Justice
__ Probation
__ Other (specify) _____

WHAT DO YOU SEE AS THE STRENGTHS OF THE ANNUAL UPDATE?

IF YOU HAVE CONCERNS ABOUT THE ANNUAL UPDATE, PLEASE EXPLAIN.

Servicios de Salúd Mental, Alcohol y Drogas del Condado de Stanislaus
Formulario Para Comentarios Públicos de 30-Días

Enviar formularios completados a: 800 Scenic Drive, Modesto, CA 95350
Enviar formularios completados por fax a: 209-525-6291
Enviar formularios completados por correo electrónico a: khurley@stanbhrs.org
Para mas información, visite o llame a: www.stanislausmhsa.com, 209-525-6247

Acta de Servicios de Salúd Mental (MHSA)
Plan Anual de MHSA Año Fiscal 2013-14

Periódo de 30-Dias Para Comentarios :
abril 24, 2013 – mayo 23, 2013

INFORMACIÓN PERSONAL (opcional)

Nombre: _____

Agencia/Organización: _____

Teléfono: _____

Dirección Electrónico:_____

Domicilio: _____

MI PAPEL COMMUNITARIO EN EL SISTEMA DE SALUD MENTAL (marque todo lo que aplique)

__ Consumidor/Recipiente de Servicios
__ Miembro de Familia
__ Educación
__ Servicios Sociales
__ Proveedor de Servicios
__ Enforsar la Ley/Justicia Criminal
__ Libertad Condicional
__ Otro (especifique) _____

QUE CONSIDERA USTÉD QUE SON LOS PUNTOS FUERTES DEL PLAN ANUAL?

SI TIENE CONCIERNES SOBRE EL PLAN ANUAL, POR FAVOR EXPLIQUE:

AGREEMENT
FOR
INDEPENDENT CONTRACTOR SERVICES

This Agreement for Independent Contractor Services (the "Agreement") is made and entered into by and between the County of Stanislaus ("County") and Center for Collective Wisdom, a California Nonprofit Corporation ("Contractor"). This Agreement shall be effective as of the date of the signature of the last party to sign it (the "Agreement").

Recitals

WHEREAS, COUNTY, through Behavioral Health and Recovery Services wishes to create a stronger and more positive internal environment for staff, board members, and others connected to the organization so they can better support the people they serve; and

WHEREAS, COUNTY, through its department of Behavioral Health and Recovery Services has a need to learn new and effective methods of engaging its partners and the community in addressing the growing need for behavioral health services, and doing so in ways that are consistent with the General Standards identified in the MHSA and Title 9, CCR, Section 3320 and the Mental Health Services Act Innovation Plan which was approved and funded by the State Department of Mental Health; and

WHEREAS, CONTRACTOR will support a collaborative transformation and learning effort among six non-profit and community-based organizations in Stanislaus County; and

WHEREAS, CONTRACTOR will help each organization better respond to the continuing need for behavioral health services in the county with the shrinking resources available that the county behavioral health system is facing, and to facilitate a deeper level of collaboration among the six organizations and between the organizations and COUNTY; and

WHEREAS, COUNTY requires and CONTRACTOR is able to provide services that will put into operation the MHSA Essential Elements: community collaboration, cultural competency, consumer / family driven system, wellness, recovery, and resilience, and, integrated service experience.

WHEREAS, the CONTRACTOR is specially trained, experienced and competent to perform and has agreed to provide such services.

NOW, THEREFORE, in consideration of the mutual promises, covenants, terms and conditions hereinafter contained, the parties hereby agree as follows:

Terms and Conditions

1. Scope of Work

1.1 The Contractor shall furnish to the County upon execution of this Agreement or receipt of the County's written authorization to proceed, those services and work set forth in **Exhibit A**, attached hereto and, by this reference, made a part hereof.

1.2 All documents, drawings and written work product prepared or produced by the

Contractor under this Agreement, including without limitation electronic data files, are the property of the Contractor; provided, however, the County shall have the right to reproduce, publish and use all such work, or any part thereof, in any manner and for any purposes whatsoever and to authorize others to do so. If any such work is copyrightable, the Contractor may copyright the same, except that, as to any work which is copyrighted by the Contractor, the County reserves a royalty-free, non-exclusive, and irrevocable license to reproduce, publish, and use such work, or any part thereof, and to authorize others to do so.

1.3 Services and work provided by the Contractor at the County's request under this Agreement will be performed in a timely manner consistent with the requirements and standards established by applicable federal, state and County laws, ordinances, regulations and resolutions, and in accordance with a schedule of work set forth in **Exhibit A**. If there is no schedule, the hours and times for completion of said services and work are to be set by the Contractor; provided, however, that such schedule is subject to review by and concurrence of the County.

2. Consideration

2.1 County shall pay Contractor as set forth in **Exhibit A**.

2.2 Except as expressly provided in **Exhibit A** of this Agreement, Contractor shall not be entitled to nor receive from County any additional consideration, compensation, salary, wages or other type of remuneration for services rendered under this Agreement. Specifically, Contractor shall not be entitled by virtue of this Agreement to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays or other paid leaves of absence of any type or kind whatsoever.

2.3 County will not withhold any Federal or State income taxes or Social Security tax from any payments made by County to Contractor under the terms and conditions of this Agreement. Payment of all taxes and other assessments on such sums is the sole responsibility of Contractor. County has no responsibility or liability for payment of Contractor's taxes or assessments.

2.4 Pursuant to Penal Code section 484b and to Business and Professions Code section 7108.5, the Contractor must apply all funds and progress payments received by the Contractor from the County for payment of services, labor, materials or equipment to pay for such services, labor, materials or equipment. Pursuant to Civil Code section 1479, the Contractor shall direct or otherwise manifest the Contractor's intention and desire that payments made by the Contractor to subcontractors, suppliers and materialmen shall be applied to retire and extinguish the debts or obligations resulting from the performance of this Agreement.

3. Term

3.1 The term of this Agreement shall be from the date of approval of this Agreement until completion of the agreed upon services unless sooner terminated as provided below or unless some other method or time of termination is listed in **Exhibit A**.

3.2 Should either party default in the performance of this Agreement or materially breach any of its provisions, the other party, at that party's option, may terminate this Agreement by giving written notification to the other party.

3.3 This Agreement shall terminate automatically on the occurrence of (a) bankruptcy or insolvency of either party, (b) sale of Contractor's business, (c) cancellation of insurance required

under the terms of this Agreement, and (d) if,for any reason, Contractor ceases to be licensed or otherwise authorized to do business in the State of California, and the Contractor fails to remedy such defect or defects within thirty (30) days of receipt of notice of such defect or defects.

3.4 The County may terminate this agreement upon 30 days prior written notice to the Contractor. Termination of this Agreement shall not affect the County's obligation to pay for all fees earned and reasonable costs necessarily incurred by the Contractor as provided in Paragraph 2 herein, subject to any applicable setoffs.

4. Required Licenses, Certificates and Permits

Any licenses, certificates or permits required by the federal, state, county or municipal governments for Contractor to provide the services and work described in Exhibit A must be procured by Contractor and be valid at the time Contractor enters into this Agreement. Further, during the term of this Agreement, Contractor must maintain such licenses, certificates and permits in full force and effect. Licenses, certificates and permits may include but are not limited to driver's licenses, professional licenses or certificates and business licenses. Such licenses, certificates and permits will be procured and maintained in force by Contractor at no expense to the County. Contractor shall comply with all applicable local, state and Federal laws, rules and regulations.

5. Office Space, Supplies, Equipment, Etc.

Unless otherwise provided in **Exhibit A**, Contractor shall provide such office space, supplies, equipment, vehicles, reference materials and telephone service as is necessary for Contractor to provide the services identified in **Exhibit A** to this Agreement. County is not obligated to reimburse or pay Contractor for any expense or cost incurred by Contractor in procuring or maintaining such items. Responsibility for the costs and expenses incurred by Contractor in providing and maintaining such items is the sole responsibility and obligation of Contractor.

6. Insurance

6.1 Contractor shall take out, and maintain during the life of this Agreement, insurance policies with coverage at least as broad as follows:

6.1.1 General Liability. Comprehensive general liability insurance covering bodily injury, personal injury, property damage, products and completed operations with limits of no less than One Million Dollars ($1,000,000) per incident or occurrence. If Commercial General Liability Insurance or other form with a general aggregate limit is used, either the general aggregate limit shall apply separately to any act or omission by Contractor under this Agreement or the general aggregate limit shall be twice the required occurrence limit.

6.1.2 Automobile Liability Insurance. If the Contractor or the Contractor's officers, employees, agents, representatives or subcontractors utilize a motor vehicle in performing any of the work or services under this Agreement, owned/non-owned automobile liability insurance providing combined single limits covering bodily injury, property damage and transportation related pollution liability with limits of no less than One Million Dollars ($1,000,000) per incident or occurrence.

6.1.3 Workers' Compensation Insurance. Workers' Compensation insurance as required by the California Labor Code. In signing this contract, the Contractor certifies under section 1861 of the Labor Code that the Contractor is

aware of the provisions of section 3700 of the Labor Code which requires every employer to be insured against liability for workmen's compensation or to undertake self-insurance in accordance with the provisions of that code, and that the Contractor will comply with such provisions before commencing the performance of the work of this Agreement.

6.2 Any deductibles, self-insured retentions or named insureds must be declared in writing and approved by County. At the option of the County, either: (a) the insurer shall reduce or eliminate such deductibles, self-insured retentions or named insureds, or (b) the Contractor shall provide a bond, cash, letter of credit, guaranty or other security satisfactory to the County guaranteeing payment of the self-insured retention or deductible and payment of any and all costs, losses, related investigations, claim administration and defense expenses. The County, in its sole discretion, may waive the requirement to reduce or eliminate deductibles or self-insured retentions, in which case, the Contractor agrees that it will be responsible for and pay any self-insured retention or deductible and will pay any and all costs, losses, related investigations, claim administration and defense expenses related to or arising out of the Contractor's defense and indemnification obligations as set forth in this Agreement.

6.3 The Contractor shall obtain a specific endorsement to all required insurance policies, except Workers' Compensation insurance and Professional Liability insurance, if any, naming the County and its officers, officials and employees as additional insureds regarding: (a) liability arising from or in connection with the performance or omission to perform any term or condition of this Agreement by or on behalf of the Contractor, including the insured's general supervision of its sub-contractors; (b) services, products and completed operations of the Contractor; (c) premises owned, occupied or used by the Contractor; and (d) automobiles owned, leased, hired or borrowed by the Contractor. For Workers' Compensation insurance, the insurance carrier shall agree to waive all rights of subrogation against the County and its officers, officials and employees for losses arising from the performance of or the omission to perform any term or condition of this Agreement by the Contractor.

6.4 The Contractor's insurance coverage shall be primary insurance regarding the County and County's officers, officials and employees. Any insurance or self-insurance maintained by the County or County's officers, officials and employees shall be excess of the Contractor's insurance and shall not contribute with Contractor's insurance.

6.5 Any failure to comply with reporting provisions of the policies shall not affect coverage provided to the County or its officers, officials, employees or volunteers.

6.6 The Contractor's insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the insurer's liability.

6.7 Each insurance policy required by this section shall be endorsed to state that coverage shall not be suspended, voided, canceled by either party except after thirty (30) days' prior written notice has been given to County. The Contractor shall promptly notify, or cause the insurance carrier to promptly notify, the County of any change in the insurance policy or policies required under this Agreement, including, without limitation, any reduction in coverage or in limits of the required policy or policies.

6.8 Insurance shall be placed with California admitted insurers (licensed to do business in California) with a current rating by Best's Key Rating Guide acceptable to the County; provided, however, that if no California admitted insurance company provides the required insurance, it is acceptable to provide the required insurance through a United States domiciled carrier that meets the required Best's rating and that is listed on the current List of Eligible Surplus Line Insurers

maintained by the California Department of Insurance. A Best's rating of at least A-:VII shall be acceptable to the County; lesser ratings must be approved in writing by the County.

6.9 Contractor shall require that all of its subcontractors are subject to the insurance and indemnity requirements stated herein, or shall include all subcontractors as additional insureds under its insurance policies.

6.10 At least ten (10) days prior to the date the Contractor begins performance of its obligations under this Agreement, Contractor shall furnish County with certificates of insurance, and with original endorsements, showing coverage required by this Agreement, including, without limitation, those that verify coverage for subcontractors of the Contractor. The certificates and endorsements for each insurance policy are to be signed by a person authorized by that insurer to bind coverage on its behalf. All certificates and endorsements shall be received and, in County's sole and absolute discretion, approved by County. County reserves the right to require complete copies of all required insurance policies and endorsements, at any time.

6.11 The limits of insurance described herein shall not limit the liability of the Contractor and Contractor's officers, employees, agents, representatives or subcontractors.

7. Defense and Indemnification

7.1 To the fullest extent permitted by law, Contractor shall indemnify, hold harmless and defend the County and its agents, officers and employees from and against all claims, damages, losses, judgments, liabilities, expenses and other costs, including litigation costs and attorneys' fees, arising out of, resulting from, or in connection with the performance of this Agreement by the Contractor or Contractor's officers, employees, agents, representatives or subcontractors and resulting in or attributable to personal injury, death, or damage or destruction to tangible or intangible property, including the loss of use; provided, however, such indemnification shall not extendto or cover loss, damage or expense arising from the sole negligence or willful misconduct of the County or its agents, officers and employees.

7.2 Contractor's obligation to defend, indemnify and hold the County and its agents, officers and employees harmless under the provisions of this paragraph is not limited to or restricted by any requirement in this Agreement for Contractor to procure and maintain a policy of insurance.

8. Status of Contractor

8.1 All acts of Contractor and its officers, employees, agents, representatives, subcontractors and all others acting on behalf of Contractor relating to the performance of this Agreement, shall be performed as independent contractors and not as agents, officers or employees of County. Contractor, by virtue of this Agreement, has no authority to bind or incur any obligation on behalf of County. Except as expressly provided in Exhibit A, Contractor has no authority or responsibility to exercise any rights or power vested in the County. No agent, officer or employee of the County is to be considered an employee of Contractor. It is understood by both Contractor and County that this Agreement shall not be construed or considered under any circumstances to create an employer-employee relationship or a joint venture.

8.2 At all times during the term of this Agreement, the Contractor and its officers, employees, agents, representatives or subcontractors are, and shall represent and conduct themselves as, independent contractors and not employees of County.

8.3 Contractor shall determine the method, details and means of performing the work and services to be provided by Contractor under this Agreement. Contractor shall be responsible to County only for the requirements and results specified in this Agreement and, except as expressly provided in this Agreement, shall not be subjected to County's control with respect to the physical action or activities of Contractor in fulfillment of this Agreement. Contractor has control over the manner and means of performing the services under this Agreement. Contractor is permitted to provide services to others during the same period service is provided to County under this Agreement. If necessary, Contractor has the responsibility for employing other persons or firms to assist Contractor in fulfilling the terms and obligations under this Agreement.

8.4 If in the performance of this Agreement any third persons are employed by Contractor, such persons shall be entirely and exclusively under the direction, supervision and control of Contractor. All terms of employment including hours, wages, working conditions, discipline, hiring and discharging or any other term of employment or requirements of law shall be determined by the Contractor.

8.5 It is understood and agreed that as an independent Contractor and not an employee of County, the Contractor and the Contractor's officers, employees, agents, representatives or subcontractors do not have any entitlement as a County employee, and do not have the right to act on behalf of the County in any capacity whatsoever as an agent, or to bind the County to any obligation whatsoever.

8.6 It is further understood and agreed that Contractor must issue W-2 forms or other forms as required by law for income and employment tax purposes for all of Contractor's assigned personnel under the terms and conditions of this Agreement.

8.7 As an independent Contractor, Contractor hereby indemnifies and holds County harmless from any and all claims that may be made against County based upon any contention by any third party that an employer-employee relationship exists by reason of this Agreement.

9. Records and Audit

9.1 Contractor shall prepare and maintain all writings, documents and records prepared or compiled in connection with the performance of this Agreement for a minimum of four (4) years from the termination or completion of this Agreement. This includesany handwriting, typewriting, printing, photostatic, photographing and every other means of recording upon any tangible thing, any form of communication or representation including letters, words, pictures, sounds or symbols or any combination thereof.

