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

DEPT: Behavioral Health And Recovery Services BOARD AGENDA #: B-7

AGENDA DATE: August 8, 2017

SUBJECT:

Approval to Adopt the Mental Health Services Act Annual Update for Fiscal Year 2017-2018 and Three-Year Program and Expenditure Plan

BOARD ACTION AS FOLLOWS: **No.** 2017-441

On motion of Supervisor Withrow, **Seconded by Supervisor** DeMartini
and approved by the following vote,
Ayes: Supervisors: Olsen, Withrow, Monteith, DeMartini, and Chairman Chiesa
Noes: Supervisors: None
Excused or Absent: Supervisors: None
Abstaining: Supervisor: None

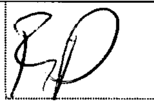
1) X **Approved as recommended**
2) ____ **Denied**
3) ____ **Approved as amended**
4) ____ **Other:**

MOTION:

ATTEST: ELIZABETH A. KING, Clerk of the Board of Supervisors File No.

THE BOARD OF SUPERVISORS OF THE COUNTY OF STANISLAUS
AGENDA ITEM

DEPT: Behavioral Health And Recovery Services BOARD AGENDA #: B-7

Urgent ○ Routine ⊙  AGENDA DATE: August 8, 2017

CEO CONCURRENCE: 4/5 Vote Required: Yes ○ No ⊙

SUBJECT:

Approval to Adopt the Mental Health Services Act Annual Update for Fiscal Year 2017-2018 and Three-Year Program and Expenditure Plan

STAFF RECOMMENDATIONS:

1. Adopt the Fiscal Year 2017-2018 Mental Health Services Act (MHSA) Annual Update and Three-Year Program and Expenditure Plan.

2. Authorize the Behavioral Health Director to sign and submit the Fiscal Year 2017-2018 MHSA Annual Update and Three-Year Program and Expenditure Plan to the Mental Health Services Oversight and Accountability Commission (MHSOAC).

3. Authorize the Auditor-Controller or designee to sign the Annual Update certifying that the fiscal requirements on the certification form have been met.

DISCUSSION:

In November 2004, residents of California passed Proposition 63, the Mental Health Services Act (MHSA). Enacted into law on January 1, 2005, the measure provides funding to counties to transform the public mental health system in the following areas:

- Community Services and Supports (CSS) to provide services to children, transition age youth, adults, and seniors
- Prevention and Early Intervention (PEI)
- Workforce Education and Training (WET)
- Capital Facilities and Technological Needs (CF/TN)
- Innovation (INN)

Stanislaus County was the first county in California to submit its MHSA Plan and implement the Community Services and Supports (CSS) component in 2006. Since that time, all remaining MHSA components have been implemented. MHSA regulations require counties to submit an Annual Update to their plans 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 the following:

- 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 Updates and Plans are required to include:

    - Certification by the County Mental Health Director to ensure county compliance with pertinent regulations, laws, and status 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 (BHRS) held Representative Stakeholder Steering Committee (RSSC) meetings on January 27, 2017, and April 14, 2017, to review MHSA program highlights and outcomes from Fiscal Year 2015-2016 in the Annual Update and endorse MHSA program staffing and funding recommendations under Community Services and Supports.

A draft of the Annual Update was posted for a 30-day public review and comment period from March 27 through April 25, 2017. A Public Hearing was held by the Behavioral Health Board on April 27, 2017, following a presentation about the Annual Update.

There were no comments received during the Public Hearing.

As noted above, the Annual Update and Three-Year Program and Expenditure Plan highlight activities and services for MHSA programs from Fiscal Year 2015-2016.

BHRS uses a 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 for each MHSA program.

The accompanying charts highlight specific outcomes of the Stanislaus Homeless Outreach Program known as SHOP. It is the largest Full Service Partnership (FSP) program and serves the most people in Stanislaus County. The FSP provides services to individuals with serious mental illness and a history of homelessness, as well as people with co-occurring substance abuse.

FSP programs are the highest, most intensive level of intervention. The reference to "partners" in these charts is the language that the State requires and is reflective of the fact that the client and provider work closely together in partnership, doing "whatever it takes" to affect recovery.

Stanislaus Homeless Outreach Program (SHOP)
Full Service Partnership – FSP-01
7/1/2015 – 6/30/2016

- 244* active partners in all FSP programs in Fiscal Year 2015-2016
- All outcomes based on 180 partners who were active in Fiscal Year 2015-2016 *and* in the program at least one year.

**Those served in the FSP and completed the data elements to be involved in the state data system (DCR).*

Homelessness Outcomes
n=180

Incarceration Outcomes
n=180

Psychiatric Hospitalization Outcomes
n=180

- # partners hospitalized 1 year prior to enrollment
- # partners hospitalized 1 year post enrollment

- # days hospitalized 1 year prior to enrollment
- # days hospitalized 1 year post enrollment

The decrease in psychiatric hospitalizations reflects an estimated savings of $580,000. The decrease in days incarcerated reflects an estimated cost avoidance of $146,000.

The Annual Update and proposed Three-Year Program and Expenditure Plan provides funding for important new staffing and the continuation of pilot programs under Community Services and Supports (CSS) to provide services to the mentally ill of Stanislaus County. The CSS component includes Full Service Partnership (FSP), General System Development (GSD), and Outreach and Engagement (O&E) programs. It also includes proposed funding contributions for new programs, as well as two Permanent Supportive Housing projects.

The following funding recommendations are included in the Fiscal Year 2017-2018 Annual Update and the Fiscal Year 2017-2018 Final Budget request for the BHRS Mental Health Services Act budget:

Program Staffing

- A Manager of Ethnic Services position to ensure quality services and delivery of those services to vulnerable racial, ethnic, and cultural communities in Stanislaus County. The manager would develop state mandated Cultural Competence Plan Requirement (CCPR) reports and other required updates. The estimated funding amount for this position is $143,794 per year.

- A Mental Health Clinician for the Integrated Forensic Team (IFT) to serve individuals with severe mental illness and co-occurring substance abuse in its Full Service Partnership (FSP) program. The estimated cost of this county operated program is $124,913 per year.

- A Staff Services Analyst position for the Prevention and Early Intervention (PEI) program to ensure accountability in the Department's contract activities within the PEI division. This position will monitor contract performance outcomes and ensure that Stanislaus

County residents receive PEI services consistent with adopted legislation. The estimated funding amount for this position is $108,073 per year. While not included in the Annual Update, this position is being requested as part of the Final Budget.

Continuation of Programs

- BHRS is proposing to continue a Crisis Intervention Pilot Program (CIP) for Children and Youth. The CIP provides acute crisis intervention in leased space near Doctor's Medical Center in Modesto and offers family support and engagement. On June 27, 2017, the Board gave approval to extend the program by four months to obtain and evaluate one complete year of program data and outcomes. Once the pilot has been completed, the Department will provide a comprehensive report to the Board of Supervisors by October 31, 2017, detailing the experience, data, outcomes, and fiscal impact as well as recommendations for the future of the CIP program. Funding in the amount of $631,061 per year has been earmarked for either the continuation of this program or its replacement with another program.

- BHRS is proposing to continue the Youth Peer Navigator Program to provide mental health education, community resources, linkages, and peer support to youth incarcerated in Juvenile Justice and in the Stanislaus County mental health system. This Innovation project has yielded positive outcomes and would transition to a General System Development program under Community Services and Supports. The estimated funding amount is $42,000 per year.

Funding Contributions for New Programs

To expand the continuum of care for Stanislaus County residents living with mental illness, BHRS is proposing to provide MHSA funding for two community proposals.

- In partnership with the Chief Executive Office, BHRS proposes to fund up to $118,404 per year for the Initial Outreach and Engagement Program to increase access for mental health services to homeless individuals with severe mental illness and co-occurring substance use disorder.

- In a multi-county collaboration with Calaveras, Mariposa, Madera, and Tuolumne counties, BHRS proposes to fund $275,393 per year for a 16-bed Crisis Residential Facility that would provide four beds for Stanislaus County residents.

Housing Projects

On April 26, 2016, the Board of Supervisors approved a Master Plan for Permanent Supportive Housing funds and a request to return remaining MHSA Housing funds held by California Housing Finance Agency to Stanislaus County. Approximately $1.1 million is available for construction, rehabilitation, and acquisition of permanent supportive housing.

BHRS has a continuum of housing options for individuals dealing with serious mental illness. These include emergency housing, transitional housing, and permanent supportive housing. The development of this continuum is based on a Housing First model, a concept that emphasizes

the need to have stable housing before issues of mental illness and substance use can be effectively treated.

The Master Plan guidelines were developed in collaboration with Stanislaus County Affordable Housing Corporation (STANCO) and include mandatory elements, priorities for financing and location, and instructions on implantation of the guidelines.

BHRS has three years to spend the Housing funds and is nearing the end of year one. The following projects are being considered and will come back to the Board of Supervisors for approval in the future.

Supportive Housing Complex – Kestrel Ridge, 416 E. Coolidge Avenue, Modesto

- Population: Adults/Older Adults/Transition Age Youth with Serious Mental Illness (SMI)
- Results: Reduce homelessness for persons with SMI; Improve the well-being of individuals with SMI
- Description: Install 10 manufactured homes between 560-620 square foot one bedroom, one bath units
- Partners: Housing Authority of Stanislaus County, City of Modesto Community Development Block Grant (CDBG) funds, and MHSA housing funds
- Estimated Funding Amount: $250,000 one-time

Supportive Housing Complex – Leonard Avenue, 1406 Leonard Avenue, Modesto

- Population: Adults/Older Adults/Transition Age Youth with SMI
- Results: Reduce homelessness for persons with SMI; Improve the well-being of individuals with SMI
- Description: Existing multi-family complex on 0.55 acre lot west of Tully and east of Kearney/16 one bedroom, one bath units
- Partners: City of Modesto CDBG funds and MHSA housing funds
- Estimated Funding Amount: $850,000 one-time

On July 25, 2017, the Health Executive Committee of the Board of Supervisors, comprised of Supervisors Withrow and DeMartini, supported the recommended actions for consideration by the full Board of Supervisors.

POLICY ISSUE:

The Mental Health Services Act (MHSA) is designed to expand and improve mental health services. Over the years, treatment and prevention services have been greatly increased in Stanislaus County. California Welfare and Institutions Code (WIC) Section 5847 states that county mental health programs shall prepare and submit a Three-Year Program and Expenditure Plan and Annual Update for MHSA programs and expenditures. Plans and Updates must be adopted by the county Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after Board of Supervisor adoption.

FISCAL IMPACT:

The services described in this Annual Update are funded through the State Mental Health Services Act. Appropriations and estimated revenue in the amount of $1,335,565 were included in the Behavioral Health and Recovery Services Fiscal Year 2017-2018 Adopted Proposed Budget. This amount is expected to sustain the additions to the Full Service Partnership (FSP) and General System Development (GSD) programs for one fiscal year, with the exception of the two housing projects currently estimated at $1,100,000. Once final costs for the housing projects are determined, the Department will return to the Board of Supervisors if additional appropriations and/or estimated revenue are needed. There is no impact to the County General Fund.

Cost of recommended action:		$ 1,335,565
Source(s) of Funding:		
Mental Health Services Act	1,335,565	
Funding Total:		$ 1,335,565
Net Cost to County General Fund		$ -

Fiscal Year:	2017-2018
Budget Adjustment/Appropriations needed:	**No**
Fund Balance	N/A

BOARD OF SUPERVISORS' PRIORITY:

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

STAFFING IMPACT:

Two new positions were requested during the Fiscal Year 2017-2018 Proposed Budget process:

- One Manager II to oversee Ethnic Services and development and implementation of MHSA cultural competence planning, mental health treatment, Substance Use Disorder (SUD) programs, and state mandated Cultural Competence Plan Requirement reports.
- One Mental Health Clinician II for Integrated Forensic Team to provide training and clinical direction to clients in FSP program.
- One Staff Services Analyst for the Prevention and Early Intervention (PEI) program to ensure accountability in the Department's contract activities within the PEI division.

Due to the uncertainty of state and federal budgets, these positions were deferred for consideration in Final Budget. The Department will be seeking approval for these positions in the Fiscal Year 2017-2018 Final Budget. It is anticipated that state and federal uncertainties will not have an impact on Mental Health Services Act funding.

CONTACT PERSON:

Rick DeGette, Behavioral Health Director, Telephone 525-6205

ATTACHMENT(S):

1. Mental Health Services Act Annual Update Fiscal Year 2017-2018 and Three-Year Program and Expenditure Plan

2. Mental Health Services Act Component Information Sheet

Attachment 1

StanUp for Wellness!

Support Mental & Emotional Health

Stanislaus County
Behavioral Health and Recovery Services

Mental Health Services Act
Annual Update FY 2017-2018 &
Three-Year Program and Expenditure Plan

August 2017

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Stanislaus County Behavioral Health and Recovery Services (BHRS)

MHSA Planning Office

800 Scenic Drive

Modesto, CA 95350

Phone: (209) 525-6247 Fax: (209) 558-4323

COUNTY COMPLIANCE CERTIFICATION

County: Stanislaus

County Mental Health Director	Project Lead
Name: Richard DeGette Telephone Number: 209-525-6225 E-mail: Rdegette@stanbhrs.org	Name: Dan Rosas Telephone Number: 209-525-5324 E-mail: drosas@stanbhrs.org
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, laws and statutes for this annual update/plan update. 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.

This Annual Update has been developed with the participation of stakeholders, in accordance with Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft FY 2017-2018 Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for public review and comment. All input has been considered with adjustments made, as appropriate.

A.B. 100 (Committee on Budget – 2011) significantly amended the Mental Health Services Act to streamline the approval processes of programs developed. Among other changes, A.B. 100 deleted the requirement that the three year plan and updates be approved by the Department of Mental Health after review and comment by the Mental Health Services Oversight and Accountability Commission. In light of this change, the goal of this update is to provide stakeholders with meaningful information about the status of local programs and expenditures.

A.B. 1467 (Committee on Budget – 2012) significantly amended the Mental Health Services Act which requires three-year plans and annual updates to be adopted by the County Board of Supervisors; requires the Board of Supervisors to authorize the Behavioral Health Director to submit the annual plan update to the Mental Health Services Oversight and Accountability Commission (MHSOAC); and requires the Board of Supervisors to authorize the Auditor-Controller to certify that the county has complied with any fiscal accountability requirements and that all expenditures are consistent with the requirements of the Mental Health Services Act.

The information provided for each work plan is true and correct.

All documents in the attached Annual Update and Three-Year Program and Expenditure Plan FY 17-18 are true and correct.

Richard DeGette

Mental Health Director/Designee (PRINT) Signature Date

STANISLAUS

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: STANISLAUS

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

Rick DeGette
Lauren Klein, CPA
209-525-6225
209-525-5673
rdegette@stanbhrs.org
kleinl@stancounty.com

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Rick DeGette	Name: Lauren Klein
Telephone Number: 209-525-6225	Telephone Number: 209-525-5673
E-mail: rdegette@stanbhrs.org	E-mail: kleinl@stancounty.com

800 Scenic Drive
Modesto, CA 95350

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 update/report is true and correct to the best of my knowledge.

Rick DeGette

Rick DeGette ____ [signature] ~~8-10-17~~ 8-9-17

Local Mental Health Director (PRINT) — Signature — Date

I hereby certify that for the fiscal year ended June 30, 2016, 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 2016 for the fiscal year ended June 30, 2016. I further certify that for the fiscal year ended June 30, 2016, 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 ____ [signature] 8/9/17

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

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

Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (02/14/2013)

Message from the Director

"Never give up on someone with a mental illness. When "I" is replaced by "We", illness becomes wellness."

– Shannon L. Alder, Author

Stanislaus County Behavioral Health and Recovery Services (BHRS) has been spreading this message of hope and healing since the passage of Proposition 63, the Mental Health Services Act (MHSA), in 2004. MHSA transformed how mental health services are delivered in California and here in Stanislaus County.

MHSA funding has allowed us to better serve the needs of our community and, through our services and continuum of care, impact the lives of residents struggling with mental illness.

This year's Annual Update highlights MHSA activities from FY 2015-2016 and reflects our ongoing commitment to improve the Stanislaus County mental health system and create recovery driven programs and services.

It's vital work that we share with our important community partners.

BHRS wishes to thank members of the MHSA Representative Stakeholder Committee, Behavioral Health Board, Stanislaus County Board of Supervisors, and representatives of community partner agencies for their support in the development of our planning process to help create this Annual Update. We also want to acknowledge the work and enthusiasm of BHRS employees to fulfill the promise of Proposition 63.

We are also thankful for our many consumers and family members who shared their remarkable stories of hope, recovery, and resiliency for this report. They are true heroes.

MHSA is making a difference in Stanislaus County. By working together, we as a community are turning "illness" into "wellness", and changing lives in the process.

Sincerely,

Richard DeGette, MA, MFT
Behavioral Health and Recovery Services Director

MENTAL HEALTH SERVICES ACT (MHSA) OVERVIEW

California voters passed Proposition 63, the Mental Health Services Act (MHSA), in November 2004 to expand and improve mental health services in the state. Enacted into law on January 1, 2005, the measure places a 1% tax on personal income above 1 million dollars with funds distributed to counties for local allocation.