9.2 Any authorized representative of County shall have access to any writings as defined above for the purposes of making audit, evaluation, examination, excerpts and transcripts during the period such records are to be maintained by Contractor. Further, County has the right at all reasonable times to audit, inspect or otherwise evaluate the work performed or being performed under this Agreement.

10. Confidentiality

The Contractor and its officers, employees, agents, representatives, subcontractors and all others acting on behalf of Contractor agree to keep confidential all information obtained or learned during the course of furnishing services under this Agreement and to not disclose or reveal such information for any purpose not directly connected with the matter for which services are provided.

11. Nondiscrimination

During the performance of this Agreement, Contractor and its officers, employees, agents, representatives or subcontractors shall not unlawfully discriminate in violation of any federal, state or local law, rule or regulation against any employee, applicant for employment or person receiving services under this Agreement because of race, religion, color, national origin, ancestry, physical or mental disability, medical condition (including genetic characteristics), marital status, age, political affiliation, sex, or sexual orientation. Contractor and its officers, employees, agents, representatives or subcontractors shall comply with all applicable Federal, State and local laws and regulations related to non-discrimination and equal opportunity, including without limitation the County's nondiscrimination policy; the Fair Employment and Housing Act (Government Code sections 12900 et seq.); California Labor Code sections 1101, 1102 and 1102.1; the Federal Civil Rights Act of 1964 (P.L. 88-352), as amended; and all applicable regulations promulgated in the California Code of Regulations or the Code of Federal Regulations.

12. Assignment

This is an agreement for the services of Contractor. County has relied upon the skills, knowledge, experience and training of Contractor and the Contractor's firm, associates and employees as an inducement to enter into this Agreement. Contractor shall not assign or subcontract this Agreement without the express written consent of County. Further, Contractor shall not assign any monies due or to become due under this Agreement without the prior written consent of County.

13. Waiver of Default

Waiver of any default by either party to this Agreement shall not be deemed to be waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach, and shall not be construed to be a modification of the terms of this Agreement unless this Agreement is modified as provided below.

14. Notice

Any notice, communication, amendment, addition or deletion to this Agreement, including change of address of either party during the term of this Agreement, which Contractor or County shall be required or may desire to make shall be in writing and may be personally served or, alternatively, sent by prepaid first classmail to the respective parties as follows:

To County:
County of Stanislaus
Behavioral Health and Recovery Services
Attention: Contract Manager
800 Scenic Drive
Modesto, CA 95350

To Contractor:
Center for Collective Wisdom
Attention: John Ott, President
425 15th St., STE 3716
Manhattan Beach, CA 90266

15. Conflicts

Contractor agrees that it has no interest and shall not acquire any interest direct or indirect which would conflict in any manner or degree with the performance of the work and services under this Agreement.

16. Severability

If any portion of this Agreement or application thereof to any person or circumstance shall be declared invalid by a court of competent jurisdiction or if it is found in contravention of any federal, state or county statute, ordinance or regulation the remaining provisions of this Agreement or the application thereof shall not be invalidated thereby and shall remain in full force and effect to the extent that the provisions of this Agreement are severable.

17. Amendment

This Agreement may only be modified, amended, changed, added to or subtracted from by the mutual consent of the parties hereto if such amendment or change is in written form and executed with the same formalities as this Agreement and attached to the original Agreement to maintain continuity.

18. Entire Agreement

This Agreement supersedes any and all other agreements, either oral or in writing, between any of the parties herein with respect to the subject matter hereof and contains all the agreements between the parties with respect to such matter. Each party acknowledges that no representations, inducements, promises or agreements, oral or otherwise, have been made by any party, or anyone acting on behalf of any party, which are not embodied herein, and that no other agreement, statement or promise not contained in this Agreement shall be valid or binding.

19. Advice of Attorney

Each party warrants and represents that in executing this Agreement, it has received independent legal advice from its attorneys or the opportunity to seek such advice.

20. Construction

Headings or captions to the provisions of this Agreement are solely for the convenience of the parties, are not part of this Agreement, and shall not be used to interpret or determine the validity of this Agreement. Any ambiguity in this Agreement shall not be construed against the drafter, but rather the terms and provisions hereof shall be given a reasonable interpretation as if both parties had in fact drafted this Agreement.

21. Governing Law and Venue

This Agreement shall be deemed to be made under, and shall be governed by and construed in accordance with, the laws of the State of California. Any action brought to enforce the terms or provisions of this Agreement shall have venue in the County of Stanislaus, State of California.

22. Survival

Notwithstanding any other provision of this Agreement, the following clauses shall remain in full force and effect and shall survive the expiration or termination of this Agreement: Paragraph 2, "Consideration"; Paragraph 7, "Defense and Indemnification"; Paragraph 9, "Records and Audit"; Paragraph 10, "Confidentiality"; and Paragraph 12, "Assignment".

IN WITNESS WHEREOF, the parties have executed this Agreement on the date(s) shown below.

COUNTY OF STANISLAUS
BEHAVIORAL HEALTH AND
RECOVERY SERVICES

By: _____
Madelyn Schlaepfer, Ph.D., CEAP Date
Behavioral Health Director

"County"

CENTER FOR COLLECTIVE WISDOM

By: _____ May 28, 2013
John Ott Date
President

"Contractor"

APPROVED AS TO FORM:
John P. Doering
County Counsel

By: _____
Vicki Fern de Castro
Deputy County Counsel

BOS Action Item: _____, _____, 2013

22. Survival

Notwithstanding any other provision of this Agreement, the following clauses shall remain in full force and effect and shall survive the expiration or termination of this Agreement: Paragraph 2, "Consideration"; Paragraph 7, "Defense and Indemnification"; Paragraph 9, "Records and Audit"; Paragraph 10, "Confidentiality"; and Paragraph 12, "Assignment".

IN WITNESS WHEREOF, the parties have executed this Agreement on the date(s) shown below.

COUNTY OF STANISLAUS
BEHAVIORAL HEALTH AND
RECOVERY SERVICES

By: Madelyn Schlaepfer 6/20/13
Madelyn Schlaepfer, Ph.D., CEAP Date
Behavioral Health Director

"County"

CENTER FOR COLLECTIVE WISDOM

By: _____
John Ott Date
President

"Contractor"

APPROVED AS TO FORM:
John P. Doering
County Counsel

By: Vicki Fern de Castro
Vicki Fern de Castro
Deputy County Counsel

BOS Action Item: 2013-284, June 11, __, 2013

EXHIBIT A

WISDOM TRANSFORMATION INITIATIVE PROJECT

1. CONTRIBUTION TO LEARNING

1.1 CONTRACTOR will advance learning on the following issues: whether the adoption of the Wisdom Transformation Framework by participating organizations increases their capacity to:

1.1.1 Improve outcomes for people suffering from or at risk of mental illness

1.1.2 Create a stronger and more positive internal environment for staff, board members, and other connected to the organization so they can better support the people they serve

1.1.3 Learn to adapt better to the current policy and fiscal chaos buffeting the behavioral system

1.1.4 Cultivate more effective collaboration among each other and with COUNTY

1.2 Overarching questions to be addressed:

1.2.1 How to help community-based organizations – each with different missions, cultures, and histories – successfully adapt the Wisdom Transformation framework within their particular programs and services

1.2.2 How to build effective learning communities among staff members, community leaders, family members, and people who receive services

1.2.3 Whether cross-organizational learning communities and Peer Allies are promising strategies for sustaining long-term transformation efforts

1.3 Over the course of the three-year project, CONTRACTOR will develop annual lessons learned documents and other products to document the tangible benefits, emerging challenges, and deepening learning by project participants.

1.4 CONTRACTOR will support a collaborative transformation and learning effort among six non-profit and community-based organizations in Stanislaus County. Participating organizations are the largest non-profit and community-based contractors who, in partnership with COUNTY, provide behavioral health services and supports to some of the county's most vulnerable individuals and families. Over time, we expect the long term impact of this project will improve outcomes for people receiving services and supports through the behavioral health system.

2. TARGET POPULATION

Stanislaus County's underserved, including the most vulnerable individuals and families.

3. TERM

The term of this Agreement shall begin on July 1, 2013 and end on June 30, 2016. CONTRACTOR shall engage in all phases of the project for the thirty-six (36) months of this Agreement.

Following the initial planning phase of three (3) months CONTRACTOR shall engage in the full learning project for the next thirty-one (31) months from September 1, 2013 through April 30, 2016.

CONTRACTOR shall have two (2) months to prepare and deliver the final project report and final expenditure/cost report to COUNTY on or before June 30, 2016.

4. PROJECT ELEMENTS

4.1 Contractor shall provide consultation support to each organization participating in the project. Examples of how organizations may use this time include training on the framework for specific audiences or the entire organization, group and 1-1 coaching, and process design and facilitation.

4.2 Contractor shall provide Webinars to staff members, people receiving services, family members, and others from participating organizations. A series of webinars will be presented throughout the project to reinforce the fundamentals of the framework and engage emerging implementation questions. Anyone from participating organizations will be able to attend the webinars.

4.3 Contractor shall provide "small" grants to each participating organization.

4.3.1 Each participating organization will receive two $5,000 grants to support its efforts in the initiative, one such grant in each of the first two years of the initiative.

4.3.2 Contractor will ensure receipt, by the participating organizations, of the first grant upon developing a plan for how the organization will work to adopt the Wisdom Transformation framework.

4.3.3 The second grant will be received by the participating organizations after submission of a progress report at the beginning of the second year of the initiative.

4.3.4 Examples of how organizations may choose to use these grants include: small stipends or incentives to enable participation by people who receive services, family members, and/or community members; and overtime or other expenses to permit staff to participate.

4.4 Contractor shall provide Peer Ally training to persons identified by each participating organizations and BHRS. Two or more people, from each organization, will receive intensive training, coaching, and support to become "in-house experts" on the Wisdom Transformation framework. Peer Allies can include managers, staff, or volunteers. This group of Peer Allies will become a peer learning community through the course of the initiative.

4.5 Contractor shall provide two Inter-organizational transformation summits with the goal of helping participants better understand and adapt the Wisdom Transformation framework, and to share with each other successes, lessons learned, and emerging questions.

4.6 Contractor shall provide support for the Leaders from the participating organizations to convene meetings throughout the project for the purpose of sharing emerging lessons and challenges, providing guidance about how to improve the project over time, and developing plans for sustaining the effort beyond the Innovation Project.

4.7 Contractor shall provide additional resources as needed to participating organizations to ensure access to a variety of on-line resources, including papers, slides, videos, peer conversations, and others.

4.8 Contractor will contract with Applied Survey Research (appliedsurveyresearch.org) to develop an initiative-wide learning and assessment protocol that will include surveys, key informant interviews, and focus groups from participants, people receiving services, family members, and others across the participating organizations and within BHRS.

4.8.1 Contractor will ensure data from this process is shared regularly with leaders from the participating organizations and BHRS to guide the assessment and the impact of the initiative, and how it will evolve over time.

4.8.2 Contractor will ensure that each partner organization has support to develop its own data sources and process for assessing the impact of the initiative on its work.

4.8.3 Contractor will ensure that participants are invited to offer written feedback in response to every major event in the process to share what they learned, what worked well, and what could be improved. Summaries of this feedback will be shared with participants and others as data about what is unfolding and what can be improved over time.

4.8.4 Contractor will produce multiple written reports assessing the progress and lessons learned during the initiative, incorporating data from all of the sources identified. Reports (and other written and visual products we develop) will document the tangible benefits, emerging challenges, and deepening learning by participating organization leaders, Peer Allies, BHRS leaders and staff members, people who receive services, family members, MHSA representative stakeholders, and others as appropriate.

5. MONITORING

CONTRACTOR agrees to participate and attend regular, on-going meetings designed to monitor this project to ensure adherence to the MHSA essential elements and project outcomes. The frequency of these meetings shall be quarterly, or as otherwise determined by mutual agreement.

6. BILLING AND PAYMENT

6.1 In consideration of CONTRACTOR's provision of services required in this Exhibit, COUNTY shall reimburse CONTRACTOR, through the following funding source: State Mental Health Services Act – Innovation, not to exceed the Agreement maximum of $844,445 for estimated expenses for consultants, salaries for technical and administrative support, and project expenses such as video, printing and other meeting supplies, salaries, benefits and operating expenses including evaluation.

6.2 CONTRACTOR shall invoice COUNTY $42,910 for start-up expenses including facility costs, salaries and other operating expenses upon the receipt of a fully executed copy of this agreement

6.3 CONTRACTOR shall invoice COUNTY following each month of service delivered during the first twenty-four (24) months of this Agreement at a rate of $30,000 per month from July 1, 2013 to June 30, 2015.

6.4 CONTRACTOR shall invoice COUNTY following each month of service delivered during the last twelve (12) months of this Agreement at a rate of $5961.25 per month from July 1, 2015 to June 30, 2016.

6.5 CONTRACTOR shall invoice COUNTY upon the submission of the final project report and final expenditure/cost report in the amount of $10,000 on or before June 30, 2016.

6.6 CONTRACTOR shall submit invoices to the COUNTY's Contract Manager, 800 Scenic Drive, Modesto, California 95350.

6.7 CONTRACTOR shall provide COUNTY a quarterly report of actual expenditures every three (3) months during the term of this Agreement.

6.8 CONTRACTOR shall also provide an annual report of actual expenditures and/or cost report on or before September 30 following each County fiscal year ending June 30 during the term of this Agreement.

6.9 Notwithstanding any other provision of this agreement, final settlement shall include direct and indirect costs, equal to the amount listed in CONTRACTOR's approved budget not to exceed the agreement maximum.

7. FUNDING

If, during the time, which this Agreement is in effect, funds are not allocated to COUNTY or Behavioral Health and Recovery Services, sufficient to allow for a continuation of this agreement, then COUNTY may, at its sole discretion, terminate this Agreement, without penalty from or further obligation to CONTRACTOR. CONTRACTOR shall have no further obligation to COUNTY.

8. REPORTING

8.1 CONTRACTOR shall submit project reports electronically to the following e-mail

address; contracts@stanbhrs.org every six (6) months from the effective date of this Agreement. The report shall include information about the Project Elements described in **Exhibit A**, what has been learned to date, challenges and strategies employed to overcome them.

8.2 CONTRACTOR shall submit a final project report on or before June 30, 2016 of the Project Elements described in **Exhibit A**, of what was learned as a result of the Innovation Project.

8.3 CONTRACTOR shall provide COUNTY with any other reports, which may be required by State, Federal or local agencies for compliance with this Agreement.

9. INVENTORY

9.1 CONTRACTOR shall report to COUNTY, with the annual project report, any equipment with a cost of $1,000 or more, purchased with funds from this Agreement. Such report shall include the item description, model and serial number (if applicable), purchase price, date of purchase and physical location of the each item.

9.2 CONTRACTOR shall make all equipment available during normal business hours for the COUNTY to conduct a physical inspection and/or place a COUNTY inventory tag on the equipment, if desired.

9.3 CONTRACTOR shall be solely responsible for maintenance of inventory while in CONTRACTOR's possession. Records evidencing maintenance and any upgrades shall be provided to COUNTY as part of the inventory in the event of termination of this Agreement.

9.4 COUNTY reserves title to any property purchased or financed from the proceeds of this Agreement, if such property is not fully consumed in the performance of this Agreement. This provision shall be operational even though such property may have been purchased in whole or in part by Federal funds and absent a Federal requirement for transfer of title.

10. CONFIDENTIALITY AND INFORMATION SECURITY

In reference to Section 10, Confidentiality, under Terms and Conditions of this Agreement, the following is added:

10.1 CONTRACTOR and its officers, employees, agents, representatives, subcontractors and all others acting on behalf of CONTRACTOR shall comply with all applicable laws and regulations, including but not limited to Section 14100.2 and 5328 et seq. of the California Welfare and Institutions (W&I) Code, and 45 CFR Parts 160, 162, and 164 regarding the confidentiality and security of individually identifiable health information (IIHI) as required by **Exhibit B** of this Agreement.

10.2 Records shall be disclosed only in accordance with all applicable State and Federal laws and regulations, including those relating to the privacy of protected health information, confidentiality of medical records, patient consents to release information, and the therapist-patient privilege. Such information shall be used only for appropriate claims and quality management purposes, unless specifically

authorized by the client. Confidentiality regulations shall apply to all electronic media.

11. MHSA CONFIDENTIALITY REQUIREMENTS

CONTRACTOR shall obtain permission from COUNTY prior to the disclosure or dissemination of data or documents generated, collected, or produced outside the scope of this Agreement.

12. RECORDS AND AUDIT

In reference to Section 9, Records and Audits, under Terms and Conditions of this Agreement, Omit 9.1, 9.2 becomes 9.1, and the following is added:

12.1 CONTRACTOR shall retain all records pertinent to this Agreement for a period of five (5) years from the date of expiration of this Agreement. If, at the end of five years, there is litigation or an audit involving those records, the COUNTY will retain the records until the resolution of such litigation or audit.

12.2 COUNTY or their designee will have access to and right to examine, monitor and audit all records, documents, conditions and activities related to programs funded by this Agreement. For purposes of this section, "access to" means that the CONTRACTOR shall at all times maintain a complete set of records and documents related to programs funding by this Agreement and shall make these records available to the COUNTY or their designee in a central location.

12.3 COUNTY may inspect facilities, systems, books and records of the CONTRACTOR to monitor compliance with this Agreement. The CONTRACTOR shall promptly remedy any violation of any provision of this Agreement and shall certify the same to the COUNTY in writing. The fact that the COUNTY inspects, or fails to inspect, or has the right to inspect, the CONTRACTOR's facilities, systems and procedures does not relieve the CONTRACTOR of its responsibilities to comply with this Agreement. The COUNTY's failure to detect or if detected, the COUNTY's failure to notify the CONTRACTOR or require the CONTRACTOR's remediation of an unsatisfactory practice, does not constitute acceptance of such practices or a waiver of the COUNTY's enforcement rights under this Agreement.

12.4 CONTRACTOR will maintain and make available to auditors, at all levels, accounting and program records including supporting source documentation and cooperate with all auditors.

12.5 COUNTY performing monitoring or audits of CONTRACTOR will immediately report to the State any incidents of fraud, abuse or other criminal activity in relation to this Agreement, the MHSA or it regulations.

13. PERSONNEL

13.1 CONTRACTOR acknowledges and shall adhere to the Statement of Compliance as

applicable in **Exhibit C**, attached hereto and made a part of this Agreement.

13.2 CONTRACTOR agrees that it will certify that none of its officers have been convicted of fraud or misappropriation of funds.

13.3 CONTRACTOR assures COUNTY that it complies with the Americans with Disabilities ACT (ADA) of 1990, (42 U.S.C. 12101 et seq.), which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA.

13.4 All personnel rendering services under this Agreement shall be employed by, or under contract to CONTRACTOR, and shall be appropriately supervised.

14. ACKNOWLEDGMENT

All public relations and educational material that is presented to the public shall mention that CONTRACTOR's Program(s) is funded by the Stanislaus County Board of Supervisors and Behavioral Health and Recovery Services.

15. NON-DISCRIMINATION

In reference to Section 11 Nondiscrimination, under Terms and Conditions of this Agreement, is deleted in its entirety and replaced with the following:

15.1 During the performance of this Agreement, Contractor and its subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, and denial of family care leave. Contractor and subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. Contractor and subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Gov. Code §12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. Contractor and its subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

15.2 Consistent with the requirements of applicable Federal or State Law, the Contractor shall not engage in any unlawful discriminatory practices in the admission of clients, assignment of accommodations, treatment, evaluation, or in any other respect on the basis of race, color, gender, religion, marital status, national origin, age (over 40), sexual preference, or mental or physical disability (including individuals with AIDS or those with a record of or who are regarded as having a substantially limiting

impairment), or medical condition (cancer-related), pregnancy related condition, or political affiliation or belief. This policy shall be in writing, in English and Spanish. It shall be posted in all public areas.

16. DUPLICATE COUNTERPART

This Agreement may be executed in duplicate counterparts, each of which shall be deemed a duplicate original.

BUSINESS ASSOCIATE EXHIBIT

Business Associate (BA) shall comply with the privacy and security requirements of Title II of the Health Insurance Portability and Accountability Act of 1996, (Public Law 104-191), also known as "HIPAA", and Title XIII of the American Recovery and Reinvestment Act of 2009, (Public Law 111-5), "the ARRA/HITECH Act" or "the HITECH Act", as these laws may be subsequently amended, and implementing regulations enacted by the Department of Health and Human Services at 45 CFR Parts 160-164, and, regulations enacted with regard to the HITECH Act. The foregoing laws and rules are sometimes collectively referred to hereafter as "HIPAA".

If COUNTY becomes aware of a pattern of activity that violates the HIPAA Privacy Rule, and reasonable steps to cure the violation are unsuccessful, the COUNTY may terminate the Agreement, or if not feasible; report the problem to the Secretary of the US Department of Health and Human Services.

COUNTY and BA desire to facilitate the billing and/or transfer of protected health information (PHI), as defined in 45 CFR, Section 164.504, by electronically transmitting and receiving data in agreed formats and to assure that such transactions comply with relevant laws and regulations.

1. Definitions

Terms used, but not otherwise defined, in this Exhibit shall have the same meaning defined in the HIPAA and HITECH Statues and Regulations.

1.1 **"Breach"** shall mean the unauthorized acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except where an unauthorized person to whom such information is disclosed would not reasonably have been able to retain such information.

1.1.1 **Exceptions.** The term "Breach" does not include:

1.1.1.1 Any unintentional acquisition, access, or use of protected health information by an employee or individual acting under the authority of a covered entity or business associate if such acquisition, access, or use was made in good faith and within the course and scope of the employment or other professional relationship of such employee or individual, respectively, with the covered entity or business associate; and such information is not further acquired, accessed, used, or disclosed by any person; or

1.1.1.2 Any inadvertent disclosure from an individual who is otherwise authorized to access protected health information at a facility operated by a covered entity or business associate to another similarly situated individual at same facility; and

1.1.1.3 Any such information received as a result of such disclosure is not further acquired, accessed, used, or disclosed without authorization by any person.

1.2 **"Business Associate"(BA)** shall mean CONTRACTOR as identified in this Agreement.

1.3 **"Covered Entity"** shall mean Stanislaus County, Behavioral Health and Recovery Services (COUNTY).

1.4 **"Individual"** shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502(g).

1.5 **"Privacy Rule"** shall mean the Standards for Privacy of individually identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

1.6 **"Protected Health Information" (PHI)** shall have the same meaning as the term "protected health information" in 45 CFR, Section 164.501, limited to the information created or received by Business Associate from or on behalf of Covered Entity.

1.7 **"Security Rule"** shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR part 164, Subpart C.

1.8 **"Physical Safeguards"** are physical measures, policies, and procedures to protect a covered entity's electronic information systems and related buildings and equipment, from natural and environmental hazards, and unauthorized intrusion.

1.9 **"Security or Security measures"** encompass all of the administrative, physical, and technical safeguards in an information system.

1.10 **"Security Incident"** means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

2. Operations

2.1 **Document Standards**. Each party may transmit to, or receive from, the other party, either electronically or using other media, PHI and/or individually identifiable health information, as defined in 42 U.S.C., Section 1320d, as it pertains to the provision of services under this Agreement. All documents shall be transmitted in accordance with the standards set forth in the Behavioral Health and Recovery Services Privacy Policy.

2.2 **System Operations.** Each party, at its own expense, shall provide and maintain the equipment, software, services, and testing necessary to effectively, reliably, and confidentially transmit and receive documents.

3. Electronic Transmissions

Documents shall not be deemed to have been properly received, and no document shall give rise to any obligation, until decrypted and accessible to the receiving party at such party's receipt counter as designated by regulation or policy.

4. Security Standards

4.1 BA shall ensure the implementation of safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits.

4.2 BA shall ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate safeguards;

4.3 BA is required to report to the covered entity any security incident of which it becomes aware.

4.4 BA shall make its policies and procedures, and documentation required by the Security Rule relating to such safeguards, available to the Secretary for purposes of determining the covered entity's compliance with the regulations.

4.5 Covered entity may terminate the contract if the covered entity determines that the BA has violated a material term of the contract.

5. Use and Disclosure of Protected Health Information

5.1 Except as otherwise provided in this Business Associate Exhibit, BA may use or disclose PHI to perform functions, activities or services for or on behalf of the COUNTY, as specified in this Agreement, provided that such use or disclosure would not violate the Privacy Rule if done by the COUNTY or the minimum necessary policies and procedures of the COUNTY.

5.2 Except as otherwise limited in this Business Associate Exhibit, BA may use and disclose PHI for the proper management and administration of the BA or to carry out the legal responsibilities of the BA, provided that disclosures are required by law, or BA obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the BA of any instances of which it is aware in which the confidentiality of the information has been breached.

5.3 Except as otherwise limited in this Business Associate Exhibit, BA may use PHI to provide data aggregation services related to the health care operation of COUNTY.

5.4 BA shall not use or further disclose PHI other than as permitted or required by this Business Associate Exhibit, or by law.

6. Breach Reporting

6.1 During the term of the agreement, BA shall notify COUNTY, in writing, within five (5) business days of the discovery of any suspected or actual breach of security, intrusion or unauthorized use or disclosure of PHI of which the BA becomes aware and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws and regulations. A breach shall be treated as discovered by the BA as of the first day on which such breach or suspected breach is known to the BA (including any person, other than the individual committing the breach, that is an employee, officer, or other agent of the BA) or should reasonably have been known to the BA to have occurred. BA shall take (a) prompt corrective action to cure any Breach, (b) investigate or fully participate in an investigation of the suspected or actual breach of security, (c) assist the COUNTY in compliance with the Notification in The Case Of Breach requirements of Section 13402 of the HITECH Act, and (d) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations. Notification of Breach shall be made to:

BHRS Privacy Officer
Behavioral Health and Recovery Services
800 Scenic Drive
Modesto, CA 95350
(209) 525-6225

6.2 Reports of suspected and actual breaches to COUNTY shall include the following, at a minimum:

a. Identify each individual whose unsecured protected health information has been, or is reasonably believed by BA to have been, accessed, acquired, used, or disclosed during the breach.
b. Identify the nature of the Breach.
c. Identify the date of the Breach.
d. Identify the date of discovery of the Breach.
e. Identify which elements of PHI were breached or were part of the Breach.
f. Identify who was responsible for the Breach and who received the PHI.
g. Identify what corrective actions the BA took or will take to prevent further incidents of Breach.
h. Identify what BA did or will do to mitigate any adverse affects of the Breach.
i. Identify BA contact individual and information for COUNTY to obtain additional information, if required.
j. Provide copies of any Individual Notice, Media Notice, Notice to Secretary, or Posting on HHS Public Website that BA may have made pursuant to the HITECH Act.
k. Provide such other information as COUNTY may reasonably request regarding the Breach.

7. Agents and Subcontractors of BA

BA shall ensure that any agent, including subcontractor, to which the BA provides PHI received from, or created or received by BA on behalf of the COUNTY, shall comply with the same restrictions and conditions that apply through this Business Associate Exhibit to the BA with respect to such information.

8. Access to PHI

8.1 BA shall provide access, within seven (7) days of such a request, to the COUNTY or, as directed by the COUNTY, to PHI in a designated record set to an individual in order to meet the requirements of Title 45, CFR, Section 164.524.

8.2 BA shall, within seven (7) days of such a request, provide individual patient or their legal representative with access to PHI contained in BA's records, pursuant to 45 CFR, Section164.504 (e)(2)(F).

9. Amendment(s) to PHI

BA shall make any amendment(s) to PHI in a designated record set that the COUNTY directs or at the

request of the COUNTY or an individual within seven (7) days of such request in accordance with Title 45, CFR, Section 164.504 (e)(2)(ii)(F).

10. Records Available

BA shall make its internal practices, books, and records related to the use, disclosure, and privacy protection of PHI received from the COUNTY, or created or received by the BA on behalf of the COUNTY, available to the COUNTY or to the Secretary of HHS for purposes of the Secretary determining compliance with the Privacy Rule, in a time and manner designed by the COUNTY or the Secretary of HHS.

11. Retention, Transfer and Destruction of Information

11.1 Upon termination of this Agreement for any reason, BA shall retain all PHI received from the COUNTY, or created or received by the BA on behalf of the COUNTY in a manner that complies with the Privacy Rule. This provision shall apply to PHI in possession of subcontractors or agents of the BA.

11.2 Prior to termination of this Agreement, the BA may be required by the COUNTY to provide copies of PHI to the COUNTY. This provision shall apply to PHI in possession of subcontractors or agents of the BA.

11.3 When the retention requirements on termination of the Agreement have been met, BA shall destroy all PHI received from the COUNTY, or created or received by the BA on behalf of the COUNTY. This provision shall apply to PHI in possession of subcontractors or agents of the BA. BA, its agents or subcontractors shall retain no copies of the PHI.

11.4 In the event that BA determines that returning or destroying the PHI is not feasible, BA shall provide the COUNTY notification of the conditions that make destruction infeasible. Upon mutual agreement of the parties that the destruction of the PHI is not feasible, BA shall extend the protections of this Business Associate Exhibit to such PHI and limit further use and disclosures of such PHI for so long as BA, or any of its agents or subcontractors, maintains such PHI.

12. Force Majeure

No party shall be liable for any failure to perform its obligations in connection with any transaction or any document where such failure results from any act of nature or other cause beyond such party's reasonable control (including, without limitation, any mechanical, electronic, or communications failure) that prevent such party from transmitting or receiving any documents.

13. Limitation of Damages

Other than specified in elsewhere, neither party shall be liable to the other for any special, incidental, exemplary, or consequential damages arising from or as a result of any delay, omission, or error in the electronic transmission or receipt of any documents pursuant to this Agreement, even if either party has been advised of the possibility of such damages.

14. Continuing Privacy and Security Obligation

BA's obligation to protect the privacy and security of the PHI, including all copies and any data derived this Agreement that may be individually identifiable, shall be continuous and survive termination, cancellation, expiration or other conclusion of the Agreement.

15. Attorney-Client Privilege

Notwithstanding the foregoing, no attorney-client, accountant-client, or other legal privilege shall be deemed waived by BA or COUNTY by virtue of this Subparagraph.

16. Interpretation

Any ambiguity in this Business Associate Exhibit shall be resolved to permit the COUNTY to comply with the Privacy Rule and Security Standards.

STATEMENT OF COMPLIANCE

A. CONTRACTOR agrees, unless specifically exempted, compliance with Government Code Section 12900 (a) and California Code of Regulations, Title 2, Division 4, Chapter 5 in matters relating to reporting requirements and the development, implementation and maintenance of a Nondiscrimination Program. Contractor agrees not to unlawfully discriminate, harass or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, and denial of family care leave. Employment of personnel shall be made solely on the basis of merit.

1. Action shall be taken to ensure applicants are employed, and employees are treated during employment, without regard to their race, religion, color, sex, national origin, age, physical or mental handicap. Such action shall include, but not be limited to, the following: Employment; upgrading; demotion or transfer; recruitment or recruitment advertising; layoff; or apprenticeship. However, recruitment and employment of applicants shall reflect the ethnic and racial composition of the County, particularly those groups not previously, nor currently, having adequate representation in recruitment or hiring. There shall be posted in conspicuous places, notices available to employees and applicants for employment provided by the County Officer responsible for contracts setting forth the provisions of the Equal Opportunity clause.

2. All solicitations or advertisements for employees placed by or on behalf of CONTRACTOR and/or the subcontractor shall state that all qualified applicants will receive consideration for employment without regard to race, religion, color, sex, national origin, age, or physical or mental handicap.

3. Each labor union or representative of workers with which the County and/or the subcontractor has a collective bargaining agreement, or other contract or understanding, must post a notice provided by the County Officer responsible for contracts, advising the labor union or workers representative of CONTRACTOR's commitments under this Equal Opportunity clause and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

4. In the event of noncompliance with the discrimination clause of this contract or as otherwise provided by State and Federal law, this contract may be canceled, terminated or suspended, in whole or in part, and CONTRACTOR and/or the subcontractor may be declared ineligible for further State contracts in accordance with the procedures authorized in the Department of Mental Health's Complaint Process.