The goal is to transform the mental health system and improve the quality of life for Californians living with a mental illness.

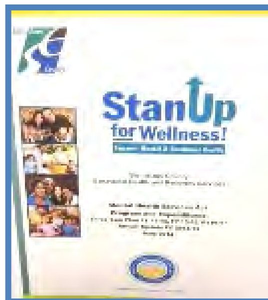
MHSA is made up of 5 components:

- Community Services and Support (CSS)
- Prevention and Early Intervention (PEI)
- Workforce Education and Training (WET)
- Capital Facilities and Technological Needs (CF/TN)
- Innovation (INN)

Stanislaus County BHRS is working to expand mental health services using a “help first” approach that enables community members to access services before they are in crisis, and invest dollars in services that comprise a full continuum of care.

In partnership with the community, our mission is to provide and manage effective prevention and behavioral health services that promote our community’s capacity to achieve wellness, resiliency, and recovery outcomes. MHSA services require five essential elements: community collaboration, cultural competence, consumer and family driven systems of care, a focus on wellness, recovery, and resiliency, and integrated services experiences for consumers and families.

ANNUAL UPDATE OVERVIEW



An Annual Update is required by MHSA statute (W&I Code §5847).

This report summarizes Stanislaus County’s progress in implementing services funded by the Mental Health Services Act (MHSA) and highlights activities during the period July 1, 2015 through June 30, 2016. In addition, the report provides an overview of programs and expenditures that make up the scope of services for each of the MHSA components. It also includes a Three-Year Program and Expenditure Plan.

Each plan must be developed with feedback from the MHSA Representative Stakeholder Steering Committee (RSSC). The committee is comprised of one primary member and one alternate from the following groups and communities: Behavioral Health and Recovery Services; Stanislaus County Chief Executive Office; Community Consumer Partners; Contract Providers of Public Mental Health Services; Stanislaus County Courts; Diverse Communities; Education; Family Member Partners; Health Care: Public and Private; Law Enforcement; Stanislaus County Probation department; Housing: Public and Private; Public Mental Health Labor Organization; Regional Areas; South and Westside; Senior Services; Social Services; and the Veterans community.

The Annual Update must also include a public review/comment period and a public hearing conducted by the Stanislaus County Behavioral Health Board.

The completed documents must be submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after adoption by the Stanislaus County Board of Supervisors.

STANISLAUS COUNTY DEMOGRAPHIC PROFILE AT A GLANCE

Located in the heart of California's fertile San Joaquin Valley, Stanislaus County is home to one of the greatest agricultural areas in the nation. Nuts, dairy products, fruits, wine grapes, and poultry products are among some of the top commodities.

Stanislaus County encompasses more than 1,500 square miles in size with a mix of rural areas and urban communities along the Highway 99 and Highway 5 corridors. The city of Modesto is the county seat, the largest city in the county.

Stanislaus County is home to **518,336 residents**. It includes the cities of Ceres, Turlock, Oakdale, Riverbank, Patterson, Hughson, Newman, and Waterford.

Stanislaus County has a total of **166,948 households**.

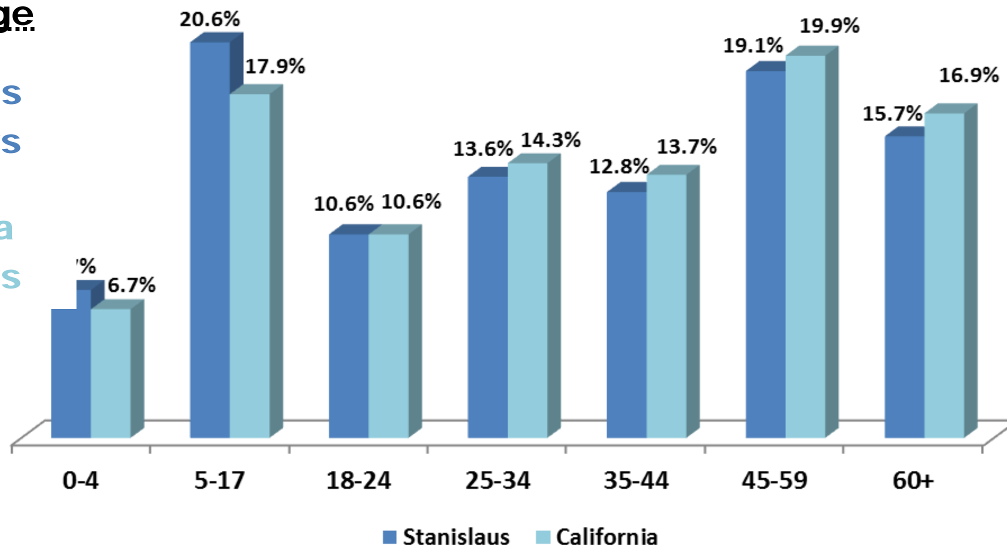
Age[1]

(Percentage of residents by age category)

Median Age

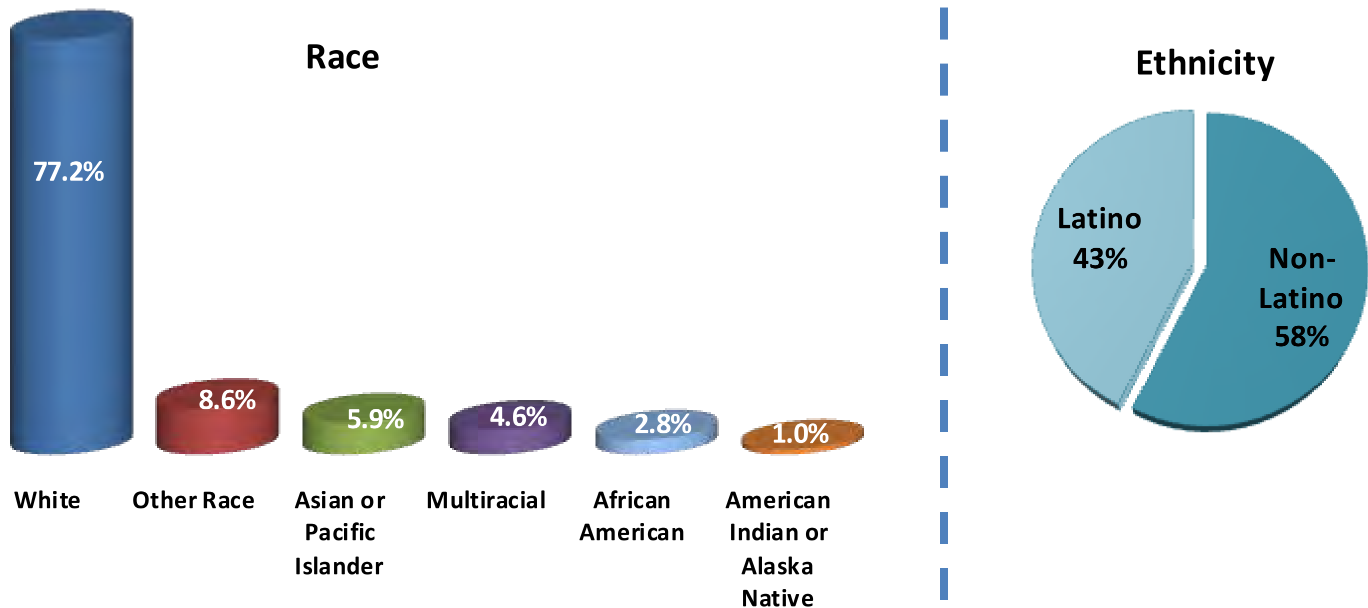
Stanislaus
33.0 years

California
35.4 years

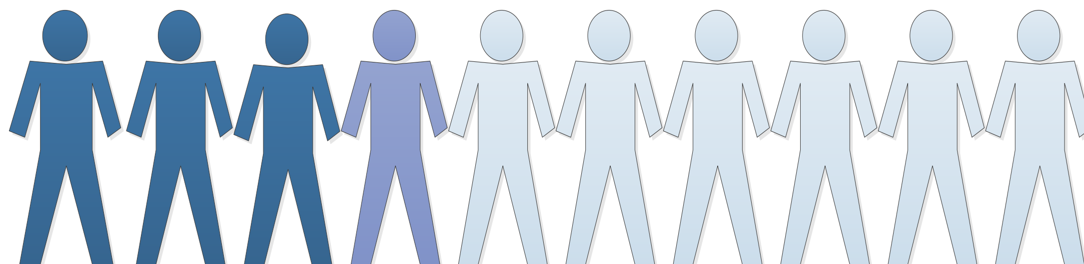


1. U.S. Census Bureau (2013). 2012 American Community Survey (three-year estimates).

Population by Race and Ethnicity[1]



Language[1]



3 in 10 speak Spanish at home

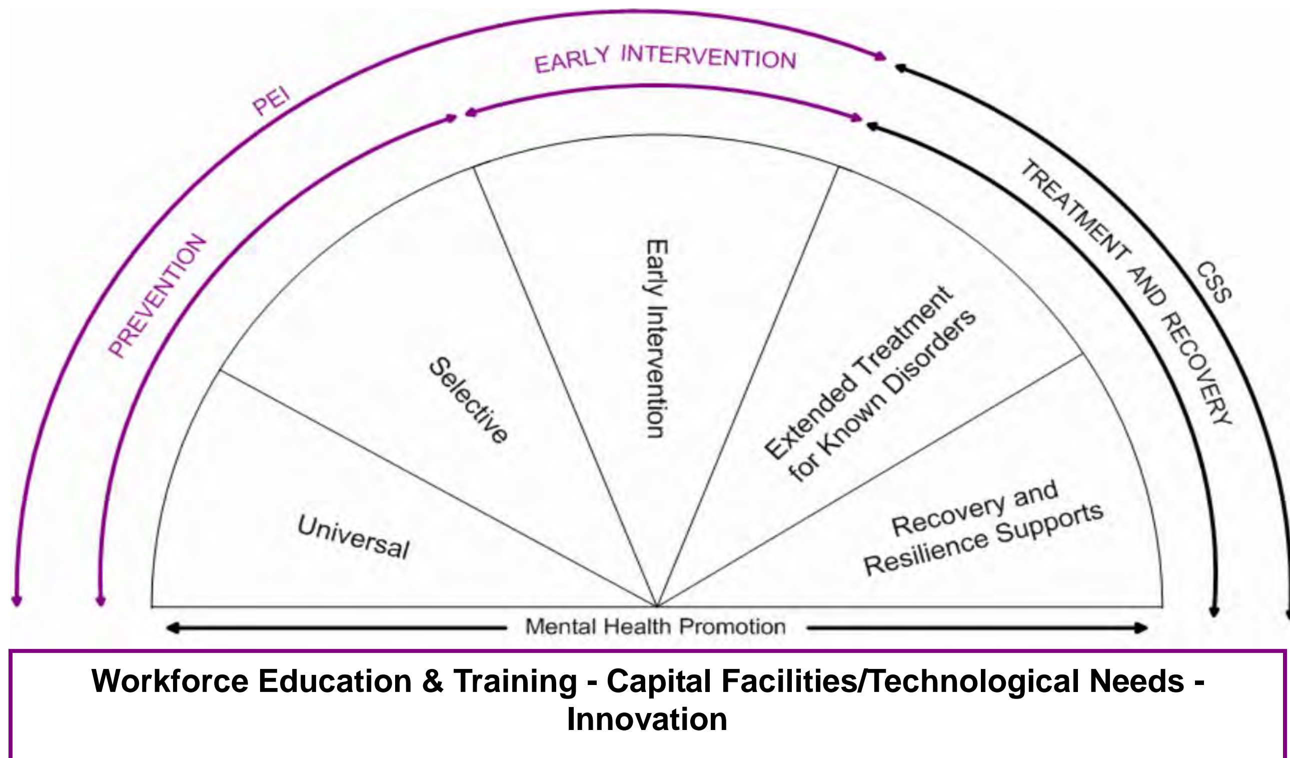
4 in 10 speak a language other than English at home

1. U.S. Census Bureau (2013). 2012 American Community Survey (three-year estimates).

MHSA FUNDING SUMMARY

Integrated Plans for MHSA:

By statute (W&I 5847), each county shall prepare and submit a three year plan that is based on existing approved plans. BHRS has developed a local approach to show how MHSA programs are integrated into the county behavioral health system. We have incorporated the Mental Health Intervention Spectrum Diagram initially adapted from Mrazek and Haggerty (1994) and Commonwealth of Australia (2000). BHRS previously used the model to showcase the continuum of mental health intervention in Prevention and Early Intervention (PEI) planning. The diagram below now shows the spectrum of services and MHSA components that reach across the entire system. It illustrates levels of behavioral health care currently available from universal prevention, treatment, and recovery. 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 and CFTN support essential infrastructure; and INN supports learning and contribution to new and better practices.



Focus on Results:

BHRS continues to refine data systems, reporting methods, and develop learning structures to align with the framework of Results Based Accountability (RBA). The focus on results is not solely to collect data but to determine priority measures to learn from the data collection and ultimately improve programs.
A number of BHRS and contracted programs are using the RBA framework to assess their work and impact, and improve participant results. In future annual updates, data and outcomes will continue to be presented in this framework.

Fiscal Sustainability:

Beginning 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. The 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 set forth by the County Behavioral Health Directors Association of California's (CBHDA) fiscal consultant.

This Annual Update includes FY 2017-2020 budget plans.

FY 2017-18 Through FY 2019-20 Three-Year Mental Health Services Act Expenditure Plan

Funding Summary

County: Stanislaus — Date: 3/21/17

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2017/18 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	17,411,919	4,138,721	2,430,555	229,228	297,971	
2. Estimated New FY2017/18 Funding	17,901,395	4,475,349	1,177,723			
3. Transfer in FY2017/18a/	(1,515,000)			515,000	1,000,000	
4. Access Local Prudent Reserve in FY2017/18						0
5. Estimated Available Funding for FY2017/18	33,798,314	8,614,070	3,608,278	744,228	1,297,971	
B. Estimated FY2017/18 MHSA Expenditures	21,082,988	4,980,596	1,807,884	657,326	1,076,325	
C. Estimated FY2018/19 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	12,715,326	3,633,474	1,800,394	86,902	221,646	
2. Estimated New FY2018/19 Funding	18,204,004	4,551,001	1,197,632			
3. Transfer in FY2018/19a/	(1,515,000)			515,000	1,000,000	
4. Access Local Prudent Reserve in FY2018/19						0
5. Estimated Available Funding for FY2018/19	29,404,330	8,184,475	2,998,026	601,902	1,221,646	
D. Estimated FY2018/19 Expenditures	21,306,253	4,976,860	1,511,319	536,027	1,084,644	
E. Estimated FY2019/20 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	8,098,076	3,207,615	1,486,707	65,875	137,002	
2. Estimated New FY2019/20 Funding	17,234,864	4,308,716	1,133,873			
3. Transfer in FY2019/20a/	(1,515,000)			515,000	1,000,000	
4. Access Local Prudent Reserve in FY2019/20						0
5. Estimated Available Funding for FY2019/20	23,817,940	7,516,331	2,620,580	580,875	1,137,002	
F. Estimated FY2019/20 Expenditures	21,386,636	4,994,700	367,831	539,766	1,093,244	
G. Estimated FY2019/20 Unspent Fund Balance	2,431,304	2,521,631	2,252,749	41,109	43,758	

H. Estimated Local Prudent Reserve Balance		
	1. Estimated Local Prudent Reserve Balance on June 30, 2014	500,000
	2. Contributions to the Local Prudent Reserve in FY 2017/18	0
	3. Distributions from the Local Prudent Reserve in FY 2017/18	0
	4. Estimated Local Prudent Reserve Balance on June 30, 2015	500,000
	5. Contributions to the Local Prudent Reserve in FY 2018/19	0
	6. Distributions from the Local Prudent Reserve in FY 2018/19	0
	7. Estimated Local Prudent Reserve Balance on June 30, 2016	500,000
	8. Contributions to the Local Prudent Reserve in FY 2019/20	0
	9. Distributions from the Local Prudent Reserve in FY 2019/20	0
	10. Estimated Local Prudent Reserve Balance on June 30, 2017	500,000