5. All provision of Paragraph 1 through this paragraph 5 will be included in every subcontract unless exempted by rules, regulations or orders of the Director of the Department of Mental Health so such provisions will be binding upon each subcontractor. CONTRACTOR will take such action with respect to any subcontract as the State may direct as a means of enforcing such provisions including sanctions for noncompliance provided; however, in the event CONTRACTOR becomes involved in, or is threatened with, litigation with a subcontractor as a result of such direction by the State, CONTRACTOR may request in writing to the State, who, in turn, may request the United States to enter into such litigation to protect the interest of the State and the United States.

B. Services, benefits and facilities shall be provided to patients without regard to their race, color, creed, national origin, sex, age or physical or mental handicap, and no one will be refused service because of inability to pay for such services.

1. Nondiscrimination in Services, Benefits and Facilities: There shall be no discrimination in the provision of services because of color, race, creed, national origin, sex, age, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by State and Federal law. For the purpose of the cortract, distinctions on the grounds of color, race, creed, national origin, sex, or age include, but are not limited to, the following: denying a participant any service or benefit to the participant which is different, or is provided in a different manner or at a different time, from that provided to other participants under this contract; subjecting a participant to segregation or separate treatment in any matter related to this receipt of any service; restricting a participant in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit; treating a participant differently from others in determining whether he/she satisfied any admission, enrollment quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any service or benefit; the assignment of times or places for the provision of services on the basis of the race, color, creed, or national origin of the participants to be served. The County and all subcontractors will take action to ensure intended beneficiaries are provided services without regard to color, race, creed, national origin, sex, age, or physical or mental handicap.

2. Procedure for Complaint Process: All complaints alleging discrimination in the delivery of services by the County and/or the subcontractor because of race, color, creed, national origin, sex, age, or physical or mental handicap, may be resolved by the State through the State Department of Mental Health's Action Complaint Process.

3. Notice of Complaint Process: The County and all subcontractors shall, subject to the approval of the Department of Mental Health, establish procedures under which recipients of the service are informed of their rights to file a complaint alleging discrimination or a violation of their civil rights with the State Department of Mental Health.

C. The County and any subcontractor will furnish all information and reports required by the Department of Mental Health and will permit access to books, records and accounts for purposes of investigation to ascertain compliance with above paragraphs.

D. The County and all subcontractors assure all recipients of service are provided information in accordance with provisions of Welfare and Institutions Code, Sections 5325 and 5325.1, and Sections 5520 through 5550, pertaining to their rights as patients, that the County has established a system whereby recipients of service may file a complaint for alleged violations of their rights.

E. CONTRACTOR agrees to the provisions of Section 504 of the Rehabilitation Act of 1973, as amended, pertaining to the prohibition of discrimination against qualified handicapped persons in all Federally-assisted programs or activities, as detailed in regulations signed by the Secretary of Health, Education and Welfare, effective June 3, 1977, and found in the Federal Register, Volume 42, Number 86, dated May 4, 1977.

PROVIDER AGREEMENT

BETWEEN

STANISLAUS COUNTY

BEHAVIORAL HEALTH AND RECOVERY SERVICES

AND

TURNING POINT COMMUNITY PROGRAMS, INC.

GARDEN GATE RESPITE CENTER

MHSA - O&E - 02

JULY 1, 2013 – JUNE 30, 2014

Table of Contents

	Section	Page
1.	RECITALS	3
2.	SERVICES	3
3.	NONDISCRIMINATION	3
4.	BILLING AND PAYMENT	4
5.	CULTURAL COMPETENCY	5
6.	QUALITY MANAGEMENT	5
7.	CONFIDENTIALITY AND INFORMATION SECURITY	5
8.	MHSA CONFIDENTIALITY REQUIREMENTS	6
9.	COMPLIANCE	6
10.	PATIENTS' RIGHTS AND PROBLEM RESOLUTION	7
11.	MONITORING/REVIEW ASSISTANCE	7
12.	RECORDS	8
13.	AUDITS	8
14.	REPORTING	9
15.	INVENTORY	10
16.	PERSONNEL	10
17.	CODE OF ETHICS	11
18.	WORKPLACE REQUIREMENTS	11
19.	ACKNOWLEDGEMENT	12
20.	FINANCIAL RELATIONSHIPS	12
21.	REQUIRED LICENSES, CERTIFICATES OR PERMITS	12
22.	INDEMNIFICATION	13
23.	INSURANCE	13
24.	NOTICE	16
25.	CONFLICTS	17
26.	SEVERABILITY	17
27.	AMENDMENT	17
28.	ENTIRE AGREEMENT	17
29.	RELATIONSHIP OF PARTIES	17
30.	REFERENCES TO LAWS AND RULES	18
31.	ASSIGNMENT	18
32.	AVAILABILITY OF FUNDS	18
33.	WAIVER OF DEFAULT	18
34.	VENUE	18
35.	TERM	18
36.	SURVIVAL	19
	SIGNATURE PAGE	19
	EXHIBIT A - SERVICES	
	EXHIBIT B - CONFIDENTIALITY AND INFORMATION SECURITY PROVISIONS	
	EXHIBIT C - STATEMENT OF COMPLIANCE	

AGREEMENT

This Agreement is made and entered into in the City of Modesto, State of California, by and between the **County of Stanislaus**, through **Behavioral Health and Recovery Services**, hereinafter referred to as "**COUNTY**", and **Turning Point Community Programs, Inc.**, a California Nonprofit Corporation with its principal place of business identified in **Section 24**, hereinafter referred to as "**CONTRACTOR**", effective the date of the last signature, for and in consideration of the premises, and the mutual promises, covenants, terms, and conditions hereinafter contained.

WHEREAS, COUNTY, through Behavioral Health and Recovery Services wishes to deliver services to persons with serious mental illness; and,

WHEREAS, COUNTY, through its department of Behavioral Health and Recovery Services, commenced implementation of its three-year-plan for Mental Health Services Act Community Services and Supports Plan (MHSA CSS) as approved and funded by the State Department of Mental Health; and

WHEREAS, COUNTY has a need for service providers in order to implement the MHSA CSS plan; and

WHEREAS, CONTRACTOR is able to provide such services in partnership with COUNTY as an organizational provider; and

WHEREAS, COUNTY requires and CONTRACTOR is able to provide services that will put into operation the MHSA Essential Elements: community collaboration, cultural competency, consumer / family driven system, wellness, recovery, and resilience, and, integrated service experience.

NOW THEREFORE, the parties hereby agree as follows:

1. RECITALS

The recitals set forth above are a material part of this Agreement.

2. SERVICES

Services required under this Agreement are described in the attached Exhibit A.

3. NONDISCRIMINATION

3.1 During the performance of this Agreement, CONTRACTOR and its subcontractors shall not unlawfully discriminate, harass, or allow harassment against any employee or applicant for employment because of sex or sexual

orientation, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, and denial of family care leave. CONTRACTOR and subcontractors shall insure that the evaluation and treatment of their employees and applicants for employment are free from such discrimination and harassment. CONTRACTOR and subcontractors shall comply with the provisions of the Fair Employment and Housing Act (Gov. Code §12990 (a-f) et seq.) and the applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Section 7285 et seq.). The applicable regulations of the Fair Employment and Housing Commission implementing Government Code Section 12990 (a-f), set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations, are incorporated into this Agreement by reference and made a part hereof as if set forth in full. CONTRACTOR and its subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other Agreement.

3.2 Consistent with the requirements of applicable Federal or State Law, the CONTRACTOR shall not engage in any unlawful discriminatory practices in the admission of clients, assignment of accommodations, treatment, evaluation, or in any other respect on the basis of race, color, gender, religion, marital status, national origin, age (over 40), sexual preference, or mental or physical disability (including individuals with AIDS or those with a record of or who are regarded as having a substantially limiting impairment), or medical condition (cancer-related), pregnancy related condition, or political affiliation or belief. This policy shall be in writing, in English and Spanish. It shall be posted in all public areas.

4. BILLING AND PAYMENT

4.1 Payment information is identified in the attached exhibit.

4.2 CONTRACTOR shall submit an invoice to COUNTY's Contract Manager, 800 Scenic Drive, Modesto, California 95350, on a monthly basis. CONTRACTOR shall make a good faith effort to submit claims by the tenth of each month

4.3 Both parties acknowledge that the State of California will continue to seek State or Federal revenue enhancements throughout the term of this Agreement. If a specific strategy adopted by the State affects the funding that COUNTY uses to support this Agreement, the parties agree to re-negotiate the applicable terms.

4.4 Final payment for services provided under the terms of this Agreement may be

withheld pending fiscal reconciliation.

5. CULTURAL COMPETENCY

5.1 CONTRACTOR shall ensure that cultural competency is integrated into the provision of services. The terms of this section of the Agreement shall be reviewed during contract monitoring meetings.

5.2 COUNTY will provide the Cultural Competence Plan (CCP) to CONTRACTOR when submitted to the California Department of Mental Health and as updated annually.

5.3 CONTRACTOR shall adhere to the provisions of the COUNTY CCP, as submitted and updated, and provide information as required for submitting and updating the CCP.

5.4 CONTRACTOR shall document evidence that interpreter services are offered and provided for threshold languages at all points of contact. CONTRACTOR shall also document the response to the offer of interpreter services.

5.5 CONTRACTOR shall regularly have a representative participate in the COUNTY Cultural Competence Oversight Committee.

5.6 CONTRACTOR staff shall attend the COUNTY Clinical and Administrative Cultural Competency Standards training.

6. QUALITY MANAGEMENT

6.1 CONTRACTOR shall be in full compliance with COUNTY's Quality Management Plan and Risk Management Program. COUNTY shall have access to, and conduct audits and reviews of, records, policies and procedures, incident reports, and related activities it deems necessary to support these functions.

6.2 CONTRACTOR and COUNTY, to the extent feasible, shall include their respective Quality Management staff in each other's Quality Management activities.

7. CONFIDENTIALITY AND INFORMATION SECURITY

7.1 CONTRACTOR and its officers, employees, agents representative, subcontractors and all others acting on behalf of CONTRACTOR shall comply with applicable laws and regulations, including but not limited to Section 14100.2 and 5328 et seq. of the California Welfare and Institutions (W&I) Code, and 45 CFR Parts 160, 162, and 164 regarding the confidentiality and security of individually identifiable health information (IIHI) as required by Exhibit B of this Agreement.

7.2 Records shall be disclosed only in accordance with all applicable State and Federal laws and regulations, including those relating to the privacy of protected health information, confidentiality of medical records, patient consents to release information, and the therapist-patient privilege. Such information shall be used only for appropriate claims and quality management purposes, unless specifically authorized by the client. Confidentiality regulations shall apply to all electronic media.

8. MHSA CONFIDENTIALITY REQUIREMENTS

CONTRACTOR shall obtain permission from COUNTY prior to the disclosure or dissemination of data or documents generated, collected, or produced in connection with this Agreement.

9. COMPLIANCE

9.1 COUNTY has accepted as policy an Organizational Compliance Plan which addresses compliance with Federal, State, and local laws, regulations, rules and guidelines. It is expected that CONTRACTOR shall maintain a similar compliance plan for its organization, which is consistent with COUNTY's Plan.

9.2 CONTRACTOR shall ensure that compliance is integrated into the provision of services. This shall be reviewed during contract monitoring meetings.

9.3 CONTRACTOR shall not allow services to be provided under the terms of this Agreement by any officer, employee, subcontractor, agent or any other individual or entity that is on the List of Excluded Individuals/Entities maintained by the U. S. Department of Health and Human Services, Office of the Inspector General (OIG), or the California State Medi-Cal Suspended and Ineligible Provider List (S&I), maintained by the California Department of Health Care Services.

9.3.1 CONTRACTOR shall insure that all officers, employees, subcontractors, agents or other individuals or entities are not on the two lists in this section at the time of hiring.

9.3.2 CONTRACTOR shall thereafter semi-annually insure that all officers, employees, subcontractors, agents or other individuals or entities are not on the two lists in this section.

9.3.3 CONTRACTOR shall immediately notify the COUNTY upon discovery of any officer, employee, subcontractor, agent or other individual or entity who are found on either of the two lists in this section.

9.3.4 COUNTY provides to CONTRACTOR the following references to the two lists found in this section. COUNTY does not guarantee that these references will not change from time to time.

9.3.4.1 OIG list is currently found at the following web address: http://exclusions.oig.hhs.gov/

9.3.4.2 A link to the S&I list is currently found at the following web address: http://www.medi-cal.ca.gov/references.asp Near the bottom of the page click, on the "Suspended & Ineligible Provider List."

10. PATIENTS' RIGHTS AND PROBLEM RESOLUTION

10.1 CONTRACTOR shall comply with all relevant rules, regulations, statutes, and COUNTY policies and procedures related to individuals' rights to a grievance process, an appeal process, and an expedited appeal process.

10.2 CONTRACTOR shall ensure that each beneficiary has adequate information about the CONTRACTOR's processes to include at a minimum:

10.2.1 Description of grievance and appeal process;

10.2.2 Posting notices explaining the process procedures;

10.2.3 Making grievance forms and appeal forms along with self addressed envelopes available for beneficiaries at CONTRACTOR sites;

10.2.4 Making interpreter services and TDD/TTY available to beneficiaries during normal business hours.

10.3 No provision of this Agreement shall be construed to replace or conflict with the duties of COUNTY's Patients' Rights Advocates as described in Section 5520 of the Welfare and Institutions Code.

11. MONITORING/REVIEW ASSISTANCE

11.1 CONTRACTOR agrees to maintain books, records, documents, and other evidence necessary to facilitate contract monitoring and audits pursuant to Section 640, Title 9, Division 1, Chapter 3, Article 9, of the California Code of Regulations and the policies of Behavioral Health and Recovery Services.

11.2 CONTRACTOR agrees that the COUNTY shall have access to facilities, program documents, records, staff, clients/patients, or other material or persons the COUNTY deems necessary to monitor and audit services rendered.

11.3 CONTRACTOR shall provide any necessary assistance to COUNTY in its conduct of facility inspections, and operational reviews of the quality of care being

provided to beneficiaries, including providing COUNTY with any requested documentation or reports in advance of a scheduled on-site review. CONTRACTOR shall also provide any necessary assistance to COUNTY and the External Quality Review Organization contracting with the State Department of Mental Health in the annual external quality review of the quality of care, quality outcomes, timeliness of, and access to, the services being provided to beneficiaries under this Agreement. CONTRACTOR shall correct deficiencies as identified by such inspections and reviews according to the time frames delineated in the resulting reports.

11.4 CONTRACTOR shall participate in regularly scheduled contract monitoring designed to review various aspects of contract services, including actual costs, cost per unit, number of units, amount of required match, and State rates.

12. RECORDS

12.1 The CONTRACTOR shall retain all records pertinent to this Agreement for a period of five (5) years from the date of expiration of this Agreement. If, at the end of five (5) years, there is litigation or an audit involving those records, the County will retain the records until the resolution of such litigation or audit.

12.2 The COUNTY or their designee will have access to and right to examine, monitor and audit all records, documents, conditions and activities related to programs funded by this Agreement. For purposes of this section, "access to" means that the CONTRACTOR shall at all times maintain a complete set of records and documents related to programs funding by this Agreement and shall make these records available to the COUNTY or their designee in a central location.

12.3 Clinical records shall be maintained according to COUNTY standards, policies and procedures and Short-Doyle Medi-Cal regulations. For each client who has received services, a legible record shall be kept in detail which permits effective quality management processes and external operational audit processes, and which facilitates an adequate system for follow-up treatment.

12.4 Clinical records shall be the property of COUNTY and maintained by CONTRACTOR in accordance with COUNTY standards.

13. AUDITS

13.1 The COUNTY may inspect facilities, systems, books and records of the CONTRACTOR to monitor compliance with this Agreement. The CONTRACTOR shall promptly remedy any violation of any provision of this Agreement and shall

certify the same to the COUNTY in writing. The fact that the COUNTY inspects, or fails to inspect, or has the right to inspect, the CONTRACTOR's facilities, systems and procedures does not relieve the CONTRACTOR of its responsibilities to comply with this Agreement. The COUNTY's failure to detect, or if detected, the COUNTY's failure to notify the CONTRACTOR or require the CONTRACTOR's remediation of an unsatisfactory practice, does not constitute acceptance of such practices or a waiver of the COUNTY's enforcement rights under this Agreement.

13.2 The CONTRACTOR will maintain and make available to auditors, at all levels, accounting and program records including supporting source documentation and cooperate with all auditors.

13.3 The COUNTY performing monitoring or audits of CONTRACTOR will immediately report to the State any incidents of fraud, abuse or other criminal activity in relation to this Agreement, the MHSA, or its regulations.

14. REPORTING

14.1 CONTRACTOR shall provide all required data to BHRS Performance Measurement in agreed upon timeframes. COUNTY may withhold payment for services until the entry of data is current.

14.2 CONTRACTOR shall submit a six- (6) month program report electronically to the following e-mail address; contracts@stanbhrs.org, by February 15, of each year. The report shall include data related to performance outcomes, cultural competency integration, challenges and the strategies employed to overcome them.

14.3 CONTRACTOR shall submit a year-end program report electronically to the following e-mail address; contracts@stanbhrs.org, by September 30, of each year. The report shall include a summary of the year's events; an update on the challenges and strategies; evidence of meeting contract outcomes; update of cultural competency activities; staff training, number and percentage of staff that have received HIPAA training; number of complaints regarding breach of confidentiality and disclosures of PHI, number of internal incidents of disclosure discovered, description of incident, action taken to mitigate risk, outcome of incident; evidence of use of the Language Line and interpreters; and inventory list.

14.4 CONTRACTOR shall submit an "annual report" on CONTRACTOR's staff

language and ethnicity as of the payroll period ending closest to December 1st. This report shall be submitted electronically to BHRS Contract Services by December 31, 2012 to the following e-mail address; contracts@stanbhrs.org.

14.5 CONTRACTOR shall provide COUNTY with any other reports, which may be required by State, Federal or local agencies for compliance with this Agreement.

15. INVENTORY

15.1 CONTRACTOR shall report to COUNTY, with the annual program report, any equipment with a cost of $1,000 or more, purchased with funds from this Agreement. Such report shall include the item description, model and serial number (if applicable), purchase price, date of purchase and physical location of the each item.

15.2 CONTRACTOR shall make all equipment available during normal business hours for the COUNTY to conduct a physical inspection and/or place a COUNTY inventory tag on the equipment, if desired.

15.3 CONTRACTOR shall be solely responsible for maintenance of inventory while in CONTRACTOR's possession. Records evidencing maintenance and any upgrades shall be provided to COUNTY as part of the inventory in the event of termination of this Agreement.

15.4 COUNTY reserves title to any property purchased or financed from the proceeds of this Agreement, if such property is not fully consumed in the performance of this Agreement. This provision shall be operational even though such property may have been purchased in whole or in part by Federal funds and absent a Federal requirement for transfer of title.

16. PERSONNEL

16.1 CONTRACTOR shall adhere to the Statement of Compliance as specified in Exhibit C.

16.2 CONTRACTOR agrees that it will certify that none of its officers have been convicted of fraud or misappropriation of funds.

16.3 All CONTRACTOR staff providing services under the terms of this Agreement shall have successfully passed a criminal background check appropriate to their job classification and duties. CONTRACTOR shall not knowingly allow services to be provided under the terms of this Agreement by any person convicted of financial fraud involving Federal or State funds.

16.4 CONTRACTOR assures COUNTY that it complies with the Americans with

Disabilities Act (ADA) of 1990, (42 U.S.C. 12101 et seq.), which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA.

16.5 All personnel rendering services under this agreement shall be employed by, or under contract to CONTRACTOR, and shall be appropriately supervised.

16.6 All CONTRACTOR staff transporting clients under the terms of this agreement shall possess a valid California Drivers License and, if not covered by CONTRACTOR for auto insurance, shall maintain at least minimum coverage.

16.7 CONTRACTOR staff shall be linguistically and culturally qualified to meet the current and projected needs of the client community. CONTRACTOR shall ensure that staff providing bilingual services are fluent in their identified language.

17. CODE OF ETHICS

CONTRACTOR's Code of Ethics shall be consistent with COUNTY's Code of Ethics, a copy of which was provided to CONTRACTOR in Fiscal Year 2001/02.

18. WORKPLACE REQUIREMENTS

18.1 CONTRACTOR shall report all incidents of client suicides, homicides, or other unusual occurrences resulting in serious harm to clients or staff, using the Outpatient Incident/Occurrence Reporting Form. Such forms shall be faxed to COUNTY's BHRS Risk Manager within twenty-four (24) hours of time of occurrence or as soon as possible.

18.2 CONTRACTOR shall participate, as appropriate, in COUNTY's Root Cause Analysis investigations related to CONTRACTOR's incidents.

18.3 CONTRACTOR shall maintain a safe facility that is as free from safety hazards as is possible. Any reporting of unsafe working conditions by employees or others shall be immediately appraised and addressed.

18.4 CONTRACTOR hereby certifies that it complies with the requirements of the Drug-Free Workplace Act of 1990 (Government Code Section 8350 et seq.) and provides a drug-free workplace.

18.5 Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and the CONTRACTOR may be ineligible for award of any future Agreements if COUNTY determines that any of the following has occurred: (1) the CONTRACTOR has made a false certification or, (2) violates the certification by failing to carry out the requirements as noted above.

19. ACKNOWLEDGEMENT

All public relations and educational material shall mention that CONTRACTOR's Program(s) is funded by the Stanislaus County Board of Supervisors and Behavioral Health and Recovery Services.

20. FINANCIAL RELATIONSHIPS

20.1 CONTRACTOR shall maintain program statistical records in the manner required by COUNTY, State Department of Mental Health, and applicable licensing agencies, and make such records available to COUNTY upon request.

20.2 CONTRACTOR shall comply with controls, record keeping and fund accounting procedure requirements of MHSA, and all applicable regulations, directives, policies and procedures to ensure the proper disbursal of, and accounting for, program funds paid to CONTRACTOR and disbursed by CONTRACTOR, under this Agreement.

20.3 CONTRACTOR shall maintain accurate accounting records of its costs and operating expenses by program. Such records shall be maintained for a period of five (5) years from the date of expiration of this Agreement. If at the end of five (5) years, there is litigation or an audit involving those records, the CONTRACTOR will retain the records until the resolution of such litigation or audit.

20.4 CONTRACTOR shall have an audit conducted by an independent auditing firm that shall be executed in accordance with generally accepted auditing standards. This audit shall be submitted to COUNTY within one hundred twenty (120) days after the end of the CONTRACTOR's fiscal year.

20.5 CONTRACTOR shall adhere to Title XIX of the Social Security Act, and conform to all other applicable Federal and State statutes and regulations.

21. REQUIRED LICENSES, CERTIFICATES OR PERMITS

Any licenses, certificates, or permits required by the Federal, State, County, or municipal governments for CONTRACTOR to provide the services and work described in this Agreement shall be procured by CONTRACTOR and be valid at the time CONTRACTOR enters into this Agreement. Further, during the term of this Agreement, CONTRACTOR shall maintain such licenses, certificates, and permits in full force and effect. Licenses, certificates, and permits may include, but are not limited to, driver's licenses, professional licenses or certificates, and business licenses. Such licenses, certificates, and permits shall be procured and maintained in force by CONTRACTOR at

no direct expense to COUNTY. CONTRACTOR shall comply with all applicable local, state, and Federal laws, rules and regulations.

22. INDEMNIFICATION

22.1 To the fullest extent permitted by law, CONTRACTOR shall indemnify, hold harmless and defend COUNTY and its agents, officers, and employees against all claims, damages, losses, judgments, liabilities, expenses and other costs, including litigation costs and attorneys' fees, arising out of, resulting from, or in connection with the performance of this Agreement by CONTRACTOR or CONTRACTOR's officers, employees, agents, representatives or subcontractors and resulting in or attributable to personal injury, death, or damage or destruction to tangible or intangible property, including the loss of use. Notwithstanding the foregoing, CONTRACTOR's obligation to indemnify the COUNTY and its agents, officers and employees for any judgment, decree or arbitration award shall extend only to the percentage of negligence or responsibility of the CONTRACTOR in contributing to such claim, damage, loss and expense.

22.2 CONTRACTOR's obligation to defend, indemnify and hold COUNTY and its agents, officers, and employees harmless under the provisions of this paragraph is not limited to or restricted by any requirement in this Agreement for CONTRACTOR to procure and maintain a policy of insurance.

22.3 To the fullest extent permitted by law, the COUNTY shall indemnify, hold harmless and defend the CONTRACTOR and its officers, employees, agents, representatives or subcontractors from and against all claims, damages, losses, judgments, liabilities, expenses and other costs, including litigation costs and attorney's fees, arising out of or resulting from the negligence or wrongful acts of COUNTY and its officers or employees.

23. INSURANCE

23.1 CONTRACTOR shall take out, and maintain during the life of this Agreement, insurance policies with coverage at least as broad as follows:

23.1.1 General Liability. Comprehensive general liability insurance covering bodily injury, personal injury, property damage, products and completed operations with limits of no less than One Million Dollars ($1,000,000) per incident or occurrence. If Commercial General Liability Insurance or other form with a general aggregate limit is used, either the general aggregate limit shall apply separately to any act or omission by CONTRACTOR

under this Agreement or the general aggregate limit shall be twice the required occurrence limit.

23.1.2 Professional Liability. Professional malpractice liability insurance with limits of no less than One Million Dollars ($1,000,000) aggregate. Such professional liability insurance shall be continued for a period of no less than one year following completion of the CONTRACTOR's services.

23.1.3 Automobile Liability Insurance. If the CONTRACTOR or the CONTRACTOR's officers, employees, agents, representatives or subcontractors utilize a motor vehicle in performing any of the work or services under this Agreement, owned/non-owned automobile liability insurance providing combined single limits covering bodily injury, property damage and transportation related pollution liability with limits or no less than One Million Dollars ($1,000,000) per incident or occurrence.

23.1.4 Workers' Compensation Insurance. Workers' Compensation insurance as required by the California Labor Code. In signing this contract, the CONTRACTOR certifies under section 1861 of the Labor Code that the CONTRACTOR is aware of the provisions of section 3700 of the Labor Code which requires every employer to be insured against liability for workers' compensation or to undertake self-insurance in accordance with the provisions of that code, and that the CONTRACTOR will comply with such provisions before commencing the performance of the work of this Agreement.

23.2 Any deductibles, self-insured retentions or named insureds must be declared in writing and approved by COUNTY. At the option of COUNTY, either: (a) the insurer shall reduce or eliminate such deductibles, self-insured retentions or named insureds, or (b) CONTRACTOR shall provide a bond, cash, letter of credit, guaranty or other security satisfactory to COUNTY guaranteeing payment of the self-insured retention or deductible and payment of any and all costs, losses, related investigations, claim administration and defense expenses. COUNTY, in its sole discretion, may waive the requirement to reduce or eliminate deductibles or self-insured retentions, in which case, CONTRACTOR agrees that it will be responsible for and pay any self-insured retention or deductible and will pay any and all costs, losses, related investigations, claim administration and

defense expenses related to or arising out of CONTRACTOR's defense and indemnification obligations as set forth in this Agreement.

23.3 CONTRACTOR shall provide a specific endorsement to all required insurance policies, except Workers' Compensation insurance and Professional Liability insurance, if any, naming COUNTY and its officers, officials and employees as additional insureds regarding: (a) liability arising from or in connection with the performance or omission to perform any term or condition of this Agreement by or on behalf of CONTRACTOR, including the insureds general supervision of CONTRACTOR; (b) services, products and completed operations of CONTRACTOR; (c) premises owned, occupied or used by CONTRACTOR; and (d) automobiles owned, leased, hired or borrowed by CONTRACTOR. For Workers' Compensation insurance, the insurance carrier shall agree to waive all rights of subrogation against COUNTY and its officers, officials and employees for losses arising from the performance of or the omission to perform any term or condition of this Agreement by CONTRACTOR.

23.4 CONTRACTOR's insurance coverage shall be primary insurance regarding COUNTY and COUNTY's officers, officials and employees. Any insurance or self-insurance maintained by COUNTY or COUNTY's officers, officials and employees shall be excess of CONTRACTOR's insurance and shall not contribute with CONTRACTOR's insurance.

23.5 Any failure to comply with reporting provisions of the policies shall not affect coverage provided to COUNTY or its officers, officials, employees or volunteers.

23.6 CONTRACTOR's insurance shall apply separately to each insured against whom claim is made or suit is brought, except with respect to the limits of the insurer's liability.

23.7 Each insurance policy required by this section shall be endorsed to state that coverage shall not be suspended, voided, canceled by either party except after thirty (30) days' prior written notice has been given to COUNTY. CONTRACTOR shall promptly notify, or cause the insurance carrier to promptly notify, COUNTY of any change in the insurance policy or policies required under this Agreement, including, without limitation, any reduction in coverage or in limits of the required policy or policies.

23.8 Insurance shall be placed with California admitted insurers (licensed to do business in California) with a current rating by Best's Key Rating Guide

acceptable to COUNTY; provided, however, that if no California admitted insurance company provides the required insurance, it is acceptable to provide the required insurance through a United States domiciled carrier that meets the required Best's rating and that is listed on the current List of Eligible Surplus Line Insurers maintained by the California Department of Insurance. A Best's rating of at least A-:VII shall be acceptable to COUNTY; lesser ratings must be approved in writing by COUNTY.

23.9 CONTRACTOR shall require that all of its subcontractors are subject to the insurance and indemnity requirements stated herein, or shall include all subcontractors as additional insureds under its insurance policies.

23.10 At least ten (10) days prior to the date CONTRACTOR begins performance of its obligations under this Agreement, CONTRACTOR shall furnish COUNTY with certificates of insurance and with original endorsements showing coverage required by this Agreement, including, without limitation, those that verify coverage for subcontractors of CONTRACTOR. The certificates and endorsements for each insurance policy are to be signed by a person authorized by the insurer to bind coverage on its behalf. All certificates and endorsements shall be received and, in COUNTY's sole and absolute discretion, approved by COUNTY. COUNTY reserves the right to require complete copies of all required insurance policies and endorsements, at any time.

23.11 The limits of insurance described herein shall not limit the liability of the CONTRACTOR and CONTRACTOR's officers, employees, agents, representatives or subcontractors.

24. NOTICE

Any notice, communication, amendments, additions, or deletions to this Agreement including change of address of either party during the term of this Agreement, which either party shall be required or may desire to make, shall be in writing and may be personally served or sent by prepaid first class mail to the respective parties as follows:

County: County of Stanislaus
Behavioral Health and Recovery Services
Attention: Contract Manager
800 Scenic Drive
Modesto, CA 95350

Contractor: John Buck, Executive Director
Turning Point Community Programs, Inc.
3440 Viking Drive, Suite 114
Sacramento, CA 95827
916-364-8395

25. CONFLICTS

CONTRACTOR agrees that it has no interest and shall not acquire any interest, directly or indirectly, which would conflict in any manner or degree with the performance of the work and services under this Agreement.

26. SEVERABILITY

If any portion of this Agreement or application thereof to any person or circumstance shall be declared invalid by a court of competent jurisdiction or if it is found in contravention of any Federal, State or County statute, ordinance, regulation, the remaining provisions of this Agreement, or the application thereof, shall not be invalidated there and shall remain in full force and effect to the extent that the provisions of this Agreement are severable.

27. AMENDMENT

This Agreement may only be modified, amended, changed, added to, or subtracted from by mutual consent of the parties hereto if such amendment or change is in written form and executed with the same formalities as this Agreement and attached to the original Agreement to maintain continuity.

28. ENTIRE AGREEMENT

This Agreement supersedes any and all other agreements, either oral or in writing, between any of the parties herein with respect to the subject matter hereof and contains all the agreements between the parties with respect to such matter. Each party acknowledges that no representations, inducements, promises or agreements, oral or otherwise, have been made by any party, or anyone acting on behalf of any party, which are not embodied herein, and that no other agreement, statement or promise not contained in this Agreement shall be valid or binding.

29. RELATIONSHIP OF PARTIES

This is an Agreement by and between two (2) independent contractors and is not intended to, and shall not be construed to be, nor create the relationship of agent, servant, employee, partnership, joint venture, or any other similar association.