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

County: Stanislaus Date: 3/21/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. FSP-01 Westside Stanislaus Homeless Outreach	4,735,377	3,141,627	1,552,500			41,250
2. FSP-02 Juvenile Justice	885,070	539,070	191,000			155,000
3. FSP-05 Integrated Forensic Team	2,166,386	1,825,341	341,045			
4. FSP-06 High Risk Health & Senior Access	2,182,107	1,529,107	612,000			41,000
5. FSP-07 Turning Point-ISA	751,274	751,274				
6. FSP-08 FSP for Children/Youth with SED	883,371	574,191	309,180			
Non-FSP Programs						
1. O&E-02 Housing Program - Garden Gate Respite	3,267,299	3,075,300		45,847		146,152
2. O&E-02 Employment - Garden Gate Respite	684,260	533,619		65,218		85,423
3. O&E-03 Outreach and Engagement	140,000	140,000				
4. GSD-01 Transition Age Young Adult Drop in Cente	1,428,780	966,780	392,000			70,000
5. GSD-02 CERT/Warmline	979,706	979,706				
6. GSD-04 Families Together	627,380	627,380				
7. GSD-05 Consumer Empowerment Center	509,377	509,377				
8. GSD-06 Crisis Stabilization Unit	1,759,541	1,088,450	584,871			86,220
9. GSD-07 Crisis Intervention Program for Children a	685,031	626,854				58,177
10. GSD Portion of Westside Stanislaus Homeless Ou	1,578,459	1,047,209	517,500			13,750
11. GSD Portion of Integrated Forensic Team	333,347	333,347				
12. GSD Portion of High Risk Health & Senior Access	404,057	404,057				
13. Crisis Residential Unit - 4 Beds	275,393	137,693	137,700			
14. Youth Peer Navigators	42,000	42,000				
CSS Administration	2,880,606	2,210,606	500,000			170,000
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	27,198,821	21,082,988	5,137,796	111,065	0	866,972
FSP Programs as Percent of Total	55.0%					

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. FSP-01 Westside Stanislaus Homeless Outreach	4,736,429	3,142,679	1,552,500			41,250
2. FSP-02 Juvenile Justice	891,952	545,952	191,000			155,000
3. FSP-05 Integrated Forensic Team	2,179,713	1,838,668	341,045			
4. FSP-06 High Risk Health & Senior Access	2,198,815	1,545,815	612,000			41,000
5. FSP-07 Turning Point-ISA	751,274	751,274				
6. FSP-08 FSP for Children/Youth with SED	883,371	574,191	309,180			
Non-FSP Programs						
1. O&E-02 Housing Program - Garden Gate Respite	3,278,166	3,086,167		45,847		146,152
2. O&E-02 Employment - Garden Gate Respite	689,898	539,257		65,218		85,423
3. O&E-03 Outreach and Engagement	140,000	140,000				
4. GSD-01 Transition Age Young Adult Drop in Cente	1,440,918	978,918	392,000			70,000
5. GSD-02 CERT/Warmline	983,474	983,474				
6. GSD-04 Families Together	632,851	632,851				
7. GSD-05 Consumer Empowerment Center	509,377	509,377				
8. GSD-06 Crisis Stabilization Unit	1,759,541	1,088,450	584,871			86,220
9. GSD-07 Crisis Intervention Program for Children a	685,031	626,854				58,177
10. GSD Portion of Westside Stanislaus Homeless Ou	1,578,810	1,047,560	517,500			13,750
11. GSD Portion of Integrated Forensic Team	333,347	333,347				
12. GSD Portion of High Risk Health & Senior Access	404,057	404,057				
13. Crisis Residential Unit - 4 Beds	550,786	275,393	275,393			
14. Youth Peer Navigators	42,000	42,000				
CSS Administration	2,719,969	2,219,969	330,000			170,000
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	27,389,779	21,306,253	5,105,489	111,065	0	866,972
FSP Programs as Percent of Total	54.6%					

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. FSP-01 Westside Stanislaus Homeless Outreach	4,736,429	3,142,679	1,552,500			41,250
2. FSP-02 Juvenile Justice	898,903	552,903	191,000			155,000
3. FSP-05 Integrated Forensic Team	2,193,174	1,852,129	341,045			
4. FSP-06 High Risk Health & Senior Access	2,214,100	1,561,100	612,000			41,000
5. FSP-07 Turning Point-ISA	751,274	751,274				
6. FSP-08 FSP for Children/Youth with SED	883,371	574,191	309,180			
Non-FSP Programs						
1. O&E-02 Housing Program - Garden Gate Respite	3,289,141	3,097,142		45,847		146,152
2. O&E-02 Employment - Garden Gate Respite	695,592	544,951		65,218		85,423
3. O&E-03 Outreach and Engagement	140,000	140,000				
4. GSD-01 Transition Age Young Adult Drop in Cente	1,453,177	991,177	392,000			70,000
5. GSD-02 CERT/Warmline	983,513	983,513				
6. GSD-04 Families Together	638,377	638,377				
7. GSD-05 Consumer Empowerment Center	509,377	509,377				
8. GSD-06 Crisis Stabilization Unit	1,759,541	1,088,450	584,871			86,220
9. GSD-07 Crisis Intervention Program for Children a	685,031	626,854				58,177
10. GSD Portion of Westside Stanislaus Homeless Ou	1,578,810	1,047,560	517,500			13,750
11. GSD Portion of Integrated Forensic Team	333,347	333,347				
12. GSD Portion of High Risk Health & Senior Access	404,057	404,057				
13. Crisis Residential Unit - 4 Beds	550,786	275,393	275,393			
14. Youth Peer Navigators	42,000	42,000				
CSS Administration	2,730,163	2,230,163	330,000			170,000
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	27,470,162	21,386,636	5,105,489	111,065	0	866,972
FSP Programs as Percent of Total	54.6%					

County: Stanislaus						Date: 3/21/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Prevention	1,277,214	1,277,214				
2. Outreach for Increasing Recognition	99,283	99,283				
3. of Early Signs of Mental Illness	0					
4. Stigma Discrimination Reduction	32,312	32,312				
5. Suicide Prevention	92,248	92,248				
6. Outcomes and Evaluation	209,450	209,450				
PEI Programs - Early Intervention						
11. Early Intervention	2,560,420	2,455,420	105,000			
PEI Administration	858,469	814,669				43,800
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	5,129,396	4,980,596	105,000	0	0	43,800

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Prevention	1,281,265	1,281,265				
2. Outreach for Increasing Recognition	120,962	120,962				
3. of Early Signs of Mental Illness	0					
4. Stigma Discrimination Reduction	32,391	32,391				
5. Suicide Prevention	92,327	92,327				
6. Outcomes and Evaluation	168,069	168,069				
PEI Programs - Early Intervention						
11. Early Intervention	2,564,978	2,459,978	105,000			
PEI Administration	865,668	821,868				43,800
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	5,125,660	4,976,860	105,000	0	0	43,800

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Prevention	1,285,357	1,285,357				
2. Outreach for Increasing Recognition	121,041	121,041				
3. of Early Signs of Mental Illness	0					
4. Stigma Discrimination Reduction	32,470	32,470				
5. Suicide Prevention	92,406	92,406				
6. Outcomes and Evaluation	169,704	169,704				
7. Statewide Initiative	0					
PEI Programs - Early Intervention						
11. Early Intervention	2,569,582	2,464,582	105,000			
PEI Administration	872,940	829,140				43,800
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	5,143,500	4,994,700	105,000	0	0	43,800

County: Stanislaus | Date:

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN-16 - Co-Occurring Disorders Project	1,150,169	861,169	289,000			
2. INN-17 - Suicide Prevention	215,589	215,589				
3. RPFs	433,000	433,000				
INN Administration	322,126	298,126				24,000
Total INN Program Estimated Expenditures	2,120,884	1,807,884	289,000	0	0	24,000

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN-16 - Co-Occurring Disorders Project	611,338	563,338	48,000			
2. INN-17 - Suicide Prevention	216,001	216,001				
3. RPFs	433,000	433,000				
INN Administration	322,980	298,980				24,000
Total INN Program Estimated Expenditures	1,583,319	1,511,319	48,000	0	0	24,000

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN-17 - Suicide Prevention	67,989	67,989				
2. RPFs	0					
INN Administration	323,842	299,842				24,000
Total INN Program Estimated Expenditures	391,831	367,831	0	0	0	24,000

County: Stanislaus					Date:	3/21/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce, Education and Training	657,426	657,326				100
WET Administration	0					
Total WET Program Estimated Expenditures	657,426	657,326	0	0	0	100

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce, Education and Training	536,127	536,027				100
WET Administration	0					
Total WET Program Estimated Expenditures	536,127	536,027	0	0	0	100

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce, Education and Training	539,866	539,766				100
WET Administration	0					
Total WET Program Estimated Expenditures	539,866	539,766	0	0	0	100

County: Stanislaus | Date: 3/21/17

	Fiscal Year 2017/18					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
CFTN Programs - Technological Needs Projects						
11. SU-01 Electronic Health Record	664,965	661,965				3,000
12. SU-02 Consumer Family Access	213,594	213,594				
13. SU-03 EH Data Warehouse	139,634	139,634				
14. SU-04 Document Imaging	61,132	61,132				
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	1,079,325	1,076,325	0	0	0	3,000

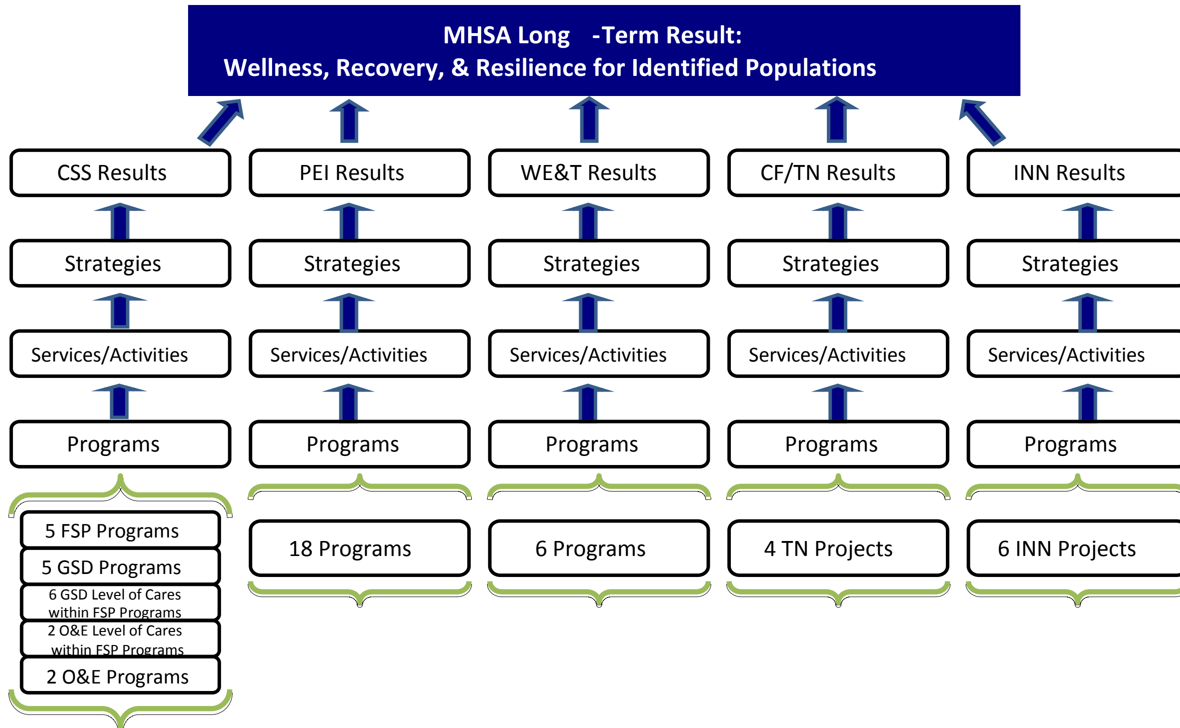
	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
CFTN Programs - Technological Needs Projects						
11. SU-01 Electronic Health Record	669,104	666,104				3,000
12. SU-02 Consumer Family Access	215,454	215,454				
13. SU-03 EH Data Warehouse	141,247	141,247				
14. SU-04 Document Imaging	61,838	61,838				
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	1,087,644	1,084,644	0	0	0	3,000

	Fiscal Year 2019/20					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
CFTN Programs - Technological Needs Projects						
11. SU-01 Electronic Health Record	671,623	668,623				3,000
12. SU-02 Consumer Family Access	219,194	219,194				
13. SU-03 EH Data Warehouse	142,877	142,877				
14. SU-04 Document Imaging	62,551	62,551				
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	1,096,244	1,093,244	0	0	0	3,000

MHSA, the Theory of Change, and Results Based Accountability Framework

Transformation of the public mental health system is the goal of BHRS as we embrace the values of the Mental Health Services Act (MHSA) to improve behavioral health outcomes for those struggling with mental illness in our community. Our long term result is to create an environment of Wellness, Recovery, and Resilience. To do that, BHRS has implemented the Theory of Change and Results Based Accountability (RBA) framework.

The Theory of Change (shown below) is a type of methodology, a road map for planning and evaluation to promote social change. It defines long-term goals and desired outcomes. RBA is a method to develop, interpret, and present program results. BHRS is utilizing RBA framework to evaluate programs and progress to show how MHSA programs are impacting lives.



COMMUNITY STAKEHOLDER PLANNING AND LOCAL REVIEW

Stanislaus County Behavioral Health and Recovery Services (BHRS) conducted community program planning and local review processes for this Annual Update in accordance with Title 9 of the California Code of Regulations, sections 3300 and 3315, and WIC 5848. As in the past, BHRS continues to engage stakeholder input for the purpose of creating transparency, facilitating an understanding of progress and accomplishments, and promoting a dialogue about present and future opportunities.

The Representative Stakeholder Steering Committee (RSSC) is a vital part of the MHSA planning process. Its role is to provide important input on all Plans and Updates as well as share information about MHSA activities with members of their represented sector or group.

The RSSC is made up of dedicated and devoted community members that care about mental health and wellness in Stanislaus County. They come from diverse backgrounds:

- Adults and seniors with severe mental illness
- Families of children, adults, and seniors with severe mental illness
- Providers of mental health services
- Law enforcement agencies
- Social services agencies
- Veterans community
- Providers of alcohol and drug services
- County mental health
- Health Care organizations
- Representatives of unserved and/or underserved populations and family members of unserved/underserved populations
- Stakeholders that reflect the diversity of the demographics of the county, including but not limited to, geographic location, age, gender, and race/ethnicity

Many members of the community also attend stakeholder meetings as observers.

COMMUNITY STAKEHOLDERS AND ACTIVITIES

During FY 2015-16, the RSSC convened six (6) times as part of the MHSA community planning process.

July 17, 2015 - The RSSC reconvened to hear BHRS program funding recommendations. During the meeting, stakeholders were reminded about their past work in determining funding priorities including their past work on the “Idea Bank” and the BOS priorities. Based on their input and feedback from their two previous meetings, the BHRS Senior Leadership Team presented three program recommendations for three MHSA funding components: CSS, INN, and PEI. A fourth proposal for an MHSA Housing proposal was also recommended for approval. There was an informative and robust discussion about the proposals.

Stakeholders approved each of the proposals presented at the meeting. During the planning process, a Gradients of Agreement exercise was used to determine whether or not there was sufficient consensus among voting stakeholders to move forward with each of the proposals. Stakeholders were asked to cast votes for the proposals individually and reach agreement using the Gradients of Agreement framework.

Gradients of Agreement

Endorse	Endorse with minor point of contention	Agree with reservations	Abstain	Stand aside	Disagree but will support the majority	Disagree and want out from implementation	Can't go forward
I like it	Basically I like it	I can live with it	I have no opinion	I don't like this, but I won't hold up the group	I want my disagreement recorded, but I'll support the decision.	I won't stop anyone else, but I don't want to make this happen.	We have to continue the conversation

The recommendations were as follows:

Community Services and Supports (CSS) – Joint Proposal to Issue a Request for Proposal (RFP) for a Full Service Partnership (FSP) for children and youth, ages 6-17, with Severe Emotional Disturbance (SED) and an Innovation (INN) Crisis Intervention Program component for children and youth – Funding amount to be determined after RFP process

Community Services and Supports (CSS) - Proposal to Expand BHRS Outreach and Engagement (O&E) program - $387,087

Community Services and Supports (CSS) - Proposal to Approve Granger Permanent Supportive Housing Project - $490,000 (CalHFA funding)

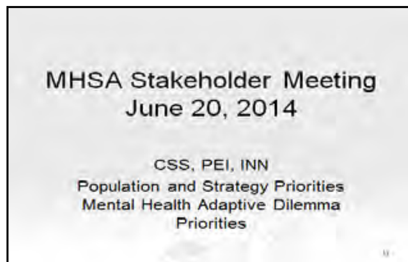
Prevention and Early Intervention (PEI) – Proposal to Increase Allocation for CalMHSA Statewide (PEI) Initiative - $30,000

*September 1, 2015 – The Plan Update went before the Stanislaus County Board of Supervisors as a non-consent agenda item. Due to a number of concerns, the Board decided to delay a decision on the Plan Update for September 2015 until further clarification and additional information about some of the components of the Plan Update could be obtained. The information was obtained and, given the BOS concerns, BHRS Senior Leadership decided to modify the Plan Update for September 2015 to include only the long term supportive housing component to allow a focused discussion of this component.

The funding for the MHSA Long Term Supportive Housing component will come from CalHFA on behalf of Stanislaus County. The estimated amount of the funding is $490,000.

*September 29, 2015 – The revised Plan Update of September 2015 was submitted to the Board of Supervisors for their consideration. In a 3-2 vote, the board approved the revised Plan Update with the Granger Permanent Supportive Housing Project.