30. REFERENCES TO LAWS AND RULES

In the event any statute, regulation, or policy referred to in this Agreement is amended during the term of this Agreement; the parties shall comply with the amended provision as of the effective date of such amendment.

31. ASSIGNMENT

31.1 COUNTY has relied upon the skills, knowledge, experience, and training presented by CONTRACTOR, as an inducement to enter into this Agreement. CONTRACTOR shall not assign or subcontract this Agreement, either in whole or in part, without prior written consent of COUNTY, which shall not be unreasonably withheld.

31.2 CONTRACTOR shall not assign any monies due or to become due under this Agreement without the prior written consent of COUNTY.

32. AVAILABILITY OF FUNDS

Payments for services provided in accordance with the provisions of this Agreement are contingent upon the availability of County, State, and Federal funds. If Federal, State, or local entities do not appropriate sufficient funds for this program, the County has the option to terminate this Agreement or amend the Agreement to reflect any reduction of funds.

33. WAIVER OF DEFAULT

Waiver of any default by either party to this Agreement shall not be deemed to be waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach, and shall not be construed to be a modification of the terms of this Agreement unless this Agreement is modified as provided below.

34. VENUE

This Agreement shall be deemed to be made under, and shall be governed by and construed in accordance with, the laws of the State of California. Any action brought to enforce the terms or provisions of this Agreement shall have venue in the County of Stanislaus, State of California.

35. TERM

35.1 This Agreement shall commence on July 1, 2013, and continue through June 30, 2014. Either party may terminate this Agreement, with or without cause, by giving thirty (30) days prior written notice to the other party. COUNTY may suspend or terminate this Agreement for cause upon written notice to CONTRACTOR

immediately, or upon such notice, as COUNTY deems reasonable. If the default is cured by CONTRACTOR to the satisfaction of COUNTY, or COUNTY determines that the default should be excused, COUNTY may reinstate the Agreement, or revoke the termination upon application by CONTRACTOR.

35.2 In the event of termination or expiration of this Agreement, CONTRACTOR shall assist COUNTY in the orderly transfer of clients. In doing this, CONTRACTOR shall make available any pertinent information necessary for efficient case management of clients as determined by COUNTY. In no case shall a client be billed for this service.

35.3 This Agreement shall terminate automatically on the occurrence of (a) bankruptcy or insolvency of either party, (b) sale of CONTRACTOR's business, (c) cancellation of insurance required under the terms of this Agreement, and (d) if, for any reason, CONTRACTOR ceases to be licensed or otherwise authorized to do business in the State of California, and CONTRACTOR fails to remedy such defect or defects within thirty (30) days of receipt of notice of such defect or defects.

36. SURVIVAL

Notwithstanding any other provision of this Agreement, the following clauses shall remain in full force and effect and shall survive the expiration or termination of this Agreement: Paragraph 4, "Billing and Payment", Paragraphs 7 and 8, "Confidentiality and Information Security" and "MHSA Confidentiality Requirements", Paragraphs 12 & 13, "Records" and "Audits", Paragraph 22, "Indemnification", and Paragraph 31, "Assignment".

IN WITNESS WHEREOF, the parties have executed this Agreement on the date(s) shown below..

COUNTY OF STANISLAUS
BEHAVIORAL HEALTH AND
RECOVERY SERVICES

Madelyn Schlaepfer, Ph.D., CEAP Date
Behavioral Health Director

TURNING POINT COMMUNITY
PROGRAMS, INC

John Buck Date
Executive Director

APPROVED AS TO FORM:
John P. Doering, County Counsel

Vicki Fern de Castro
Deputy County Counsel

BOS Action Item:_____ Date:_____

IN WITNESS WHEREOF, the parties have executed this Agreement on the date(s) shown below.

COUNTY OF STANISLAUS
BEHAVIORAL HEALTH AND
RECOVERY SERVICES

Madelyn Schlaepfer, Ph.D., CEAP Date
Behavioral Health Director

TURNING POINT COMMUNITY
PROGRAMS, INC

John Buck 5/24/13
John Buck Date
Executive Director

APPROVED AS TO FORM:
John P. Doering, County Counsel

Vicki Fern de Castro
Deputy County Counsel

BOS Action Item: _____ Date: _____

EXHIBIT A

GARDEN GATE RESPITE CENTER

A. SERVICES

1. CONTRACTOR shall operate a twenty-four hour, seven days a week (24/7) Garden Gate Respite Center at 609 Fifth Street, in Modesto. CONTRACTOR shall be responsible for utilities, while COUNTY shall pay rent on the facility. This program shall be staffed with a minimum of two Full Time Equivalent's (FTE's) staff on all shifts who are awake and alert at all times.

2. CONTRACTOR shall use the Fifth Street facilities, which have the capacity for six (6) beds, to provide short-term respite care and support. For the purposes of this Agreement, short term is defined, as between one (1) and seven (7) days. Any days beyond seven (7) days needs to be authorized by the BHRS Housing Program Manager. Other services shall be those associated with basic care and support and linkage to housing resources.

3. CONTRACTOR shall provide services to target populations to include Transitional Age Young Adults, Adults, Older Adults, and unserved or underserved individuals including those whose race or ethnicity is Latino, African American, and Southeast Asian (Asian/Pacific Islander).

4. CONTRACTOR shall assign incoming clients a room and provide the basic needs for their stay, including, but not limited to, a bed, access to shower and toilet, personal care items, and meals. Each client shall be offered use of a locked container in which to store personal items.

5. CONTRACTOR's staff shall provide each client with a brief information-gathering intake, a general needs assessment, brief care, including meals and housing, and referrals to resources within the community. The intake shall be completed within twenty (20) minutes from the time a client enters the facility.

6. CONTRACTOR's staff shall link each client with the client's existing case manager, if the client is currently open to BHRS, or to appropriate community services on the first business day for non-24 hour programs, for the purposes of developing housing alternatives. CONTRACTOR's staff shall also provide basic coordination of service with support staff from other mental health programs and other community resource agencies.

7. CONTRACTOR shall respond to individuals residing in the Transitional Living component of the Fifth Street Project after hours and on weekends and holidays, for situations that, if not attended to promptly, would jeopardize the resident's well-being or the well-being of other residents, or the surrounding community. In such situations, the Garden Gate Respite Center staff shall offer support and assistance within their scope of experience and/or skill, and shall contact the appropriate resource if more is required.

8. CONTRACTOR shall make a refrigerator, microwave, and toaster oven available to clients for basic meal preparation.

9. CONTRACTOR shall participate in BHRS outcome studies and supply data on the Garden Gate Respite Center on or before the 4th working day of the following month.

10. CONTRACTOR shall collaborate closely with BHRS and other outreach and engagement providers regarding outreach strategies. This shall include presentations to community providers regarding Garden Gate Respite Center and services available.

11. CONTRACTOR shall provide grassroots outreach and networking by Garden Gate Respite Center staff through existing community members.

12. CONTRACTOR will provide outreach and engagement services at non-traditional sites such as faith-based and community-based organizations.

13. Contractor will work with County's Administration to identify and develop specific client and program outcomes and objectives based on Results Based Accountability principles with data collection.

B. OUTCOMES

1. Outcome: It is expected that incarcerations will decrease.
   Indicator: Law enforcement report of client circumstances at time of admission to Garden Gate Respite Center.
   Target: Sixty percent (60%) of law enforcement admissions to the Garden Gate Respite Center will result in avoiding arrest and/or at risk for victimization.

2. Outcome: It is expected that CONTRACTOR will provide respite services and support services pursuant to this Agreement that meet State Department of Mental Health, Mental Health Services Act required outcomes as set out in the State MHSA contract, Exhibit 6.
   Indicator: Measured by Initial Contact Forms submitted to Performance Measurement, on or before the 4th working day of the following month.
   Target: A minimum of 97 clients will receive respite services and support services.

3. Outcome: It is expected that incidents of homelessness will be reduced.
   Indicator: Referral source report of client circumstances at time of admission to Garden Gate Respite Center.
   Target: One hundred percent (100%) of admissions to the Garden Gate Respite Center will be persons who are homeless or at risk of homelessness.

4. Outcome: It is expected that referrals to service providers will be made to meet the client's immediate housing, behavioral and physical healthcare needs.
   Indicator: Garden Gate Respite Center staff will document referrals.
   Target: Ninety percent (90%) of Garden Gate Respite Center clients will be referred to appropriate service providers prior to leaving the Garden Gate Respite Center.

5. Outcome: It is expected that law enforcement personnel using the Garden Gate Respite Center will be satisfied or very satisfied with the service.
   Indicator: Satisfaction of officers using the Garden Gate Respite Center.
   Target: Seventy percent (70%) of officers will report that they are satisfied or very satisfied with the Garden Gate Respite Center service as reported at admission or on a follow-up satisfaction survey.

6. Outcome: It is expected that clients will be satisfied with Garden Gate Respite Center services.
   Indicator: Clients' responses to the survey administered at the end of their respite stay.
   Target: Seventy-five percent (75%) of the clients will report that they are satisfied or very satisfied with Garden Gate Respite Center services.

7. It is expected that CONTRACTOR will meet any other outcomes that the State Department of Mental Health may later define.

C. ELIGIBILITY

Individuals to be served by the CONTRACTOR in this program are adults with psychiatric disabilities who do not meet Welfare and Institutions Code 5150 criteria, appear to be homeless, transient, at risk for victimization or incarceration, or any or all of the above.

D. COMMUNITY POLICY

CONTRACTOR's staff and participants of the Garden Gate Respite Center shall promote positive relationships within the community to the extent possible. Staff and clients shall be expected to conduct themselves in a manner that demonstrates they care for the property they live in as well as for the surrounding neighborhood. As a part of CONTRACTOR's Good Neighbor Policy, staff shall be easily accessed through a telephone number that shall be provided to those who live and work nearby. This will make it possible for neighbors and surrounding community members to contact CONTRACTOR's staff with any concerns.

E. PERSONNEL

1. CONTRACTOR shall recruit staff on the basis of ability to be friendly, congenial, and supportive. Training or skills in the provision of mental health services shall not be a prerequisite for hire. Immediate training for new staff shall focus on increasing their knowledge of community resources so that they are able to skillfully link clients to these resources.

2. CONTRACTOR shall emphasize to staff that their primary responsibility is to provide a safe, secure, and stable temporary living environment while providing clients with the support necessary to contribute to their success in achieving a longer-term living status in the community.

F. BILLING AND PAYMENT

1. COUNTY shall reimburse CONTRACTOR for services delivered under the terms of this Agreement from the following funding sources: Mental Health Services Act - Community Services and Supports.

2. In consideration of CONTRACTOR's provision of services required under this Agreement, COUNTY shall reimburse CONTRACTOR an amount not to exceed the Contract Maximum of $443,074 (GL5184080) for salaries, benefits, and other operating costs.

3. CONTRACTOR shall invoice COUNTY monthly. The invoice shall be equal to the monthly program costs for -delivering all the services required by this Agreement. The CONTRACTOR shall provide a monthly expenditure report to accompany the invoice in support of the program cost on the invoice.

4. COUNTY shall reimburse CONTRACTOR for any undisputed invoices, which COUNTY and CONTRACTOR agree represent the costs of delivering the services required under the terms of this Agreement for the period covered by the invoice, within 30 days of invoice receipt.

5. CONTRACTOR shall provide COUNTY a quarterly projection of annual expenditures. In the event projected annual expenditures are to be less than the contract maximum, the rate used to calculate the monthly invoices may be modified to reflect the reduced cost of providing the required services.

6. CONTRACTOR shall submit an annual Cost Report to COUNTY, and COUNTY shall settle to the CONTRACTOR's actual costs of delivering the services during the term of this Agreement in approximately January 2015. Settlement is limited to the contract maximum and is also limited to the Net County Cost after applying the FFP revenue,

G. FUNDING

If, during the time which this Agreement is in effect, funds are not allocated to County or Behavioral Health and Recovery Services, sufficient to allow for a continuation of this Agreement , then County may, at its sole discretion, terminate this Agreement without penalty from or further obligation to Contractor. Contractor shall have no further obligation to County.

H. DUPLICATE COUNTERPARTS

This Agreement may be executed in duplicate counterparts, each of which shall be deemed a duplicate original.

Confidentiality and Information Security Provisions
Direct Service Providers

1. As a covered entity, the Contractor shall comply with applicable laws and regulations, including but not limited to Sections 14100.2 and 5328 et seq. of the Welfare and Institutions Code and with the privacy and security requirements of Title II of the Health Insurance Portability and Accountability Act of 1996, (Public Law 104-91), also known as "HIPAA", and Title XIII of the American Recovery and Reinvestment Act of 2009, (Public Law 111-5), "the ARRA/HITECH Act" or "the HITECH Act", as these laws may be subsequently amended, and implementing regulations enacted by the Department of Health and Human Services at 45 CFR Parts 160-164, and, regulations enacted with regard to the HITECH Act. The foregoing laws and rules are sometimes collectively referred to hereafter as "HIPAA".

2. Permitted Uses and Disclosures of IIHI by the Contractor.

   A. *Permitted Uses and Disclosures.* Except as otherwise provided in this Agreement, the Contractor, may use or disclose IIHI to perform functions, activities or services identified in this Agreement provided that such use or disclosure would not violate federal or state laws or regulations.

   B. *Specific Uses and Disclosures Provisions.* Except as otherwise indicated in the Agreement, the Contractor may:

      (1) Use and disclose IIHI for the proper management and administration of the Contractor or to carry out the legal responsibilities of the Contractor, provided that such use and disclosures are permitted by law.

      (2) Use IIHI to provide data aggregation services to County. Data aggregation means the combining of IIHI created or received by the Contractor for the purposes of this Agreement with IIHI received by the Contractor in its capacity as the Contractor of another HIPAA covered entity, to permit data analyses that relate to the health care operations of County.

3. Responsibilities of the Contractor.

   The Contractor agrees:

   A. *Safeguards.* To prevent use or disclosure of IIHI other than as provided for by this Agreement. The Contractor shall develop and maintain an information privacy and security program that includes the implementation of administrative, technical, and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities. The information privacy and security programs must reasonably and appropriately protect the confidentiality, integrity, and availability of the IIHI that it creates, receives, maintains, or transmits; and prevent the use or disclosure of IIHI other than as provided for by this Agreement. The Contractor shall provide County with information concerning such safeguards as County may reasonably request from time to time.

      The Contractor shall restrict logical and physical access to confidential, personal (e.g., PHI) or sensitive data to authorized users only.

      The Contractor shall not transmit confidential, personal, or sensitive data via e-mail or other Internet transport protocol over a public network.

B. *Mitigation of Harmful Effects.* To mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of IIHI by Contractor or its subcontractors in violation of the requirements of this Agreement.

C. *Agents and Subcontractors of the Contractor.* To ensure that any agent, including a subcontractor to which the Contractor provides IIHI received from County, or created or received by the Contractor, for the purposes of this contract shall comply with the same restrictions and conditions that apply through this Agreement to the Contractor with respect to such information.

D. *Notification of Electronic Breach or Improper Disclosure.* During the term of this Agreement, Contractor shall notify County immediately upon discovery of any breach of IIHI and/or data, where the information and/or data is reasonably believed to have been acquired by an unauthorized person. Immediate notification shall be made to the County BHRS Privacy Officer, within five (5) business days of discovery. Contractor shall take prompt corrective action to cure any deficiencies and any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations. Contractor shall investigate such breach and provide a written report of the results of the investigation, including any corrective actions taken, and copies of all Notifications made as a result of the breach, to the BHRS Officer, postmarked within thirty (30) calendar days of the discovery of the breach to the address below:

BHRS Privacy Officer
Behavioral Health and Recovery Services
800 Scenic Drive
Modesto, CA 95320
(209) 525-6225

E. *Employee Training and Discipline.* To train and use reasonable measures to ensure compliance with the requirements of this Agreement by employees who assist in the performance of functions or activities under this Agreement and use or disclose IIHI; and discipline such employees who intentionally violate any provisions of this Agreement, including by termination of employment.

4. Termination.

A. *Termination for Cause.* Upon County's knowledge of a material breach of this Agreement by Contractor, County shall either:

(1) Provide an opportunity for Contractor to cure the breach or end the violation and terminate this Agreement if Contractor does not cure the breach or end the violation within the time specified by County.

(2) Immediately terminate this Agreement if Contractor has breached a material term of this Agreement and cure is not possible; or

(3) If neither cure nor termination is feasible, the BHRS Privacy Officer shall report the violation to the DMH Information Security Officer of the Department of Mental Health.

B. *Judicial or Administrative Proceedings.* County may terminate this Agreement, effective immediately, if (i) Contractor is found liable in a civil matter or guilty in a criminal proceeding for a violation of the HIPAA Privacy or Security Rule or (ii) a finding or stipulation is made, in

an administrative or civil proceeding in which the Contractor is a party, that the Contractor has violated a privacy or security standard or requirement of HIPAA, or other security or privacy laws.

C. *Effect of Termination.* Upon termination or expiration of this Agreement for any reason, Contractor shall return or destroy all IIHI received from County that Contractor still maintains in any form, and shall retain no copies of such IIHI or, if return or destruction is not feasible, it shall continue to extend the protections of this Agreement to such information, and limit further use of such IIHI to those purposes that make the return or destruction of such IIHI infeasible. This provision shall apply to IIHI that is in the possession of subcontractors or agents of the Contractor.

5. Miscellaneous Provisions.

A. *Disclaimer.* County makes no warranty or representation that compliance by Contractor with this Agreement, HIPAA or the HIPAA regulations will be adequate or satisfactory for Contractor's own purposes or that any information in the Contractor's possession or control, or transmitted or received by the Contractor, is or will be secure from unauthorized use or disclosure. Contractor is solely responsible for all decisions made by Contractor regarding the safeguarding of IIHI.

B. *Assistance in Litigation or Administrative Proceedings.* Contractor shall make itself, and use its best efforts to make any subcontractors, employees or agents assisting Contractor in the performance of its obligations under this Agreement, available to County at no cost to County to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings against County, its directors, officers or employees for claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy based upon actions or inactions of the Contractor and/or its subcontractor, employee, or agent, except where Contractor or its subcontractor, employee, or agent is a named adverse party.

C. *No Third-Party Beneficiaries.* Nothing expressed or implied in the terms and conditions of this Agreement is intended to confer, nor shall anything herein confer, upon any person other than County or Contractor and their respective successors or assignees, any rights remedies, obligations or liabilities whatsoever.

D. *Interpretation.* The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HIPAA regulations and applicable State laws. The parties agree that any ambiguity in the terms and conditions of this Agreement shall be resolved in favor of a meaning that complies and is consistent with applicable laws.

E. *Regulatory References.* A reference in the terms and conditions of this Agreement to a section in the HIPAA regulations means the section as in effect or as amended.

F. *Survival.* The respective rights and obligations of Contractor under Section 5.B of this Exhibit shall survive the termination or expiration of this Agreement.

G. *No Waiver of Obligations.* No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

EXHIBIT C

STATEMENT OF COMPLIANCE

A. CONTRACTOR agrees, unless specifically exempted, compliance with Government Code Section 12900 (a-f) and California Code of Regulations, Title 2, Division 4, Chapter 5 in matters relating to reporting requirements and the development, implementation and maintenance of a Nondiscrimination Program. Contractor agrees not to unlawfully discriminate, harass or allow harassment against any employee or applicant for employment because of sex, race, color, ancestry, religious creed, national origin, physical disability (including HIV and AIDS), mental disability, medical condition (cancer), age (over 40), marital status, and denial of family care leave. Employment of personnel shall be made solely on the basis of merit.

1. Action shall be taken to ensure applicants are employed, and employees are treated during employment, without regard to their race, religion, color, sex, national origin, age, physical or mental handicap. Such action shall include, but not be limited to, the following: Employment; upgrading; demotion or transfer; recruitment or recruitment advertising; layoff; or apprenticeship. However, recruitment and employment of applicants shall reflect the ethnic and racial composition of the County, particularly those groups not previously, nor currently, having adequate representation in recruitment or hiring. There shall be posted, in conspicuous places, notices available to employees and applicants for employment provided by the County Officer responsible for contracts setting forth the provisions of the Equal Opportunity clause.

2. All solicitations or advertisements for employees placed by or on behalf of CONTRACTOR and/or the subcontractor shall state that all qualified applicants will receive consideration for employment without regard to race, religion, color, sex, national origin, age, or physical or mental handicap.

3. Each labor union or representative of workers with which the County and/or the subcontractor has a collective bargaining agreement, or other contract or understanding, must post a notice provided by the County Officer responsible for contracts, advising the labor union or workers representative of CONTRACTOR's commitments under this Equal Opportunity clause and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

4. In the event of noncompliance with the discrimination clause of this contract or as otherwise provided by State and Federal law, this contract may be canceled, terminated or suspended, in whole or in part, and CONTRACTOR and/or the subcontractor may be declared ineligible for further State contracts in accordance with the procedures authorized in the Department of Mental Health's Complaint Process.

5. All provision of Paragraph 1 through this paragraph 5 will be included in every subcontract unless exempted by rules, regulations or orders of the Director of the Department of Mental Health so such provisions will be binding upon each subcontractor. CONTRACTOR will take such action with respect to any subcontract as the State may direct as a means of enforcing such provisions including sanctions for noncompliance provided; however, in the event CONTRACTOR becomes involved in, or is threatened with, litigation with a subcontractor as a result of such direction by the State, CONTRACTOR may request in writing to the State, who, in turn, may request the United States to enter into such litigation to protect the interest of the State and the United States.

B. Services, benefits and facilities shall be provided to patients without regard to their race, color, creed, national origin, sex, age or physical or mental handicap, and no one will be refused service because of inability to pay for such services.

1. Nondiscrimination in Services, Benefits and Facilities: There shall be no discrimination in the provision of services because of color, race, creed, national origin, sex, age, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 U.S.C. Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by State and Federal law. For the purpose of the contract, distinctions on the grounds of color, race, creed, national origin, sex, or age include, but are not limited to, the following: denying a participant any service or benefit to the participant which is different, or is provided in a different manner or at a different time, from that provided to other participants under this contract; subjecting a participant to segregation or separate treatment in any matter related to this receipt of any service; restricting a participant in any way in the enjoyment of any advantage or privilege enjoyed by others receiving any service or benefit; treating a participant differently from others in determining whether he/she satisfied any admission, enrollment quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any service or benefit; the assignment of times or places for the provision of services on the basis of the race, color, creed, or national origin of the participants to be served. The County and all subcontractors will take action to ensure intended beneficiaries are provided services without regard to color, race, creed, national origin, sex, age, or physical or mental handicap.

2. Procedure for Complaint Process: All complaints alleging discrimination in the delivery of services by the County and/or the subcontractor because of race, color, creed, national origin, sex, age, or physical or mental handicap, may be resolved by the State through the State Department of Mental Health's Action Complaint Process.

3. Notice of Complaint Process: The County and all subcontractors shall, subject to the approval of the Department of Mental Health, establish procedures under which recipients of the service are informed of their rights to file a complaint alleging discrimination or a violation of their civil rights with the State Department of Mental Health.

C. The County and any subcontractor will furnish all information and reports required by the Department of Mental Health and will permit access to books, records and accounts for purposes of investigation to ascertain compliance with above paragraphs.

D. The County and all subcontractors assure all recipients of service are provided information in accordance with provisions of Welfare and Institutions Code, Sections 5325 and 5325.1, and Sections 5520 through 5550, pertaining to their rights as patients, that the County has established a system whereby recipients of service may file a complaint for alleged violations of their rights.

E. CONTRACTOR agrees to the provisions of Section 504 of the Rehabilitation Act of 1973, as amended, pertaining to the prohibition of discrimination against qualified handicapped persons in all Federally-assisted programs or activities, as detailed in regulations signed by the Secretary of Health, Education and Welfare, effective June 3, 1977, and found in the Federal Register, Volume 42, Number 86, dated May 4, 1977.

Behavioral Health and Recovery Services

Mental Health Services Act
Three-Year Program and Expenditure Plan
Annual Update FY2013-2014

Stanislaus County Board of Supervisors
June 11, 2013

Change brings opportunity.

Nido Qubein

Background

- In November 2004, the Mental Health Services Act (MHSA)/Proposition 63 was passed
  - Provides funding to *transform* the public mental health system
  - Funds have been allocated for:
    - Community Services and Supports
    - Prevention and Early Intervention
    - Workforce Education and Training
    - Technological Needs, and
    - Innovation

Background

- MHSA funds came with very specific regulations regarding how the funds could be used

Background

- An annual update is required which includes a report of services delivered in the most recent full year of data available (FY2011/2012) and a forecast of services for the upcoming year (FY2013/2014)
- Highlights are included on all approved programs in all components

Background

- Updates include successes, challenges, and forecasts for services in the coming fiscal year, including a summary proposed budget
- As required by regulation, annual updates are subject to a 30-day public review and a public hearing that is convened by the Mental Health Board

Background

- After the hearing, any substantive comments are incorporated into the document with a response
- This year, as required, a 30-day review period occurred from 4/24/13 to 5/23/13

Background

- A Public Hearing was held on May 23, 2013
- No substantive comments were received

Background

- All 3-year plans and annual updates must be adopted by the County Board of Supervisors
- Once adopted by the Board, the Annual Update can be submitted to the Mental Health Services Oversight and Accountability Commission

Local Stakeholder Process

- Stanislaus County is known throughout the state for our inclusive stakeholder process and our willingness to accept and incorporate stakeholder input
- Every effort is made to obtain stakeholder input, including moving the site of the Public Hearing into the community

Who Are Our Stakeholders

- Required by regulation:
  - Consumers and family members
  - Providers of mental health and/or related services such as physical health, social services
  - Educators
  - Law enforcement
  - Other organizations representing the interests of consumers

Who Are Our Stakeholders

- In addition, we have always included:
  - Other county departments that may have contact with consumers and family members
  - BHRS Staff
  - Chief Executive Office
  - Courts
  - Faith-based Communities

Who Are Our Stakeholders

- Mental Health Board Members
- Labor Organizations
- Representatives from diverse, underserved communities throughout the county
- Representatives from substance use treatment services

Annual Update

- Beginning with the Annual Update for FY 2012/2013, we designed the format to be more user friendly and valuable to stakeholders

Annual Update

- This Annual Update report:
  - is less repetitious
  - has graphics
  - highlights our commitment to Results-Based Accountability
  - **includes narratives showing how lives have changed**

Annual Update Highlights

- What is Results-Based Accountability (RBA)?
  - A way to evaluate effort and progress
  - Shows how conditions of well-being for participants are being created
  - Answers three questions:
    - How much did we do?
    - How well did we do it?
    - Is anyone better off?

Annual Update Highlights

- RBA efforts started with MHSA-funded PEI programs and one CSS program
- This year, we extended RBA to other programs

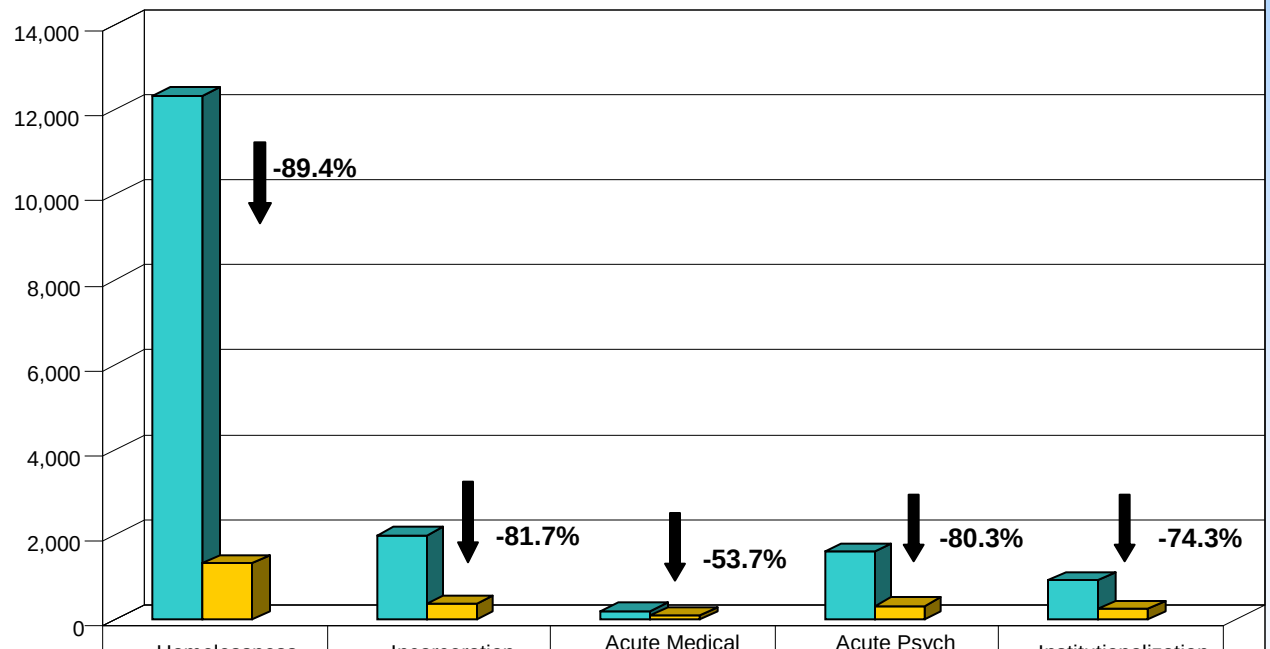
Annual Update Highlights

- Community Services and Supports (CSS) have been in place beginning FY2005/2006
- CSS - Full Service Partnerships (FSPs) are part of this MHSA component
- FSPs provide very intensive services to individuals of all ages who have serious mental illness and serious emotional disturbance

FSP Outcomes

SHOP, Partnership TRAC, and Josie's TRAC Program Outcomes

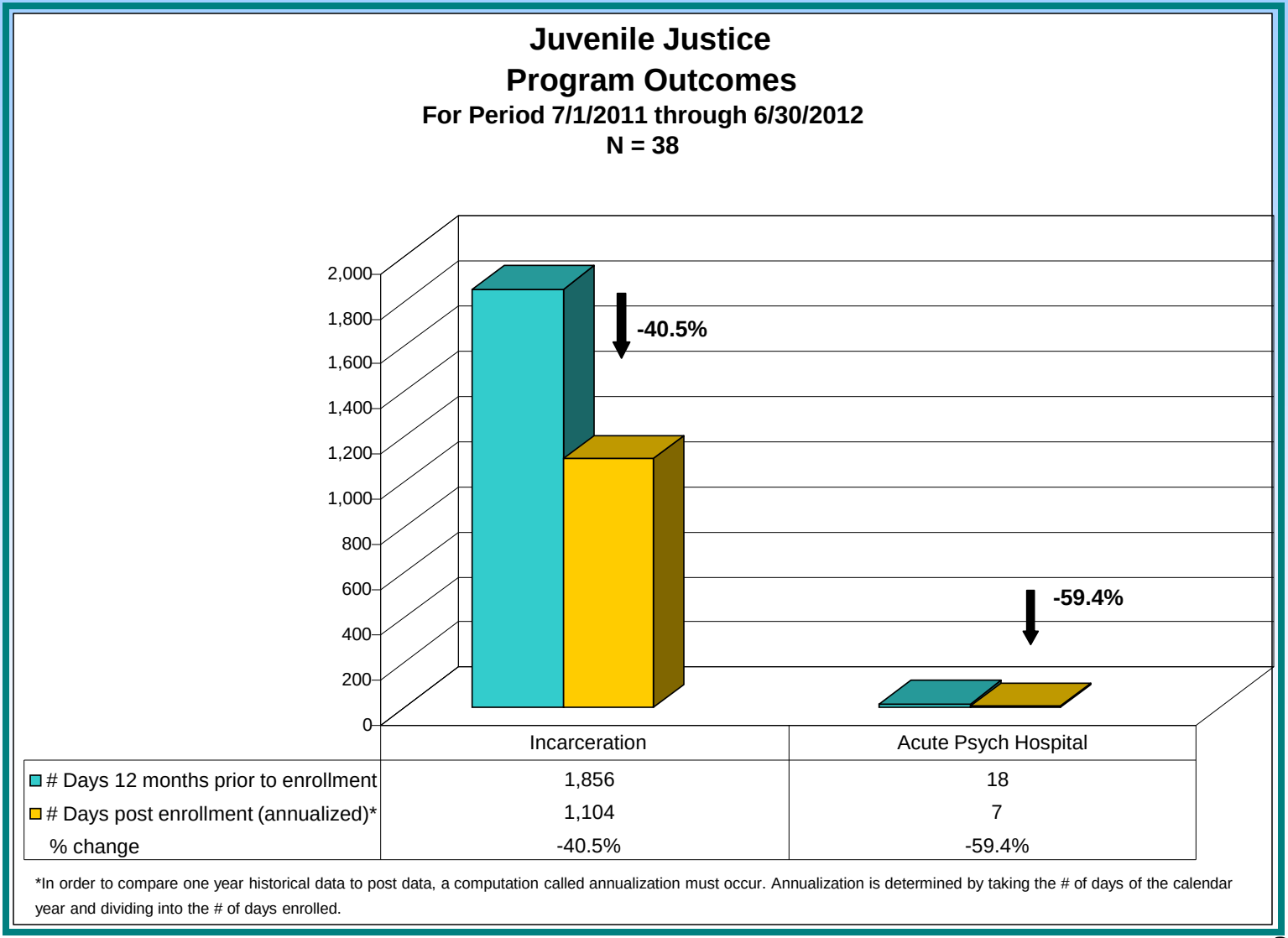
For Period 7/1/2011 through 6/30/2012
n = 167



	Homelessness	Incarceration	Acute Medical Hospital	Acute Psych Hospital	Institutionalization
# Days 12 months prior to enrollment	12,331	1,976	190	1,598	918
# Days post enrollment (annualized)*	1,311	362	88	315	236
% change	-89.4%	-81.7%	-53.7%	-80.3%	-74.3%

*In order to compare one year historical data to post data, a computation called annualization must occur. Annualization is determined by taking the # of days of the calendar year and dividing into the # of days enrolled.