October 23, 2015 - The RSSC convened and approved an Innovation proposal to address the problem of suicides in Stanislaus County. During the meeting, stakeholders were reminded about their past work in determining funding priorities and how they developed an "Idea Bank" which highlighted program ideas that included suicide prevention efforts. Below are power point slides from the RSSC meeting that show stakeholder population and strategy priorities.



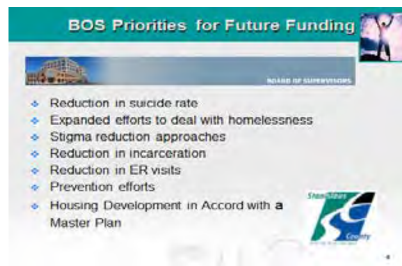
CSS
Population and Strategy Priorities

Population	Strategy	Points
1. Children/Youth		53
	FSP - Full Service Partnership	28
	GSD - General System Development	19
	O&E - Outreach and Engagement	6
2. Adults		30
	FSP	19
	GSD	0
	O&E	11
3. TAYA		7
	FSP	7
	GSD	0
	O&E	0
4. Older Adults		7
	FSP	6
	GSD	0
	O&E	1

Innovation

Mental Health Adaptive Dilemma	Points
1. [illegible]	38
2. Improving the well-being of children, TAY, TAYA	35
3. [illegible]	10
4. Connecting people receiving services to community based supports	9
5. Honoring and identifying more holistic approaches to well-being	7
6. Connecting and linking underserved and diverse communities with resources	3

The problem of suicides was also a priority for the Stanislaus County Board of Supervisors. Below is a slide from the MHSA meeting that was shared with stakeholders.



Based on their input and feedback from previous stakeholder meetings, the BHRS Leadership Team presented the suicide prevention proposal recommendation which was approved by the group. During the meeting, a Gradients of Agreement exercise was used to determine whether or not there was sufficient consensus among voting stakeholders to move forward with the proposal. The vote was unanimous to endorse the recommendation.

*October 27, 2015 – A second Plan Update went before the Stanislaus County Board of Supervisors. It contained two funding proposals, both under Community Services and Supports (CSS). One was a Request for Proposal (RFP) for a Full Service Partnership (FSP) for children and youth, ages 6-17, with Severe Emotional Disturbance (SED). The other was an Outreach and Engagement (O&E) proposal to expand employment opportunities for persons with lived experience.

*December 15, 2015 – Another Plan Update went before the Board of Supervisors. Of the proposals recommended for approval by stakeholders on July, 2015, the following were brought to the board for consideration:

- CSS - Full Service Partnership (FSP) for Children/Youth with SED
- CSS - Supportive Housing Services/Outreach and Engagement proposal to expand services to include a Mental Health Consumer program
- Crisis Intervention Program (CIP) for Children/Youth (This was intended as an INN project but BHRS Leadership decided to fund it as a CSS General System Development (GSD) program instead.)

The board approved the recommendations and directed BHRS staff to report back to board members with an annual report on the FSP for Children/Youth program.

January 29, 2016 – The RSSC convened a third time to review highlights from MHSA programs from FY 14-15. The group heard presentations about the MHSA components including information on program outcomes. Stakeholders were also informed about future MHSA funding based on growth and community needs. A discussion began on stakeholder ideas for possible future projects.

February 26, 2016 – The RSSC convened to discuss project ideas for future funding for CSS, PEI, and INN. During the meeting, stakeholders were reminded about community priorities they developed during a comprehensive mapping exercise on June 20, 2014 where populations and strategies were prioritized. A total of seven (7) ideas were submitted for consideration.

March 17, 2016 – The RSSC convened to discuss and prioritize MHSA program expansions and concept ideas for funding in CSS, PEI, and INN.

June 3, 2016 – The RSSC approved a proposal to fund the Central Valley Suicide Prevention Hotline in the estimated funding amount of $48,371 and apply remaining funding for future PEI projects. (The Board of Supervisors on September 1, 2015 took no action on a proposal to increase the funding allocation to CalMHSA. Its PEI Initiative included funding a suicide prevention hotline. The board concerns were that local suicide prevention efforts could be more effective. The Central Valley Suicide Prevention Hotline serves Stanislaus, Merced, Fresno, Tulare, Kings, Madera, and Mariposa counties. It is funded by central valley counties and operated by Kings View Behavioral Health Systems)

On April 28, 2015, during the MHSA Annual Update Public Hearing before the Behavioral Health Board, BHRS staff advocated that five (5) beds from the Garden Gate Respite (GGR) INN project be moved to the Garden Gate Respite CSS program. The GGR Innovation project, located next door to the GGR CSS program, was coming to an end and the need for ongoing emergency housing was great and needed in the community. The cost of the expansion would be $526,694 yearly.

Voting through e-mail with twenty-six (26) votes in favor and one (1) opposed, stakeholders approved the expansion request. It was included in the Annual Update that went before the Board of Supervisors on June 28, 2016.

LOCAL REVIEW PROCESS

This Annual Update was posted for 30-day public review and comment March 27, 2017 – April 25, 2017. Notification of the public review dates and access to copies of the Annual Update was made available through the following methods:

- ✓ An electronic copy was posted on the County's MHSA website: www.stanislausmhsa.com
- ✓ Paper copies of the Annual Update were delivered to Stanislaus County Public Libraries throughout the county where the report is available at resource desks
- ✓ 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, Behavioral Health Board members, as well as other community stakeholders were sent the Public Notice informing them of the start of the 30-day review, and how to obtain a copy of the Annual Update and Three-Year Program and Expenditure Plan
- ✓ Public Notices were posted in nine newspapers throughout Stanislaus County including a newspaper serving the Spanish speaking community. The Public Notice included access to the Annual Update on-line at www.stanislausmhsa.com and a phone number to request a copy of the document.
- ✓ BHRS Cultural Competency Newsletter

January 27, 2017 – The RSSC convened to hear MHSA program highlights and outcomes from the MHSA Annual Update FY 17-18 and Three-Year Program and Expenditure Plan. Program representatives gave presentations to the group and answered questions.

April 14, 2017 – The RSSC convened a second time to consider eight BHRS staffing and funding recommendations. The recommendations were in the following categories: New Staffing, Funding Contributions for New Programs, Continuation of New Programs, and Housing Projects.

Using the Gradients of Agreement to reach consensus, a total of 16 MHSA stakeholders fully endorsed the recommendations. Two recommendations were endorsed with a minor point of

contention. The recommendations must now be approved by the Stanislaus County Board of Supervisors.

<u>BHRS New Staffing Recommendations</u>

Manager of Ethnic Services

- Population: Racial, ethnic, and cultural communities across Stanislaus County including at-risk unserved and underserved individuals with SMI
- Results: Quality services and delivery of services to vulnerable racial, ethnic, and cultural communities
- Activities: Ensure delivery of appropriate services; Lead development/implementation of MHSA cultural competence planning, mental health treatment, SUD programs; Develop state mandated Cultural Competence Plan Requirement (CCPR) report and other required updates; Chair Cultural Competency, Equity, Social Justice (CCESJC) meetings; lead annual Diversity Week county event
- Estimated Funding Amount: $143,794 per year

  Endorsed – 15 of 16
  Endorsed with minor point of contention – 1
  Comments:
  - *Is it sustainable? If so, with what funds?*

Mental Health Clinician for Integrated Forensic Team (IFT)

- Population: Individuals with SMI and Co-Occurring Substance Abuse issues in this Full Service Partnership (FSP) program
- Strategy: Full Service Partnership (FSP)
- Results: Quality services and delivery of services for individuals coming out of jail, prison, or state hospitals; Divert clients from acute in-patient hospitalization; Reduction in incarceration days
- Activities: Provide training, clinical direction, and focus on evidence based practices; general clinical supervision; facilitate clinical groups
- Estimated Funding Amount: $124,913 per year

  Endorsed – 16 of 16

<u>Funding Contributions for New Programs</u>

Initial Outreach and Engagement Program

- Population: Homeless individuals with SMI and Co-Occurring SMI/SUD
- Results: Increase capacity and access mental health services and resources to underserved groups; Decrease stigma; Increase self-sufficiency and self-care; Target ethnic and cultural populations including families with children; Decrease need for extensive and expensive services
- Activities: BHRS would contribute funding for this project to develop an access center for the homeless
- Estimated Funding Amount: Up to $118,404 per year

  Endorsed – 16 of 16

Crisis Residential Beds/Multi-County Collaboration

- Population: Individuals with SMI
- Results: Decreased psychiatric hospitalizations
- Activities: Collaboration with Calaveras, Mariposa, Madera, and Tuolumne counties for 16 bed Crisis Residential Facility located in Merced County; Use of 4 beds for Stanislaus County residents; Includes car to transport clients to facility; telecommunications equipment for face to face contact with county clients
- Estimated Funding Amount: $275,393 per year

  Endorsed – 16 of 16

Continuation of Programs

Crisis Intervention Project for Children and Youth

- Population: Children and youth ages 6-17
- Strategy: General System Development (GSD)
- Results: Reduce need for psychiatric inpatient services and allow time to stabilize an acute crisis in a non-stressful setting; Reduce hospitalization; serve 80-100 children and youth yearly; Improve well-being of children, TAY, and TAYA
- Activities: Provide acute crisis intervention in leased space near Doctor's Medical Center; offer family support and engagement
- Estimated Funding Amount: $631,061 per year

Endorsed – 16 of 16

Youth Peer Navigators

- Population: Children and youth ages 6-17 involved in the Juvenile Justice system, Children's System of Care including Child Welfare (Katie A/Pathways to Well-Being) and youth involved with multiple service providers (special education, mental health, etc.)
- Strategy: General System Development (GSD)
- Results: Improve the well-being of children, TAY, and TAYA
- Activities: Provide mental health education, community resources, linkages, and peer support to youth incarcerated in Juvenile Justice and in the mental health system
- Estimated Funding Amount: $42,000 per year

Endorsed – 16 of 16

Housing Projects

On April 26, 2016, the Board of Supervisors approved a Master Plan for Permanent Supportive Housing funds and a request to return remaining MHSA Housing funds currently held by California Housing Finance Agency to Stanislaus County. Approximately $1.1 million would be made available for construction, rehabilitation, and acquisition of permanent supportive housing.

BHRS has a continuum of housing options for individuals dealing with serious mental illness. These include emergency housing, transitional housing, and permanent supportive housing. The development of this continuum is based on a Housing First model, a concept that emphasizes the need to have stable housing before issues of mental illness and substance use can be effectively treated.

The Master Plan guidelines were developed in collaboration with Stanislaus County Affordable Housing Corporation (STANCO) and include mandatory elements, priorities for financing and location, and instructions on implantation of the guidelines.

BHRS has three years to spend the Housing funds and is nearing year one. The following projects are being considered.

Supportive Housing Complex – Kestrel Ridge, 416 E. Coolidge Avenue, Modesto

- Population: Adults/Older Adults/TAY with severe mental illness (SMI)
- Strategy: Housing Funds
- Results: Reduce homelessness for persons with SMI; Improve the well-being of individuals with SMI
- Activities: Provide supportive housing units for individuals with SMI
- Estimated Funding Amount: $250,000 one-time

Endorsed – 16 of 16

Supportive Housing Complex – Leonard Avenue, 1406 Leonard Avenue, Modesto

- ❑ Population: Adults/Older Adults/TAY with SMI
- ❑ Strategy: Housing Funds
- ❑ Results: Reduce homelessness for persons with SMI; Improve the well-being of individuals with SMI
- ❑ Activities: Provide supportive housing units for individuals with SMI
- ❑ Estimated Funding Amount: $850,000 one-time

Endorsed – 14 of 16
Endorsed with minor point of contention – 2
Comments:

- *Concern about increase in funding needed for possible discoveries while renovating the building. Where will excess funds come from?*
- *Reservations regarding actual costs of renovation*

There were no comments received during the 30-day public review and comment period for the MHSA Annual Update FY 17-18 and Three-Year Program and Expenditure Plan draft.

On April 27, 2017, a Public Hearing on the Annual Update and Expenditure Plan draft was held at the Stanislaus County Behavioral Health Board meeting. It took place at the Sutter Health Education and Conference Center at 1700 McHenry Village, Suite 60B, in Modesto at 5 pm.

Board members were provided with a power point presentation which highlighted MHSA programs and activities from FY 15-16. Following the presentation, which served as an outreach venue for the public to learn more about MHSA and the Annual Update, the Behavioral Health Board opened the public hearing.

There were no comments received during the Public Hearing.

EXECUTIVE SUMMARY

A mental illness is a disease that causes mild to severe disturbances in thought and/or behavior, resulting in an inability to cope with life's ordinary demands and routines. According to the National Alliance on Mental Illness (NAMI), one in five adults in the United States experience a mental illness and 1 in 25 (10 million) adults live with a serious mental illness.

In Stanislaus County, funding from the Mental Health Services Act (MHSA) is helping Behavioral Health and Recovery Services (BHRS) to address this important issue and expand and improve programs for people living with mental illness. Our goal is to build a "help first" system of care to eliminate disparities, promote wellness, recovery, and resiliency, and ensure positive outcomes.

This year's Annual Update reflects our ongoing work to fulfill the promise of Proposition 63 approved by California voters in 2004. As an agency and a community partner, BHRS is committed to improve Stanislaus County's public mental health system. This Annual Update highlights the five integral components of MHSA and features programs that work together to create a continuum of care and services to meet the needs of our diverse community.

FY 15-16 Highlights

Community Services and Supports (CSS) provide funding for direct services to individuals with severe mental illness. Full Service Partnerships (FSP) are in this category and provide wrap-around or "whatever it takes" services to consumers. Housing is also included in CSS. Stanislaus County Behavioral Health and Recovery (BHRS) has twelve programs that provide mental health services to children and adults. Here are some of their outcomes:

- A total of 9,294 individuals were served through CSS programs.
- A total of 627 individuals were active partners in Full Service Partnership (FSP) programs. Of that number, 477 partners were active in FY 15-16 and in the program at least one year.
- There was a 31% decrease in homelessness one year prior to enrollment and one year post enrollment.

Prevention and Early Intervention (PEI) is the second largest component of MHSA funding designed to recognize early signs of mental illness and improve early access to services and programs including the reduction of stigma and discrimination. BHRS has eight (8) projects and 18 programs that promote wellness, foster health, and prevent the suffering that results from untreated mental illness. Among the outcomes for this component are:

- A total of 1,686 individuals (unduplicated) received brief counseling intervention services
- A total of 3,037 individuals (unduplicated) engaged in prevention services
- A total of 834 potential responders (includes families, employers, school personnel/teachers, leaders of faith based organizations) were trained to recognize and respond effectively to early signs of mental illness
- 20,579 PEI services were provided (includes screenings, support, peer and volunteer development, brief counseling groups, and other engagement)

Workforce Education and Training (WE&T) has six (6) programs committed to help improve and build the capacity of the local, diverse mental health workforce. Here are some of the outcomes:

- A total of 87 trainings were held in Stanislaus County with 2,385 BHRS, contractor staff, and community members in attendance.
- A total of 23 CASRA Based Stipend Program participants completed the academic requirements and volunteer/internship hours need to receive their Skills Recognition Certificate for the Modesto Junior College (MJC) 9-unit Psychosocial Rehabilitation Program.
- A total of 118 individuals participated in the Consumer and Family Member Volunteerism program and contributed 23,712 volunteer hours with a total dollar value to BHRS (@ $23.07 an hour) of $547,044.

Capital Facilities/Technological Needs (CF/TN) provides funding for building projects and increases technological capacity to improve mental illness service delivery. BHRS has four projects in various stages of implementation to modernize information systems and increase consumer/family empowerment by providing tools for secure access to health and wellness information. Among the outcomes:

- Installed four major upgrades to the Electronic Health Record (EHR) production system; one related to security and the other to the medication module, patient portal, and improved filtering and navigation
- A total of 114 staff (83 BHRS and 31 contract providers) were trained on how to navigate the EHR

Innovation (INN) funds and evaluates new approaches that increase mental health access to the unserved and/or underserved communities. Innovation projects can also promote interagency collaboration and increase the quality of services. BHRS had six (6) unique, time-limited learning projects during FY 15-16. Their focus: to learn and develop a new and effective practice or approach to mental health service delivery.

Each project reflected an unmet need and was developed through the community planning process. Project details can be found in the Innovation section of this report.

- INN-11 – Wisdom Transformation Initiative
- INN-12 – Garden Gate Innovative Respite
- INN-13 – Quiet Time
- INN-14 – Father Involvement
- INN-15 – Youth Peer Navigators
- INN-16 – Full Service Partnership (FSP) Co-Occurring Disorders
- INN-17 – Suicide Prevention

COMMUNITY SERVICES AND SUPPORTS (CSS)

Community Services & Supports (CSS) programs provide direct services to individuals of all ages with mental illness in Stanislaus County. There are three levels of service under Adult/Older Adult, Forensic and Children's Systems of Care: (1) Full Service Partnership (2) General System Development (3) Outreach and Engagement.

CSS is the largest component and makes up 80% of county MHSA funding. It provides funds for direct services to individuals with severe mental illness and children with serious emotional problems. The culturally competent services are focused on wellness, recovery, and resiliency while integrating the service experience for clients and families. Long term supported housing is also part of CSS funding. Stanislaus County has twelve CSS programs including five FSP programs, five GSD programs, and two O&E programs.

Full Service Partnership (FSP) funded programs provide integrated services to the most unserved or underserved and those at high risk for homelessness, incarceration, hospitalization, and out-of-home placement. MHSA mandates that the majority of CSS funding must be used for services to this population. Strategies are considered a "wraparound" approach to engaging service recipients as partners in their own self-care, treatment, and recovery. In doing so, they can achieve and sustain stability in medical and psychiatric well-being and help end their homelessness and involvement in the criminal justice system. Program results include reductions in incarceration, homelessness, psychiatric hospitalizations, and emergency medical services/hospitalization.

FY 15-16 Programs:

- 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)
- FSP-07 - Turning Point Integrated Services Agency (ISA)

General System Development (GSD) funded programs were established to increase capacity to provide crisis services, peer/family support, and drop-in centers for individuals with mental illness and serious emotional disturbance. These programs are focused on reducing stigma, encouraging and increasing self-care, recovery and wellness, and accessing community resources. The goal is to increase overall well-being and decrease the need for more intensive and expensive services.

FY 15-16 Programs:

- 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
- GSD-06 - Crisis Stabilization Unit (CSU)/Operational Costs

Outreach & Engagement (O&E) funded programs focus on special activities needed to reach diverse underserved communities. Strategies include community outreach to diverse community-based organizations. Crisis-oriented respite housing was also established to avoid unnecessary incarceration and psychiatric hospitalization and to provide short-term housing, and linkage to services.

FY 15-16 Programs:

- O&E-02 – Supportive Housing Services (Includes Garden Gate Respite, Intensive Transitional Housing, Vine Street Emergency Housing, and Supportive Housing Services/Transitional Board and Care).
- O&E-03 – Outreach and Engagement/Underserved Rural Communities (This program was approved by stakeholders and included in the FY 14-15 MHSA Plan Update as a Request for Proposal (RFP). The contract was awarded to Telecare Corporation.

CSS Budget:

FY 2015-16

Total MHSA Budget	Actual	Total Number Served	Estimated MHSA Cost Per Participant
$18,326,717	$12,845,955	9,294*	$1,382

Unduplicated within each CSS program

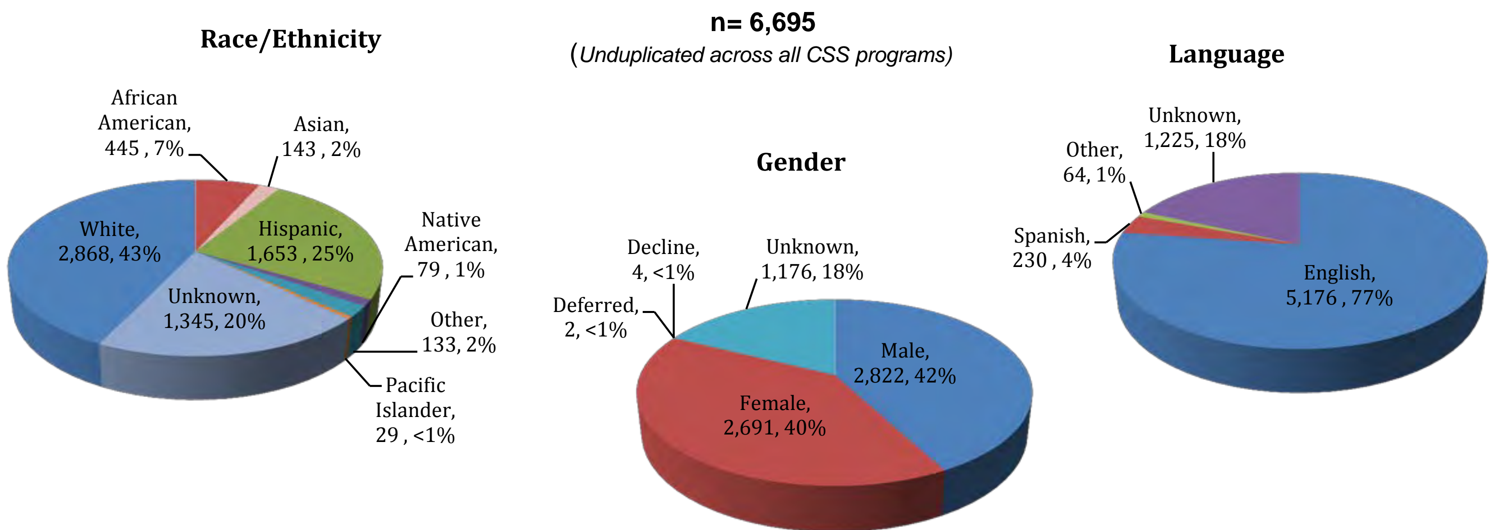
FY 16-17 Budgeted	FY 16-17 Projected	FY 17-18 Projected	FY 18-19 Projected	FY 19-20 Projected
$20,064,065	$18,136,440	$21,082,988	$21,306,253	$21,386,636

CSS Demographics:

MHSA data collection and reports focus on how many individuals were served and whether programs were meeting service targets. Data collected provides an indication of how programs 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%.



*Unknown values due to some types of services (non-treatment services)

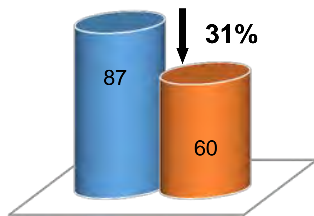
CSS Highlights:

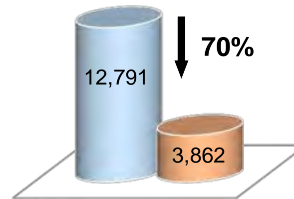
All FSPs
7/1/2015 – 6/30/2016

- 627 active partners in FY'15 -'16*
- All outcomes based on the 477 partners who were active in FY'15 -'16 and in the program at least one year.

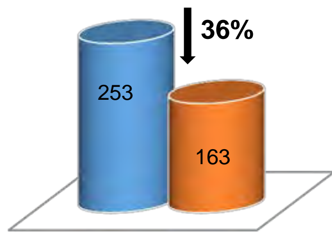
* Those served in the FSP and completed data elements to be included in the state data system (DCR)

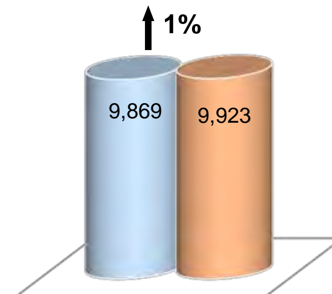
Homelessness Outcomes



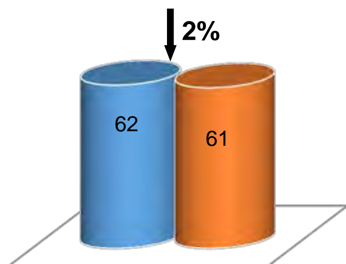


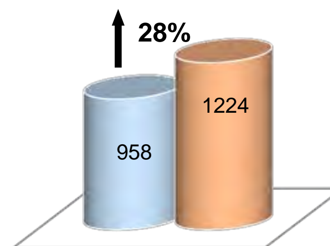
Psychiatric Hospitalization Outcomes



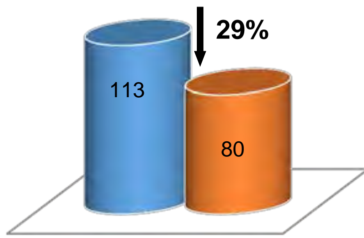


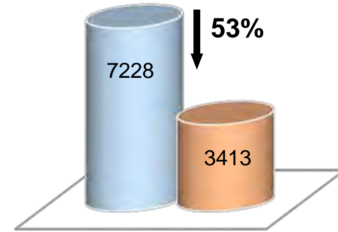
Medical Hospitalization Outcomes

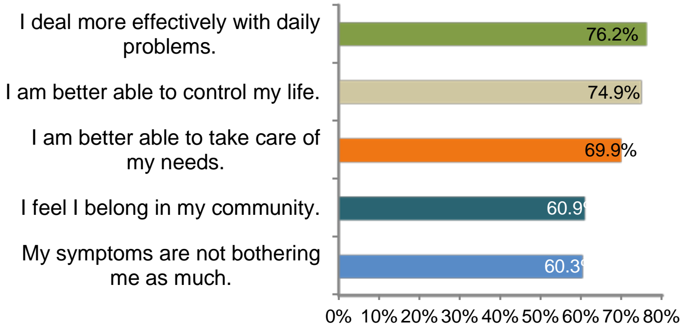


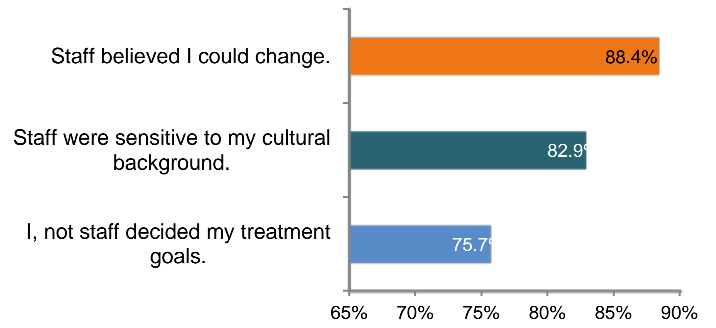


Incarceration Outcomes







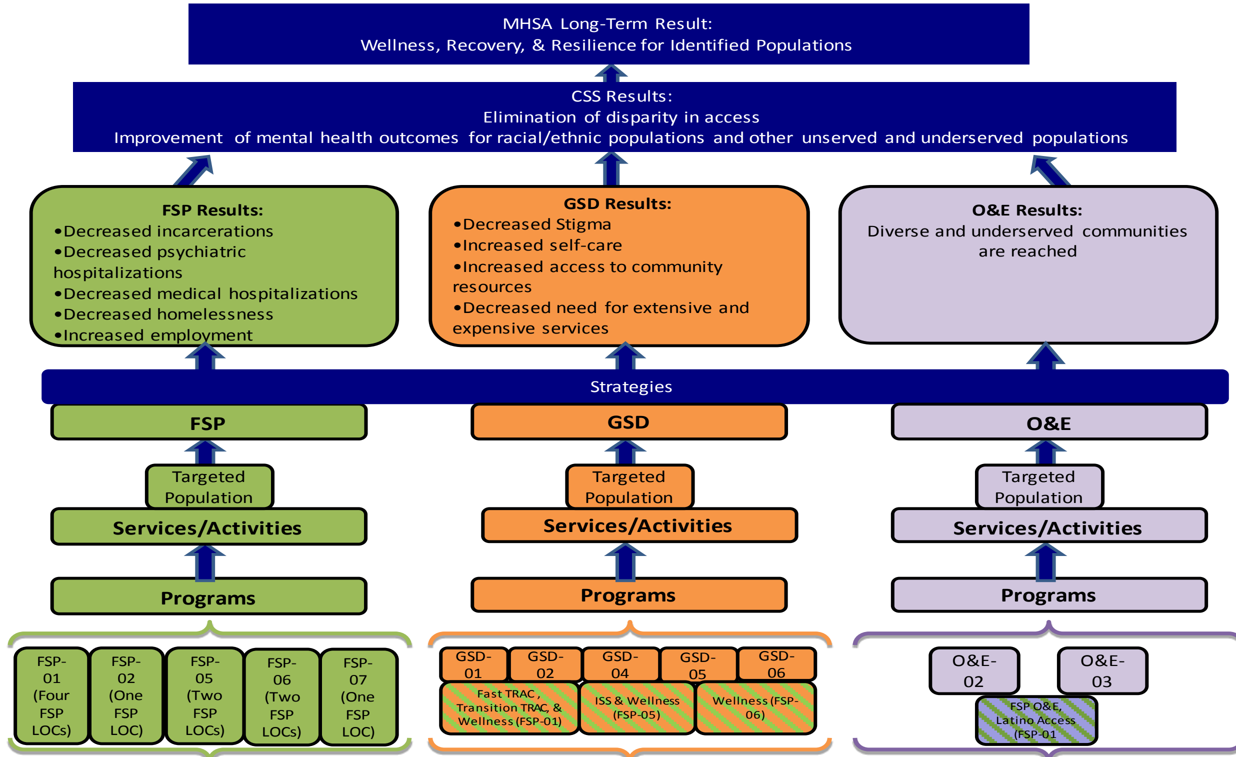


* These surveys were developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.
November 2015 & May 2016 Consumer Perception Survey

**Josie's Place, CERT and Warm Line, Empowerment Center, Juvenile Justice, Integrated Forensics Team, Telecare, Housing(O&E), Employment (O&E), and Garden Gate Crisis (O&E).

Theory of Change:

The Community Services and Support (CSS) component plays an important role in reaching the desired MHSA long-term results of wellness, recovery, and resilience for identified populations. Below is the CSS component for FY 2015-2016 displayed in the Theory of Change Framework which was presented during the stakeholder process.



CSS - Stanislaus Homeless Outreach Program (FSP- 01)
Operated on Contract to Telecare Corporation within Behavioral Health and Recovery Services
Adult System of Care

Program Description

The Stanislaus Homeless Outreach Program (SHOP) program provides culturally competent mental health services to individuals with serious mental illness and a history of homelessness that have mental health or co-occurring issues of mental health and substance abuse. These individuals may also be uninsured or underinsured and involved with other agencies. The program goals are to reduce the risk for emergency room use, contact with law enforcement, homelessness, and psychiatric hospitalization.

Target Population

Transitional Aged Young Adults (TAYA) 16-25, Adults 26-59, and Older Adults 60+

Services and Activities

SHOP programs utilize a team approach to provide a continuity of care and a menu of treatment options utilizing the Assertive Community Treatment (ACT) model. Clients receive support including individualized housing plans to successfully achieve their own personal recovery goals.

The estimated number of individuals to be served in FY 16-17 is 615; 456 in the Full Service Partnership and 159 in Intensive Support Services and Wellness/Recovery. The estimated number of individuals to be served in FY 18-19 and FY 19-20 will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2015-16

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$3,697,326	***$3,206,186***	***2,957***	***$1,084***

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$4,278,545	***$4,357,670***	***$4,188,836***	***$4,190,239***	***$4,190,239***

SHOP offers 3 levels of care and utilizes Full Service Partnership (FSP) funding.

GSD Funding

1) Intensive Support Services (ISS) TRAC/Fast TRAC
2) Wellness/Recovery
3) Transition TRAC

Led by clinical service staff, SHOP group support is offered to individuals, along with peer-led wellness/recovery support groups. All levels of care include a multi-disciplinary approach.

In the GSD Transition TRAC, the staff focuses on discharges from the acute psychiatric inpatient hospital in Stanislaus County. The team tracks individuals who are not open to behavioral health services prior to hospitalization and engage those who are not open to services post-hospitalization to connect them to resources. The aim is to prevent re-admissions to inpatient psychiatric services.

Highlights for FSP Level of Care:

- Collaboration with Stanislaus County BHRS to expand its existing Outreach Program with a new outreach team that works to meet the needs of the county's underserved/unserved Latino population. This new team, Latino Access, offers a unique approach to serve individuals.
- Proficient in English and Spanish, Latino Access teams connected with neighborhoods including Latino communities to talk about mental health issues and reduce the stigma of receiving mental health services.
- Established partnerships that include the following organizations: Center for Human Services, BHRS, Sutter Health, Golden Valley Health Centers, Catholic Charities, Riverbank Community Collaborative and the Modesto and Turlock Police departments.
- Implemented various stages of Cerner and began using the Comprehensive Assessment for Adults (CAA) and crisis assessments fully by July 2014.
- Staff received training to improve understanding of treatment plan goals and interventions.
- Agency was granted a three-year CARF accreditation renewal in September 2014.
  Josie's TRAC completed an audit by the county and received an overall rating of 98%. The following month, the remaining TRAC programs were audited and received an overall rating of 94%.

(The following SHOP activities/highlights were also funded by General System Development (GSD) dollars.)

- Staff utilized the Common Ground program as a resource library to help individuals and families in crisis, persons with mental illness, and people trying to cope with critical situations.
- Partnership TRAC and Westside SHOP staff worked with clients prior to seeing a psychiatrist in preparing the "Health Questionnaire."
- Staff completed four hour training in Non-Violent Intervention (CPI) and started a series of Telecare's Recovery Centered Clinical System cultural training.
- Program benefited from a culturally diverse staff including 26 staff members who are fluent in various languages including Armenian, Assyrian, Cambodian, Farsi, Portuguese, Spanish, Pilipino, Ukrainian, and Russian.