FSP Outcomes



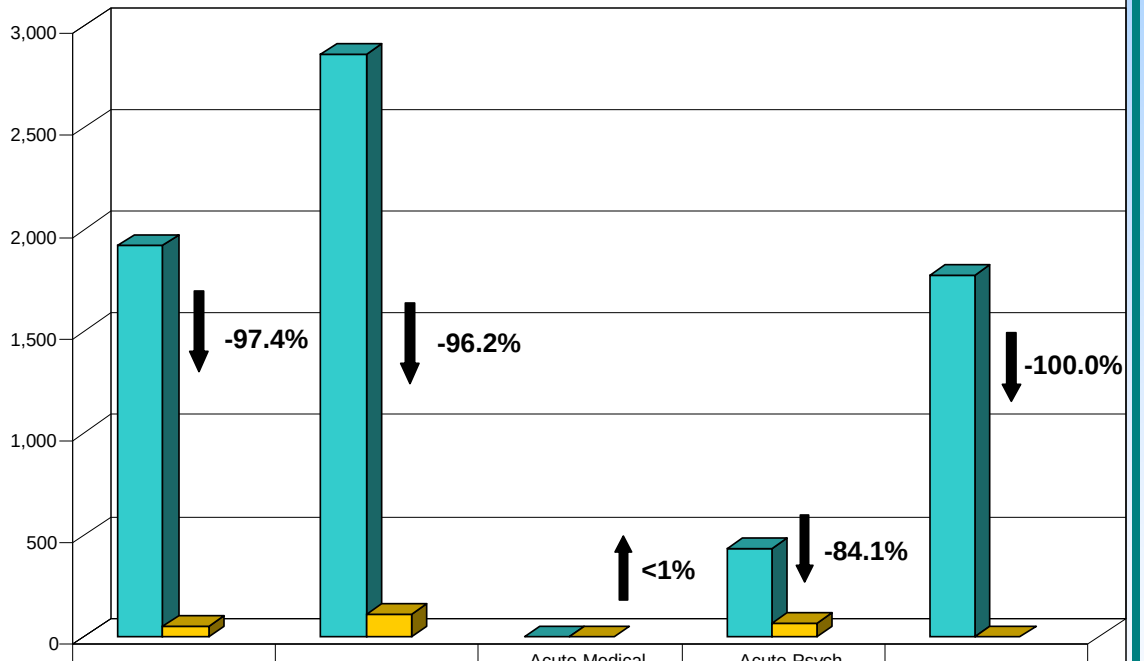
	Incarceration	Acute Psych Hospital
# Days 12 months prior to enrollment	1,856	18
# Days post enrollment (annualized)*	1,104	7
% change	-40.5%	-59.4%

*In order to compare one year historical data to post data, a computation called annualization must occur. Annualization is determined by taking the # of days of the calendar year and dividing into the # of days enrolled.

FSP Outcomes

Integrated Forensic Team Program Outcomes

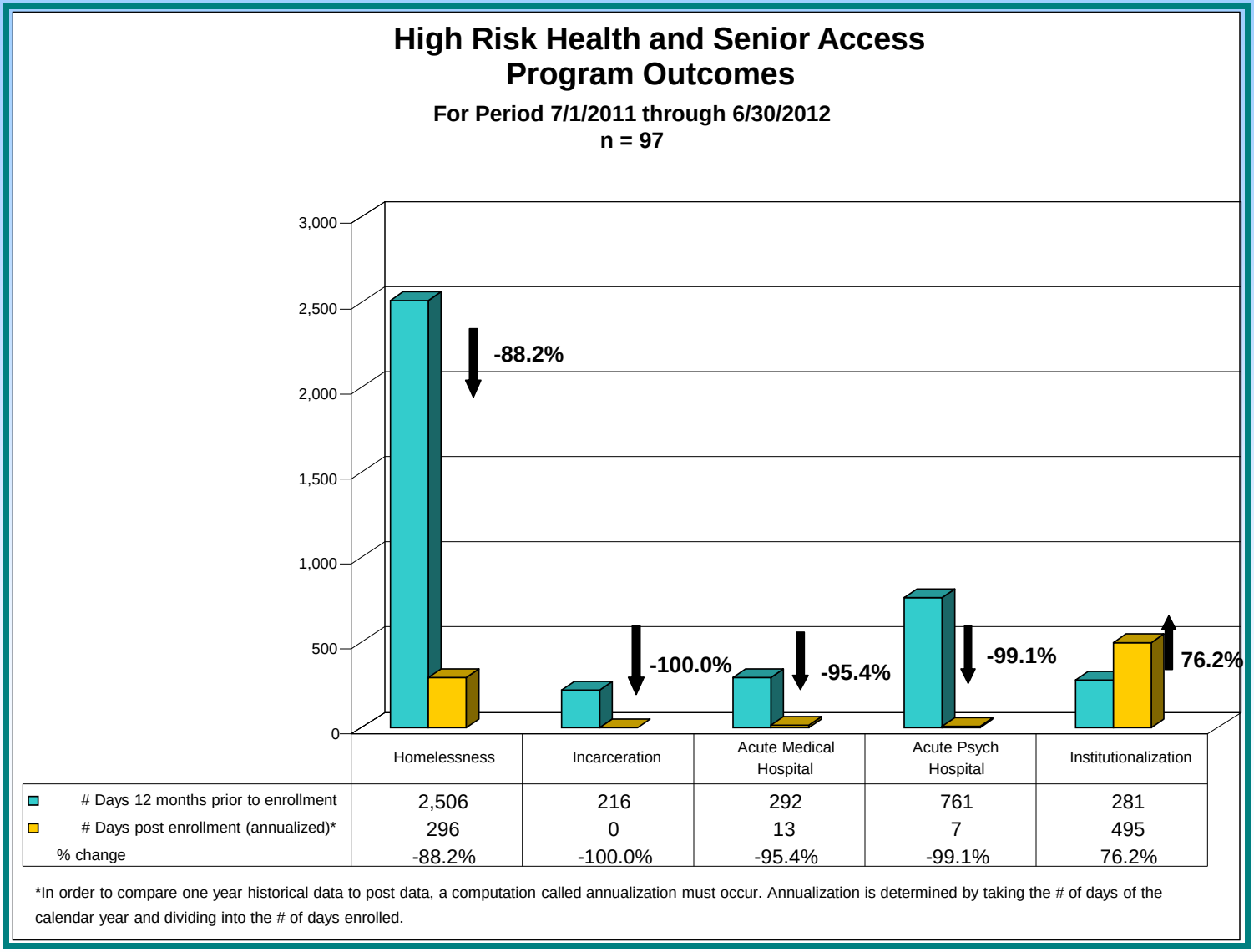
For Period 7/1/2011 through 6/30/2012
N = 35



	Homelessness	Incarceration	Acute Medical Hospital	Acute Psych Hospital	Institutionalization
# Days 12 months prior to enrollment	1,925	2,858	0	433	1,777
# Days post enrollment (annualized)*	50	109	3	69	0
% change	-97.4%	-96.2%	0.0%	-84.1%	-100.0%

*In order to compare one year historical data to post data, a computation called annualization must occur. Annualization is determined by taking the # of days of the calendar year and dividing into the # of days enrolled.

FSP Outcomes



	Homelessness	Incarceration	Acute Medical Hospital	Acute Psych Hospital	Institutionalization
# Days 12 months prior to enrollment	2,506	216	292	761	281
# Days post enrollment (annualized)*	296	0	13	7	495
% change	-88.2%	-100.0%	-95.4%	-99.1%	76.2%

*In order to compare one year historical data to post data, a computation called annualization must occur. Annualization is determined by taking the # of days of the calendar year and dividing into the # of days enrolled.

FSP Outcomes

SHOP, Partnership TRAC, and Josie's TRAC		
	Incarceration	Acute Psych Hospital
Difference between # of days prior to enrollment and # of days post enrollment (annualized)	1,614	1,283
Average daily rate	$92	$974

Based only on current ('11-'12) average daily costs and annualized outcome data:

- number of incarceration days avoided was **1,614**, for a total estimated cost of $**148,488**
- number of hospital days avoided was **1,283**, for a total estimated cost of **$1,249,642**

FSP Outcomes

Integrated Forensic Team		
	Incarceration	Acute Psych Hospital
Difference between # of days prior to enrollment and # of days post enrollment	2,749	364
Average Daily Rate	$92	$974

Based only on current (’11-’12) average daily costs and annualized outcome data:

- the number of incarceration days avoided was **2,749**, for a total estimated cost of $**252,908**
- the number of hospital days avoided was **364** for a total estimated cost of $**354,536**

FSP Outcomes

High Risk Health and Senior Access		
	Incarceration	Acute Psych Hospital
Difference between # of days prior to enrollment and # of days post enrollment	216	754
Average Daily Rate	$92	$974

Based only on current (’11-’12) average daily costs and annualized outcome data:

- the number of incarceration days avoided was **216**, for a total estimated cost of $**19,872**
- the number of hospital days avoided was **754** for a total estimated cost of $**734,396**

Other MHSA Components

- **Prevention and Early Intervention**
  - Provides opportunities to intervene early ("help first") rather than letting individuals "fail first"
  - Can have immediate and long-term positive outcomes in otherwise debilitating conditions and reduce long-term costs

Other MHSA Components

- **Prevention and Early Intervention**
  - Research shows that prevention is effective in reducing health care costs
  - Part of federal standards for a “good and modern addictions & mental health service system”
  - Reflects local priorities

Other MHSA Components

- **Workforce Education and Training**
  - Addresses shortages in the workforce
  - Trains the existing workforce to incorporate MHSA values into practice
  - Identifies hard to fill positions

Other MHSA Components

- **Workforce Education and Training**
  - Develops career pathways for diverse populations and individuals with lived experience
  - One-time funding to be expended within ten years

Other MHSA Components

- **Technological Needs**
  - Electronic Health Record System
  - Consumer/Family Access to Computing Resources Project
  - Data Warehousing

Other MHSA Components

- **Technological Needs**
  - Document Imaging
  - One-time funding to be expended within ten years

Other MHSA Components

Although both Workforce Education and Training and Technological Needs were initiated with one-time funding, they can be allocated some of the Community Services and Supports funding in future years as appropriate

Other MHSA Components

- **Innovation**
  - Projects that demonstrate ways to:
    - Increase access to underserved groups
    - **Increase the quality of services including better outcomes**
    - **Promote interagency collaboration**
    - Increase access to services

Other MHSA Components

- **Innovation**
  - By regulation, the primary focus is learning and contributing to practice – not service delivery
  - Innovation funds cannot be used to sustain projects once learning project is completed

Other MHSA Components

- **Innovation Project - 01**
  - Evolving a Community-owned Behavioral Health System of Supports and Services
  - Based on the “adaptive dilemma” - decreased revenue, increased costs and increased need

Other MHSA Components

- **Innovation Project – 01**
  - Traditional strategies for managing budget shortfalls no longer worked well
  - For this project, learning was focused on how much involvement stakeholders would want in the development of a fiscally sustainable behavioral health system

Other MHSA Components

- **Innovation Project – 01**
  - Outcomes
    - Led to far better recommendations than would have emerged using traditional approaches
    - Added value to the behavioral health system
    - Pushed us to near absolute budget clarity and transparency
    - Reached consensus among more than sixty participants

Other MHSA Components

- **Innovation Project – 01**
  - Lesson Learned
    - If stakeholders are invited and supported in understanding complex issues, they are more than willing to participate and **take ownership** of shared problems and high quality solutions

Other MHSA Components

- **Innovation Projects – 02 to 10**
  - For the second round of projects, an extensive stakeholder-driven process occurred with community meetings to identify and prioritize opportunities for learning that would contribute to practice in the future

Other MHSA Components

- **Innovation Projects**
  - The opportunities for learning that were identified in these meetings became the basis for a Request for Proposal (RFP) process
  - Nine (9) new innovations projects were selected for two or three years of funding

Other MHSA Components

- **Innovation Projects**
  - Implementation began in FY2011-2012
  - Projects are still in progress
  - Several that were two-year projects will be completed in FY2013/2014 and the three-year projects, a year later

Other MHSA Components

- **Innovation Project - 11**
  - Our major partner agencies are facing similar adaptive dilemmas as we have
    - Dramatically increasing numbers of people seeking services
    - Often significantly beyond contract maximums
  - Requires a qualitatively different response

Other MHSA Components

- **Innovation Project – 11**
  - Builds on lessons learned from Innovation Project 01
  - Focus on the four commitments to:
    - Community capacity building
    - Results
    - Fiscal sustainability
    - Leadership development

Other MHSA Components

- **Innovation Project – 11**
  - Learning Questions:
    - Improve outcomes
    - Create stronger and more positive internal environments in an organization
    - Help us and our community partners adapt better to fiscal uncertainties
    - Cultivate more effective collaboration among each other and with BHRS

Other MHSA Components

- **Innovation Project – 12**
  - Impetus from our 24/7 Secure Mental Health Services Strategic Plan
  - More alternatives to psychiatric hospitalization are needed
  - Moving beyond two choices for people in a mental health crisis, i.e., treatment or no treatment

Other MHSA Components

- **Innovation Project – 12**
  - Based on BHRS' long-standing commitment to incorporating peer and family member support in and around mental health services
  - Will expand the beds at the Respite Center at Garden Gate from 5 to 10

Other MHSA Components

- **Innovation Project – 12**
  - This is an engagement program, providing a safe haven and a philosophy of “moving toward wellness”
  - Learning is focused on finding a new cost-effective approach to reducing psychiatric hospital admits.

Recommendations

1. Adopt the Fiscal Year 2013-2014 Mental Health Services Act (MHSA) Annual Plan Update
2. Authorize the Behavioral Health Director to sign and submit the Fiscal Year 2013-2014 MHSA Annual Plan Update to the Mental Health Services Oversight and Accountability Commission (MHSOAC).

Recommendations

3. Authorize the Auditor-Controller to sign the Annual Plan certifying that the fiscal requirements on the certification form have been met
4. Approve the agreements with the Center for Collective Wisdom and Turning Point Community Programs, Inc. to provide Innovation Projects

Recommendations

5. Authorize the Behavioral Health Director, or her designee, to sign the agreements discussed in this agenda item, and any amendments to add services and payment for services up to $75,000 per agreement, budget permitting, throughout Budget Year 2013-2014

Questions