The program was also able to offer a variety of groups for clients. These groups included but are not limited to:

- Spirituality
- Art
- Women's Group
- Stress Reduction
- Men's Group
- Life Skills
- Peer Support

Highlights for GSD Levels of Care:

- Transition Team engaged and provided referral information to all individuals (on the psychiatric units) that the County Emergency Response Team had deemed to require an inpatient admit that were not already connected to treatment service providers.
- Team responded to individuals that required subsequent crisis contact evaluations to determine whether they could benefit from other alternatives to a psychiatric admit.
- Team provided clients short-term case management which included accompanying individuals as they accessed community resources.
- Team reported that it had avoided 468 hospital admits at time of crisis and had provided case management services to 417 individuals.
- Team worked with county personnel to implement a database to determine how many individuals were served, how many were admitted to the psychiatric hospital, and how many received case management services. It also worked closely with the county to implement High Utilizer Intervention Plans (HUIP) to better serve the needs of clients.
- Team added two additional clinicians to ensure individuals received mental health/SUD assessments as needed.
- Fast TRAC and Wellness successes included serving 28 new individuals admitted to the programs/agency was able to see 19 individuals graduate back out into the community.

Challenges for FSP and GSD Levels of Care:

- A larger number of temporary conservatorships and permanent conservatorships entered the SHOP program and it made it difficult to find placement for these individuals due to the high demand.
- There have also been challenges regarding space at the 9th street location.
- Hiring and maintaining staffing is a challenge due in part of the particular skills required for positions as well as the competitiveness of the mental health field.

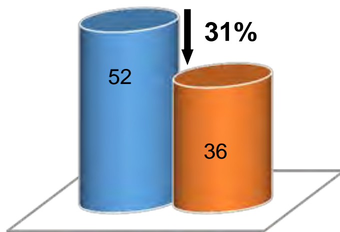
SHOP, Partnership TRAC, Josie's TRAC - FSP 01
7/1/2015 – 6/30/2016

- 244 active partners in FY'15 -'16*
- All outcomes based on the 180 partners who were active in FY'15 -'16 *and* in the program at least one year.

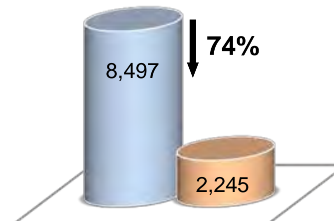
* Those served in the FSP and completed data elements to be included in the state data system (DCR)

Homelessness Outcomes

■ # partners homeless 1 year prior to enrollment
■ # partners homeless 1 year post enrollment

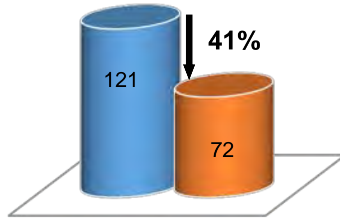


■ # days homeless 1 year prior to enrollment
■ # days homeless 1 year post enrollment

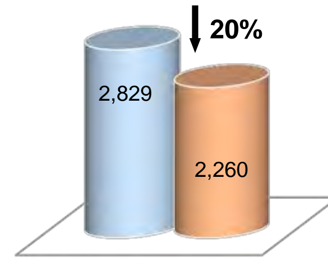


Psychiatric Hospitalization Outcomes

■ # partners hospitalized 1 year prior to enrollment
■ # partners hospitalized 1 year post enrollment

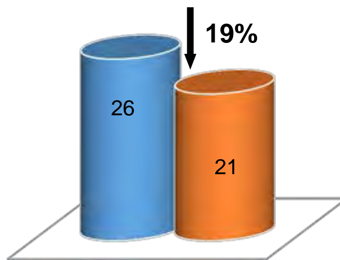


■ # days hospitalized 1 year prior to enrollment
■ # days hospitalized 1 year post enrollment

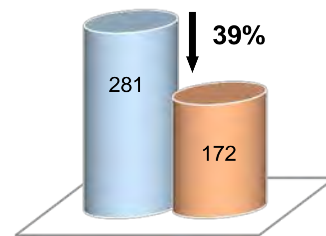


Medical Hospitalization Outcomes

■ # partners hospitalized 1 year prior to enrollment
■ # partners hospitalized 1 year post enrollment

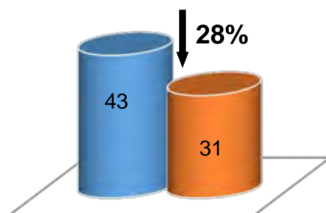


■ # days hospitalized 1 year prior to enrollment
■ # days hospitalized 1 year post enrollment

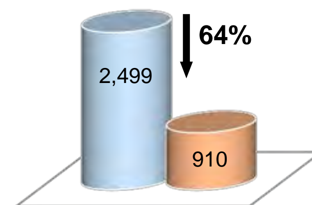


Incarceration Outcomes

■ # partners incarcerated 1 year prior to enrollment
■ # partners incarcerated 1 year post enrollment

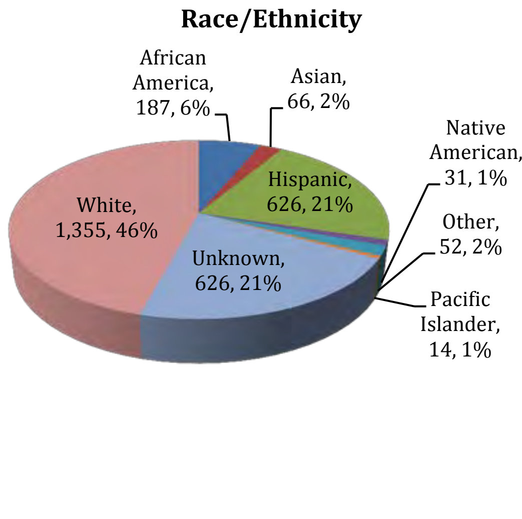


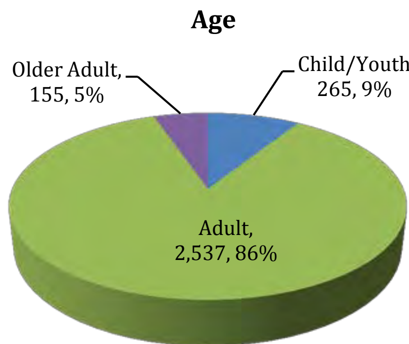
■ # days incarcerated 1 year prior to enrollment
■ # days incarcerated 1 year post enrollment

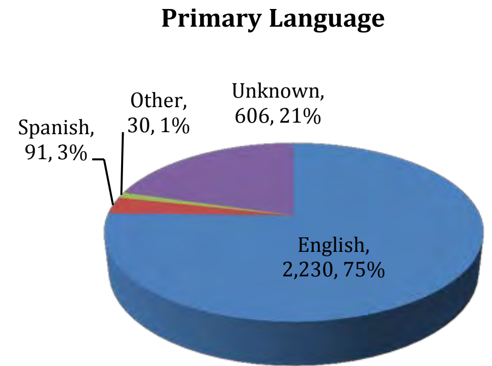


CSS - Stanislaus Homeless Outreach Program (SHOP)
FSP-01 FY 2015 - 2016

2,957 Individuals Served







Program Results for FSP Level of Care

How Much?

- 236 individuals were served *
- 38.9 – average number of clinical services per individual
- 9.06 – average number of support services per individual

How Well?

- 134.09% of annual target of individuals served was met (Target: 176)
- 653.4 days –average length of FSP services
- 89.7% (105/117) of surveyed individuals were satisfied with services**
- 87.1% (101/116) of surveyed individuals said that "Staff believed I could change"**

Better Off?

- 79.7% (91/115) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**
- 71.9% (82/114) of surveyed individuals indicated that as a results of services, they feel they belong to their community**
- 81.5% (560/687) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, and decreased need for extensive and expensive services**

Program Results for GSD Level of Care

How Much?

- 1328 individuals served *
- 1.95 – average number of clinical services per individual
- 0.38 – average number of support services per individual

How Well?

- 92.2% (47/51) of surveyed individuals reported being satisfied with services**
- 80% (40/50) of surveyed individuals indicated that "Staff believed I could change"**

Better Off?

- 67.35% (33/49) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**
- 60% (30/50) of surveyed individuals indicated that they feel they belong to their community as a result of services**
- 84.33% (253/300) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, or decreased need for extensive and expensive services**

** Individuals served in both FSP and GSD levels of care are counted in each category.*
***Mental Health Statistics Improvement Program (MHSIP) Consumer Survey*
***The number of individuals served is an unduplicated count between all levels of care.*

CSS - Juvenile Justice (FSP- 02)

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

Program Description

This program is a Full Service Partnership (FSP) that provides mental health services to high risk youth in the Juvenile Justice Mental Health Program. Services are also provided to their families. Many youth are victims of trauma and have not successfully been engaged by traditional methods of treatment. As a result, they tend to become more seriously ill, have more aggressive behavior, and higher rates of incarceration and institutionalization.

Target Population

Children and Youth 0-16, and Transition Aged Young Adults 16-25 on formal or informal probation, diagnosed with a serious mental illness or serious emotional disturbance.

- Youth from racially and ethnically diverse communities
- History of domestic violence, gang involvement, and multi-generational incarceration
- Youth often made formal wards of the court and at risk of out-of-town placement due to levels of aggression involved in crimes committed and continued recidivism

Services and Activities

This FSP provides 24 hour a day, seven (7) days a week crisis response and on-site intensive mental health services. The FSP is designed to do "whatever it takes" to engage youth and their families. The program goals are to reduce recidivism, out of home placement, homelessness, and involuntary hospitalization and institutionalization. This program receives FSP and GSD funding.

In FY 16-17, there are no proposed changes in the population to be served. The estimated number of individuals to be served will be a total of 25 at any given time; 13 Children/Youth and 12 Transition Age Young Adults. The estimated number of individuals to be served in FY 18-19 and FY 19-20 will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2015-16

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$571,412	***$357,173***	***138***	***$2,588***

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$386,316	***$376,961***	***$539,070***	***$545,952***	***$552,903***

Through GSD funding, Juvenile Justice continue to offer Youth Leadership and Youth In Mind programs to give young people access to supports that encourage the development of leadership skills. Transition-aged staff leads youth leadership meetings and help support, mentor, and educate youth group members and also run and operate the Youth Leadership and Drop-in Center at Juvenile Justice called "The Spot".

"The Spot" at Juvenile Justice

"The Spot" is a youth-ran and led Drop-In Center for youth. It's a safe place where youth can grow, inspire, empower one another, or just hang out. Activities include the following:

- Billiards
- Ping Pong
- Youth Recovery Groups
- Life Skills Education and Coaching
- Volunteer Program
- Opportunities to serve community
- Youth Leadership and Peer Support Groups

- Speakers Bureau Training
- Computer Lab
- Housing Information
- Healthcare information
- Help with Resumes
- Assistance in applying for employment

Youth Leadership and Stanislaus Youth in Mind

- Youth participate in leadership and advocacy, including attending member leadership summits, mental health conferences, and local advocacy activities to promote positive change through authentic youth engagement.
- Improve lives of young people impacted by mental health system through education, advocacy, and collaboration.
- Promotes "Nothing About Us, Without Us" belief that there are no bad or un-healable youth/that a healthy transition to adulthood is made possible by eliminating stigma, extending respect to all constituents, and advocating non-restrictive services.
- Envisions a mental health system that provides all youth with developmentally appropriate services, empowerment, and peer support services where youth are involved in decision making on individual, local, and policy levels.

Stanislaus County Youth Leadership Network (SCYLN)

- A collaborative networking group formed in 2010 that consists of youth leadership groups throughout Stanislaus County. The mission: to bring youth groups and youth leaders together to build collaboration within the county.

Youth Peer Navigator Project

- Integrated youth-centered approach to help young people in need of mental health services navigate through Stanislaus County's mental health services system and to help youth improve their mental health and well-being.
- Navigators provide mental health education, peer support, and mentoring to youth in the Behavioral Health and Recovery Service's (BHRS) Children's Systems of Care (CSOC) and to those youth that need help connecting to mental health services.
- Project goals include increasing youth's developmental assets, reducing psychiatric hospitalization and reduce the Juvenile criminal recidivism rate.

Parent Support Services

- Parent support groups offered to families who wish to receive support in navigating the juvenile justice system or improving parenting skills.
- Groups coordinated by a Parent Support Specialist to give parents/grandparents an opportunity to gain better understanding of the Juvenile Justice System. It's also a place for parents to support each other and share their experience.

Highlights:

- "The Spot" exceeded its goal of attracting 75 youth within the first year drawing more than 100 participants.
- Youth shared life experiences to empower and educate students at Modesto Junior College and CSU, Stanislaus, to help decrease mental health stigma and discrimination.
- "The Spot" provided a venue to allow "Stanislaus Youth In Mind" to provide mental health education, wellness techniques, leadership development and advocacy opportunities.
- Four youth in the program have gained work experience through volunteering at the youth leadership center.

Challenges:

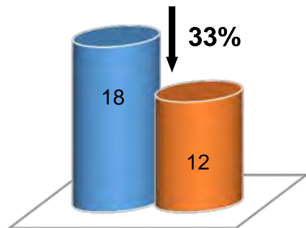
- Co-location with Probation/Juvenile Hall can make it difficult to engage youth in activities when some have distrust of the justice system.
- Getting to "The Spot" can be challenging for some youth who take the bus to the center.
- The program is experiencing growing pains with leadership activities, mentoring, and treatment groups all held in a small triple-wide trailer.

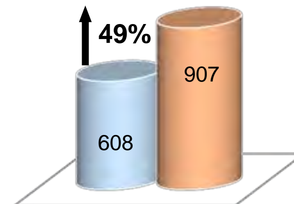
Juvenile Justice - FSP 02
7/1/2015 – 6/30/2016

- 41 active partners in FY'15 -'16*
- All outcomes based on the 24 partners who were active in FY'15 -'16 and in the program at least one year.

* Those served in the FSP and completed data elements to be included in the state data system (DCR)

Incarceration Outcomes

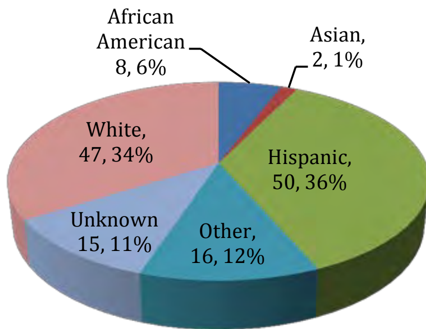




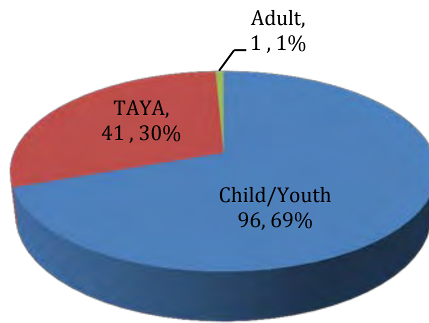
CSS - Juvenile Justice
FSP-02 FY 2015 - 2016

138 Individuals Served

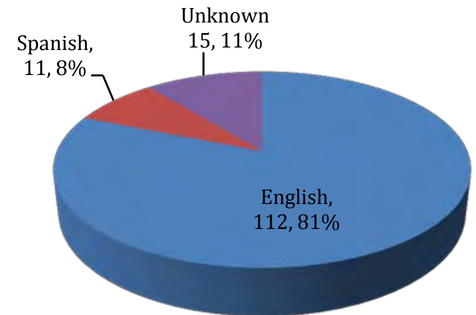
Race/Ethnicity



Age



Primary Language



Program Results for FSP Level of Care

How Much?

- 138 individuals were served; Includes 42 in FSP and 96 in GSD levels
- 26.76 – average number of clinical services per individual
- 7.22 – average number of support services per individual

How Well?

- 168% of annual target of individuals served was met (Target: 25)
- 323.79 days – average length of FSP services
- 92.86% (26/28) of surveyed individuals were satisfied with services*

Better Off?

- 89.29% (25/28) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems*
- 90.32% (56/62) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, or decreased need for extensive and expensive services*

** Mental Health Statistics Improvement Program (MHSIP) Consumer Survey*

CSS – Integrated Forensic Team (FSP- 05)

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

Program Description

The Integrated Forensic Team (IFT) partners closely with the Stanislaus County Criminal Justice System to provide services to individuals with serious mental illness or co-occurring substance abuse issues. This population is also at risk for more serious consequences in the criminal justice system.

Target Population

Transition age young adults 18 - 25, Adults 26 - 59, and Older Adults 60+ with a serious mental Illness or co-occurring substance abuse.

Services and Activities

A multidisciplinary team provides a “wrap around” approach to individuals that includes 24/7 access to a known service provider, individualized service planning, crisis stabilization alternatives to jail, re-entry support from a state hospital, and linkages to existing community support groups. Both service recipients and family members are offered education regarding the management of both mental health issues, benefits advocacy, and housing support. Culturally and linguistically appropriate services are provided to diverse consumers.

Partner collaboration 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 Turning Point Community Programs, Salvation Army, United Samaritans Homeless Services, and Golden Valley Health Center (a Federally Qualified Health Clinic).

As reported in the FY 16-17 Annual Update, IFT changed its funding formula from an FSP/GSD combination to a 100% FSP funded program, an internal accounting measure that will not change the program or the integrity of its services. The change will enable the program to better track client progress as they move through the appropriate levels of care. It will also allow for the capture of all relevant data using the DCR (Data Collection and Reporting). IFT will continue employing capacity building GSD related strategies to provide crisis services peer and family support, and access to community resources for its clients.

In FY 16-17, there are no proposed changes in the population to be served. The estimated number of individuals to be served is 92; 52 Full Service Partnership level and 40 in Intensive Support Services or Wellness/Recovery Levels. The estimated number of individuals to be served in FY 18-19 and FY 19-20 will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2015-16

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$1,698,681	***$1,333,927***	***135***	***$9,911***

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$1,882,710	***$1,855,975***	***$2,158,688***	***$2,172,015***	***$2,185,476***

Highlights:

- Collaborative efforts between IFT and other BHRS programs have successfully sustained the Housing First initiative, which continues to provide housing and support services to some of the most disenfranchised and challenging individuals in the community.
- Program has successfully created an internal Quality Improvement Committee to better oversee quality of services as well as assess, implement, and analyze any necessary improvement measures.
- Increased outreach and engagement efforts in outlying communities (Oakdale, Hughson, and Riverbank) as a means to increase access to services for all county residents.
- GSD: Increased use of Clinicians to provide therapy to individuals as the progress through treatment and levels of care.
- GSD: Focused on re-assessments of all clients.

Challenges:

- Housing First initiative continues to present issues for both IFT and associated teams. Housing "difficult to house" individuals requires flexibility, ingenuity, and frequent communication by all involved.
- Limited residential substance abuse treatment options present challenges for clients who have been dually diagnosed with a substance use disorder.
- Staffing issues presented challenges around continuity and making sure clients were not over looked/Staff turnover and challenges with psychiatrist coverage and changes were main aspects of this challenge.
- FSP & GSD: Challenges around psychiatrist coverage, consistency, and rapport.

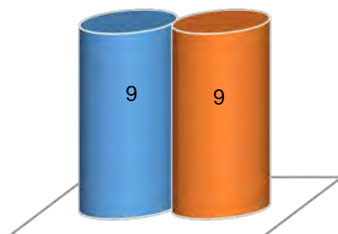
Integrated Forensic Team – FSP 05
7/1/2015 – 6/30/2016

- 65 active partners in FY'15 -'16*
- All outcomes based on the 45 partners who were active in FY'15 -'16 and in the program at least one year

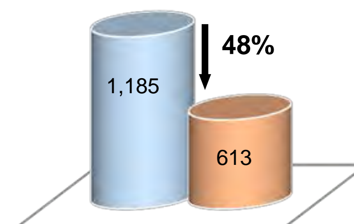
* Those served in the FSP and completed data elements to be included in the state data system (DCR)

Homelessness Outcomes

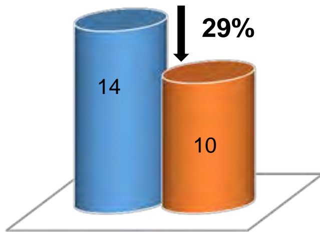
■ # partners homeless 1 year prior to enrollment
■ # partners homeless 1 year post enrollment

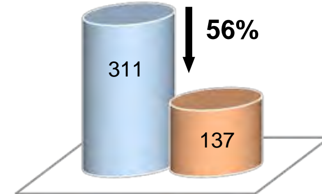


■ # days homeless 1 year prior to enrollment
■ # days homeless 1 year post enrollment

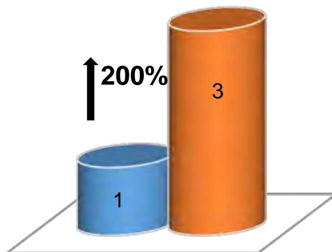


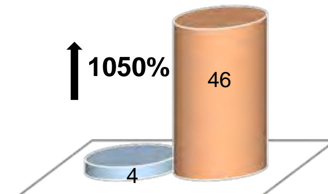
Psychiatric Hospitalization Outcomes



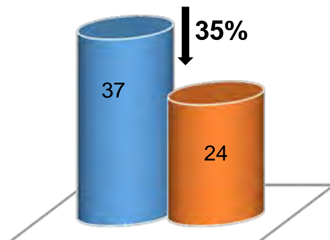


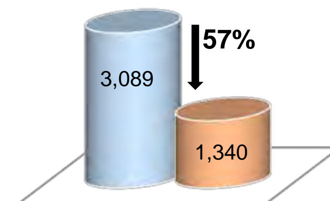
Medical Hospitalization Outcomes





Incarceration Outcomes

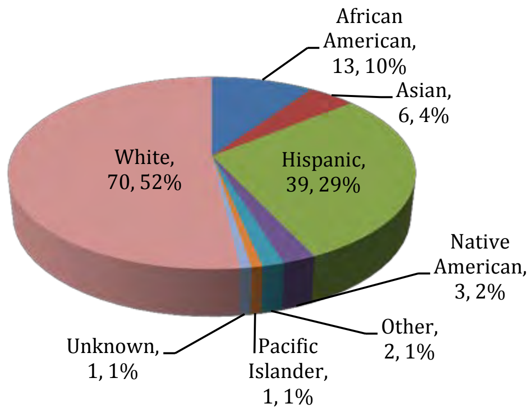




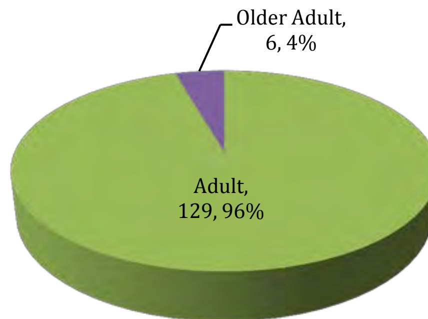
CSS - Integrated Forensic Team
FSP-05 FY 2015 - 2016

135 Individuals Served

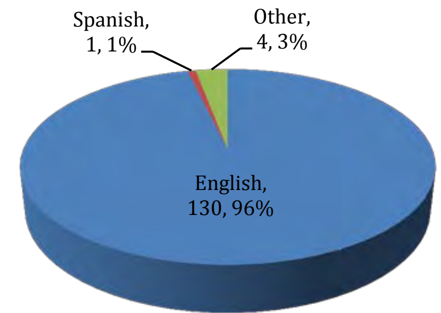
Race/Ethnicity



Age



Primary Language



Program Results for FSP Level of Care

How Much?

- 68 individuals were served
- 15.56 – average number of clinical services per individual
- 23.46 – average number of support services per individual

How Well?

- 130.77% of annual target of individuals served was met (Target: 52)
- 421.09 days –average length of FSP services
- 85.72% (12/14) of surveyed individuals were satisfied with services**
- 76.9 (10/13) of surveyed individuals said that "Staff believed I could change"**

Better Off?

- 61.5% (8/13) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**
- 41.7% (5/12) of surveyed individuals indicated that they feel they belong to their community as a result of services**
- 68.4% (52/76) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, and decreased need for extensive and expensive services**

Program Results for GSD Level of Care

How Much?

- 67 individuals were served
- 12.48 – average number of clinical services per individual
- 6.81 – average number of support services per individual

How Well?

- 167.5% of annual target of individuals served was met (Target: 40)
- 291.84 days –average length of GSD services
- 93.75% (15/16) of surveyed individuals were satisfied with services**
- 80% (12/15) of surveyed individuals said that "Staff believed I could change"**

Better Off?

- 86.67% (13/15) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems**
- 86.67% (13/15) of surveyed individuals indicated that they feel they belong to their community as a result of services**
- 83.33% (80/96) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, and decreased need for extensive and expensive services**

** Individuals served in both FSP and GSD levels of care are counted in each category.*
***Health Statistics Improvement Program (MHSIP) Consumer Survey*

CSS – High Risk Health and Senior Access (FSP- 06)

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

Program Description

This program is a Full Service Partnership (FSP) that provides mental health services to adults with co-occurring health and mental health disorders. The program offers two levels of care: FSP and Intensive Support Services. 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 if necessary. A graduated level of care allows more individuals to access the FSP level of service when needed.

Target Population

Transitional Aged Young Adults (TAYA) 18-25, Adults 26-59, and Older Adults 60+ with significant ongoing possibly chronic health conditions co-occurring with serious mental illness; Population also includes those at risk of homelessness, institutionalization, hospitalization, or nursing home care or frequent users of emergency rooms.

Services and Activities

Outreach and engagement services are focused on engaging diverse ethnic/cultural populations and individuals, as well as those who have mental illness and are homeless. Strategies include 24/7 access to a known service provider, individualized service plans, a multidisciplinary treatment approach, access to wellness and recovery focused groups and peer support, and linkage to existing community support groups. 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.

In FY 17-18, there are no changes in the population to be served and strategies to be used. The estimated number of individuals projected to be served is 125. The estimated number of individuals to be served in FY 18-19 and FY 19-20 will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2015-16

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$1,704,397	***$1,466,036***	***129***	***$11,365***

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$1,694,361	***$1,661,945***	***$1,933,164***	***$1,949,872***	***$1,965,157***

Highlights:

- Ethnically and culturally diverse workforce continues to provide outreach to diverse and underserved communities through engagement in community events; Activities include National Depression Screening Day and Peer Support/Volunteer program staff participation in local fairs, summits, countywide Homeless vigil, and other events to provide education and outreach.
- Growth of Peer Support/Volunteer program to support clients; Individuals are community volunteers, and former and current clients involved in different community services projects; Program has grown to just under 30 individuals.
- Development of a supportive physical environment where clients and peers can relax and socialize with each other; Development of both inside and outside areas that are welcoming and provide a place of safety.
- Operation of a Clothes Closet and collaboration with community agencies that supply food to needy families and individuals.
- Continued participation as a mental health rotation site for nursing students in the RN program at Modesto Junior College and CSU, Stanislaus.
- Expansion of computer lab for clients and volunteers.

Challenges:

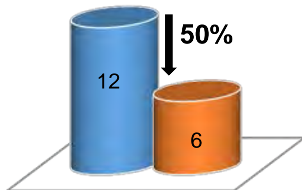
- Facility space due to the growth of the volunteer program; Program working to accommodate staffing and programming needs.
- Transportation in reaching out to underserved populations in the Westside of Stanislaus County.
- Change in manager and staff turnover.

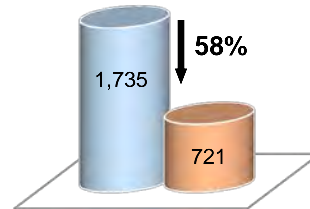
High Risk Health and Senior Access – FSP 06
7/1/2015 – 6/30/2016

- 121 active partners in FY'15 -'16*
- All outcomes based on the 80 partners who were active in FY'15 -'16 and in the program at least one year.

* Those served in the FSP and completed data elements to be included in the state data system (DCR)

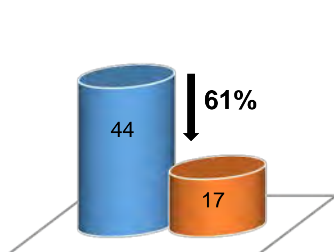
Homelessness Outcomes



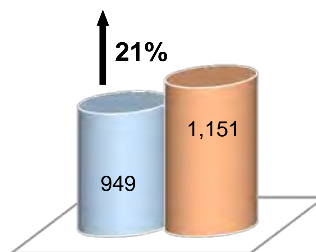


Psychiatric Hospitalization Outcomes

■ # partners hospitalized 1 year prior to enrollment
■ # partners hospitalized 1 year post enrollment

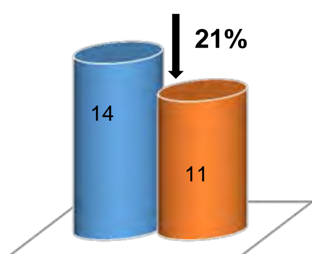


■ # days hospitalized 1 year prior to enrollment
■ # days hospitalized 1 year post enrollment

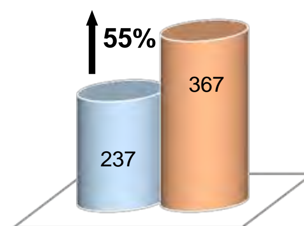


Medical Hospitalization Outcomes

■ # partners hospitalized 1 year prior to enrollment
■ # partners hospitalized 1 year post enrollment

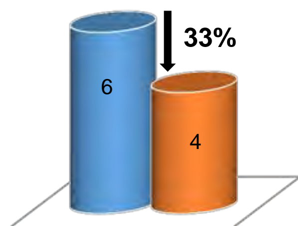


■ # days hospitalized 1 year prior to enrollment
■ # days hospitalized 1 year post enrollment

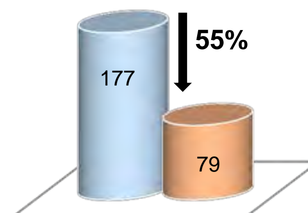


Incarceration Outcomes

■ # partners incarcerated 1 year prior to enrollment
■ # partners incarcerated 1 year post enrollment

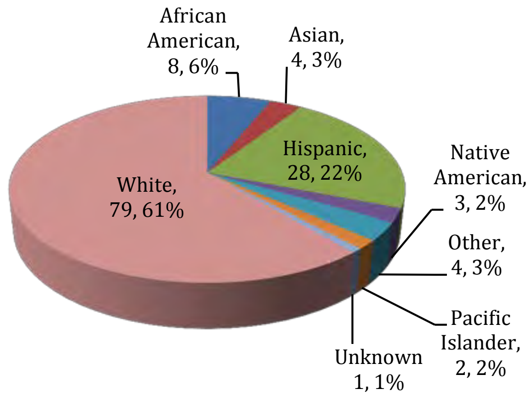


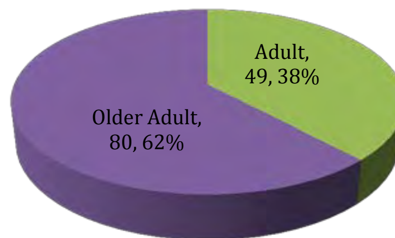
■ # days incarcerated 1 year prior to enrollment
■ # days incarcerated 1 year post enrollment

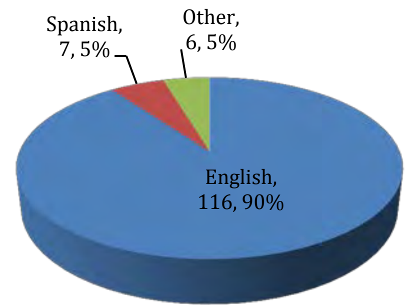


CSS - High Risk Health & Senior Access
FSP-06 FY 2015 - 2016

129 Individuals Served







Program Results for FSP Level of Care

How Much?

- 129 individuals were served
- 32.84 – average number of clinical services per individual
- 18.71 – average number of support services per individual

How Well?

- 103.2% of annual target of individuals served was met (Target: 125)
- 589.35 days – average length of FSP services
- 100% (60/60) of surveyed individuals were satisfied with services*
- 90.2% (55/61) of surveyed individuals said that "Staff believed I could change"

Better Off?

- 82.76% (48/58) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems*
- 86.85% (317/365) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, or decreased need for extensive and expensive services*

** Mental Health Statistics Improvement Program (MHSIP) Consumer Survey*

CSS – Turning Point Integrated Services Agency (FSP- 07)
Operated by Turning Point Community Programs

Program Description

The Integrated Services Agency (ISA) is a Full Service Partnership (FSP) that works closely with individuals on conservatorship and persons with high hospitalization rates to help them successfully reintegrate back into the community. The program provides intensive case management to adults with serious psychiatric disabilities who are Medi-Cal eligible.

The primary focus is on relationship building with service recipients and how to better assist them on the path of wellness and recovery. This FSP includes a continuum of care, crisis intervention, and wraparound funds, in alignment with the severity of the mental health challenges experienced by these service recipients.

Target Population

Adults 26-59 with serious psychiatric disabilities

Services and Activities

This FSP offers the following:

- Provide services 24 hours a day including crisis response, seven days a week to clients.
- Provide support services including wraparound funds to help client's immediate and temporary needs such as food, clothing, and shelter.
- Work collaboratively with Doctor’s Behavioral Health Center, the Psychiatric Health Facility (PHF), the Public Guardian’s Office, and the Community Emergency Response Team (CERT) and Warmline to ensure client immediate needs are met.

In FY 17-18, there are no changes in the population to be served and strategies to be used. The estimated number of individuals projected to be served is a maximum of 155 at the FSP level and in intensive support services or wellness/recovery levels.

The estimated number of individuals to be served in FY 18-19 and FY 19-20 will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2015-16

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$682,300	***$398,409***	***164***	***$2,429***

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$751,274	***$751,274***	***$751,274***	***$751,274***	***$751,274***

Highlights:

- The majority of the population served did not accrue hospital, homeless, and incarceration days, as well as emergency interventions. 77.8% (n=126) of the population served (N=162) did not accrue any psychiatric hospital days, 97.5% (n=158) did not accrue incarceration days, 95.7% (n=155) did not accrue any homeless days, and 87.7% (n=142) did not accrue any emergency interventions.
- Total number of emergency interventions accrued within the fiscal year decreased from 51 episodes to 46
- General Satisfaction domain within the MHSIP Consumer Satisfaction Survey scored above 80% (81.7%) suggesting that individuals served were generally satisfied with the services they received
- Of the total 86 IMD admissions, 33 (38.4%) transitions to a lower level of care occurred at some point within FY 15/16.

Challenges:

- Limited and backlogged placements; Placement in Transition Board and Cares, and Board and Cares are limited because of few beds available.
- Clients in locked settings spend longer periods of time in acute hospitals.
- Increase in acuity level of its members; Due to the specialized services provided by this FSP, many of the most difficult and challenging cases in the community have been transferred to the ISA. In response, the ISA has tried to meet the needs of those clients with creative thinking and use of wraparound resources. An example is hiring additional 1:1 support staff for individuals needing more 1:1 attention and after hour's supervision. Wrap around funds have also been used to help with the basic needs of food, clothing, and shelter, so that clients do not become homeless or use emergency services due to lack of resources.

Turning Point Integrated Service Agency - FSP 07
7/1/2015 – 6/30/2016

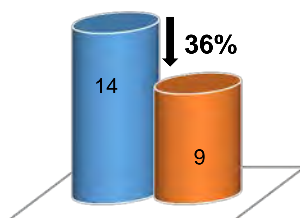
- 156 active partners in FY'15 -'16*

- All outcomes based on the 148 partners who were active in FY'15 -'16 and in the program at least one year.

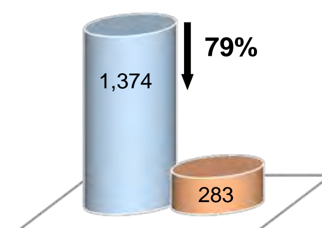
* Those served in the FSP and completed data elements to be included in the state data system (DCR)

Homelessness Outcomes

■ # partners homeless 1 year prior to enrollment
■ # partners homeless 1 year post enrollment

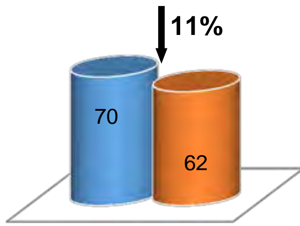


■ # days homeless 1 year prior to enrollment
■ # days homeless 1 year post enrollment

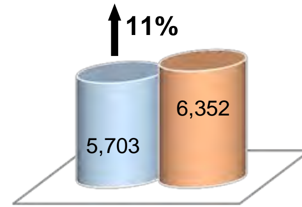


Psychiatric Hospitalization Outcomes

■ # partners hospitalized 1 year prior to enrollment
■ # partners hospitalized 1 year post enrollment

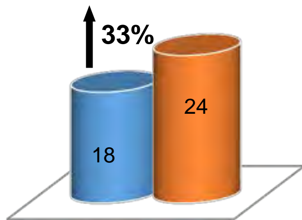


■ # days hospitalized 1 year prior to enrollment
■ # days hospitalized 1 year post enrollment

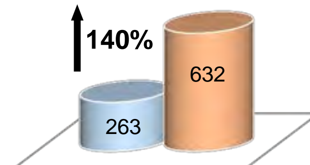


Medical Hospitalization Outcomes

■ # partners hospitalized 1 year prior to enrollment
■ # partners hospitalized 1 year post enrollment

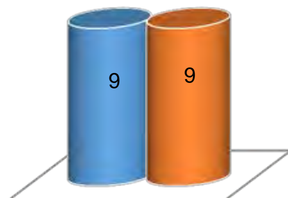


■ # days hospitalized 1 year prior to enrollment
■ # days hospitalized 1 year post enrollment

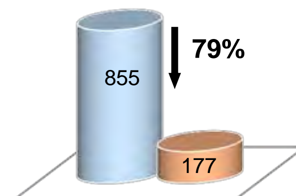


Incarceration Outcomes

■ # partners incarcerated 1 year prior to enrollment
■ # partners incarcerated 1 year post enrollment



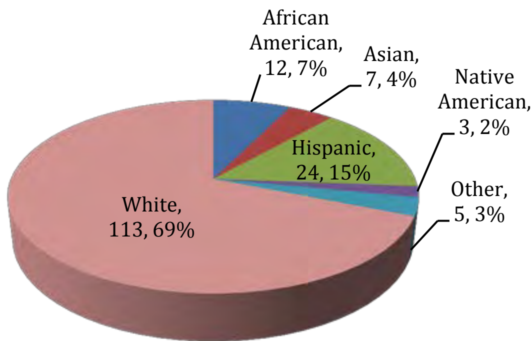
■ # days incarcerated 1 year prior to enrollment
■ # days incarcerated 1 year post enrollment



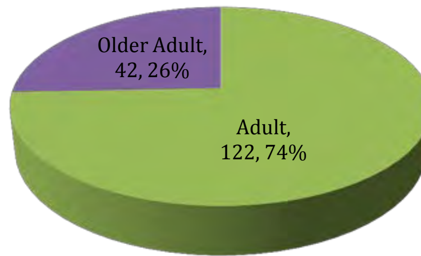
CSS - Turning Point Integrated Service Agency
FSP-07 FY 2015 - 2016

164 Individuals Served

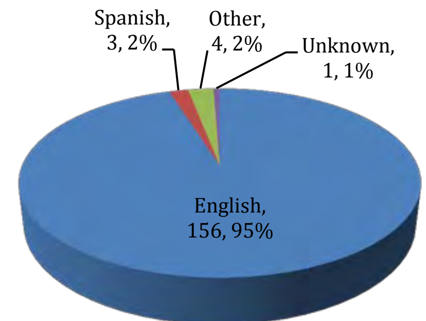
Race/Ethnicity



Age



Primary Language



Program Results for FSP Level of Care

How Much?

- 164 individuals were served
- 32.6 – average number of clinical services per individual
- 24.01 – average number of support services per individual

How Well?

- 105.8% of annual target of individuals served was met (Target: 155*)*
- 2740.84 days – average length of FSP services
- 93.85% (61/65) of surveyed individuals were satisfied with services*
- 89.9% (62/69) of surveyed individuals said that "Staff believed I could change"

Better Off?

- 84.13% (53/63) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems*
- 82.5% (330/400) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, or decreased need for extensive and expensive services*

** Mental Health Statistics Improvement Program (MHSIP) Consumer Survey*

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

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

Program Description

Josie's Place is a membership-driven "clubhouse" type center for diverse transition age young adults with mental illness. Programming consists of: 1) Drop in Center, 2) Regional Level Outpatient Mental Health (Josie's Service Team) and 3) Full Service Partnership (Josie's TRAC).

Target Population

Transition age young adults (TAYA); Drop in Center 16-25; Service Team and TRAC 18-25.

Services and Activities

Service Team and TRAC:

- Therapy, Intensive case management, Psychiatrist/medication services, Psychiatric RN support.
- Work collaboratively with client and programs to reduce mental health symptoms.
- Work to help stabilize housing, reduce hospitalizations, reduce incarcerations, reduce substance use
- Work to increase healthy coping skills, socialization and community supports.

Drop in Center:

- Provide Social Skills and activities including independent living skills.
- Provide Groups including Anger Management, Seeking Safety, LGBTQ and Transgendered support groups, SUD Peer support, Gender specific Peer Support Groups.
- Linkage and Advocacy for Independent Living skills including: Housing, Eligibility, California IDs, SSI, Vocational and education support.
- Outreach and Engagement with homeless TAY population to provide resource and referral.

Josie's Place is also home to the Young Adult Advisory Council (YAAC), a consumer-based group that provides leadership opportunities for youth to get involved in daily activities. Services can be provided in English, Spanish, Laotian and Sign Language currently.

In FY 17-18, there are no changes in the population to be served and strategies to be used. The estimated number of individuals projected to be served is 250. The estimated number of individuals to be served in FY 18-19 and FY 19-20 will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2015-16

Total MHSA Budget	Actual	Total Number Served	Estimated MHSA Cost Per Participant
$832,737	$551,865	376	$1,468

FY 16-17 Budgeted	FY 16-17 Projected	FY 17-18 Projected	FY 18-19 Projected	FY 19-20 Projected
$757,091	$802,987	$966,780	$978,918	$991,177

Highlights:

- Currently working on a Parent Partnership project to help support Young Parenting TAY.
- Increased hours to support Working TAY; Center is open from 8a.m.-6p.m. weekdays and 10a.m.-12p.m. on Saturday.
- Added structured and comprehensive job/school training program to center's list of activities this year; Program is run by staff and provides peer support to help young people find work and return to school
- Center expanded its reach to young people in neighboring cities; there are Drop in Center sites in both Oakdale and Turlock open two to three days a week to bring services to the TAY population.
- Center has been an active participant in Stanislaus County's Focus on Prevention Initiative to represent the TAY homeless population.

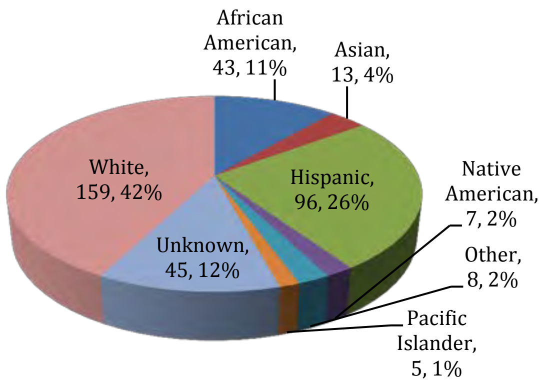
- Collaboration Outreach and Engagement started to reach the Forensic Youth population.

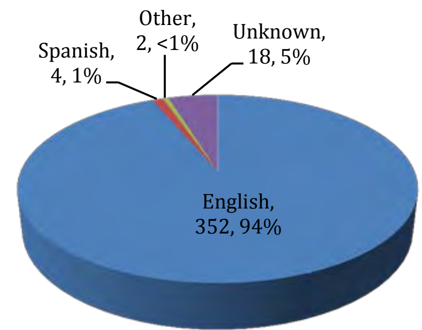
Challenges:

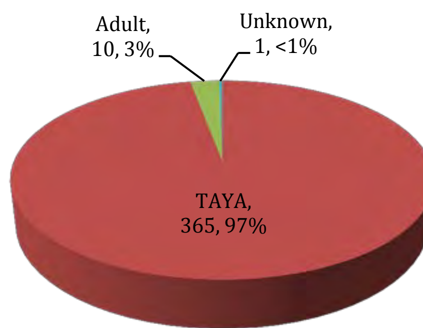
- Lack of housing for the homeless TAY population.
- Lack of adequate resources for transgendered and LGBTQ youth.
- Transportation to the center continues to be a barrier because of limited mass transit.
- Facility space to deal with increase in the level of services needed by clients.

CSS – Josie's Place Drop-In Center
GSD-01 FY 2015 - 2016

376 Individuals Served







Program Results for GSD Level of Care

How Much?

- 376 individuals were served
- 9.39 – average number of clinical services per individual
- 4.71 – average number of support services per individual

How Well?

- 150.4% of annual target of individuals served was met (Target: 250)
- 236.69 days – average length of GSD services
- 91.21% (83/91) of surveyed individuals were satisfied with services*
- 90.81% (79/87) of surveyed individuals said that "Staff believed I could change"

Better Off?

- 79.76% (67/84) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems*
- 56.3% (45/80) of surveyed individuals indicated that as a results of services, they feel they belong to their community
- 82.15% (428/521) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, or decreased need for extensive and expensive services*

** Mental Health Statistics Improvement Program (MHSIP) Consumer Survey*

CSS – Community Emergency Response Team & Warmline (GSD-02)
Operated by Behavioral Health and Recovery Services in the Adult System of Care and Turning Point Community Programs

Program Description

This program provides consumers with a team of licensed clinical staff to provide interventions in crisis situations. The "Warm Line", administered under a contract with Turning Point Community Programs, is a telephone assistance program that provides non-crisis peer support, referrals, and follow-up contacts. In 2015, Warm Line expanded services to provide Peer Navigators to help support CERT to connect individuals to specialty mental health services and avoid hospitalization.

Target Population

Children 0-16, Transition Age Youth 16-25, Adults 26-59, and Older Adults 60 +. The primary focus is on acute and sub-acute situations of children and youth with serious emotional disturbances (SED) and individuals with serious mental illness.

Services and Activities

The Mobile-CERT component provides site-based and mobile crisis response 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 Modesto Police Department patrol officers. Licensed clinical staff may accompany patrol officers to act as a community resource when they encounter individuals with mental health needs.

Collaboration is central to the success of emergency mental health assessment and referrals. It occurs on a daily basis with families, consumers, law enforcement, and 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.

This program is home to Communities Activities and Rehabilitation Transportation (CART) operated by Turning Point Community Programs. CART is a transit service that provides consumers and their families with greater access to support all aspects of their participation in community activities. In addition, the program also houses the following programs: Crisis Intervention Program (CIP) and Peer Navigators. Program descriptions are included in the Highlights section.

In FY 17-18, there are no proposed changes in the population to be served and strategies to be used. The estimated number of individuals projected to be served is 3000. The estimated number of individuals to be served in FY 18-19 and FY 19-20 will be based on approved budget targets, fiscal sustainability, and stakeholder input.

FY 2015-16

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$943,004	***$901,477***	***3,024***	***$298***

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$974,884	***$974,824***	***$979,706***	***$983,474***	***$983,513***

Highlights:

Mobile-CERT:

- Provides Modesto Police officers with additional information and strategies for helping individuals with mental illness
- Often reduces the need for hospitalizations by providing community members with immediate access to a mental health clinician while in crisis
- Allows CERT staff to explain/refer additional community resources available to individuals who may not be in crisis but are in need of mental health services

CERT:

In October 2013, CERT expanded its services to include a Crisis Intervention Program. This voluntary 24 hour program allows CERT to better serve the community by:

- Offering immediate counseling services to clients in crisis
- Providing meals and safe shelter for up to 24 hours
- Providing constant monitoring to ensure client's safety and stability.
- Offering peer support and providing information regarding community resources (housing, support groups, AOD options, etc.)
- Connecting clients to contracted provider (Telecare) to explore the option of continued mental health services
- Assisting clients in establishing medication services (Golden Valley, Aspen Medical) as needed

CIP:

Crisis Intervention Program (CIP) is a voluntary 24 hour program. It provided assistance to 219 individuals. The CIP includes the following services:

- Offers immediate counseling services to clients in crisis
- Provides constant monitoring to ensure clients' safety and stability
- Offers peer support and provides information regarding community resources (housing, support groups, SUD options, etc.)
- Provides meals and safe shelter for up to 24 hours
- Connects clients to contracted provider (Telecare) to explore the option of continued mental health services
- Connects to Peer Navigators to provide community linkages, information, education, and peer support
- If client is open to a mental health provider, CIP staff notifies clients' treatment team to ensure continuity of services
- Assists clients in establishing medication services (Golden Valley, Aspen medical) as needed

Warm Line:

This program is dedicated to answering all incoming calls to Stanislaus County BHRS 24/7. This program has provided support to the CERT team by providing peer support via telephone, face to face, and now with Peer Navigators, we are helping connect individuals and family members to our community.

- Warm line has answered 33,361 calls within this FY 15-16
- 56 calls were Emergent/Urgent calls
- 12,567 calls were Peer support calls
- 17,006 calls were for CERT
- 480 callers were referred to 800 Access team
- 3,252 calls taken were for individuals working at the office or hang up/wrong number

Peer Navigators:

This program offers supportive peer services to help individuals and family members get connected to specialty mental health services. In FY15/16, Peer Navigators received 718 referrals, 318 referrals from CERT and supported 170 individuals who accepted peer navigation support. Those 173 individuals were linked 2046 times to supportive services.

Peer Navigators provide but are not limited to the following services:

- Coordinating physician visits and other medical appointments
- Assist in signing up for benefits

- Providing education about medical conditions and recovery strategies
- Facilitation communication with health care provider
- Maintaining telephone contact between patient and healthcare
- Motivate and educate individuals and their family about the importance of preventative services
- Identifying and addressing barriers to healthcare for disparate populations
- Arranging or providing transportation to and from medical appointments
- Providing education to improve health literacy
- Assist with medication financing and management

CART (Community Activities & Rehabilitation Transportation):
CART provides rides to support the CERT team in transporting individuals to the CIP or other community agencies as requested. Drivers provide sensitivity, empathy, and a listening ear to help with fears and barriers to services.

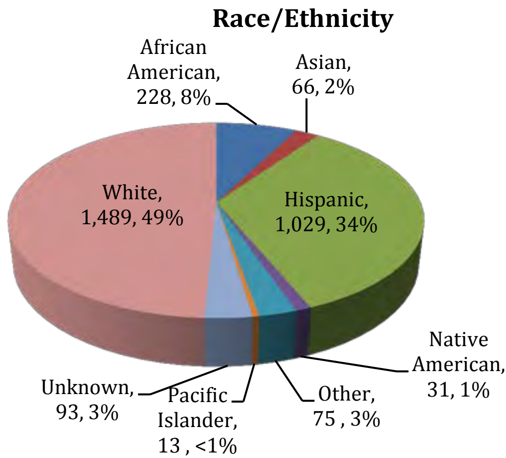
- CART began providing transportation in April of FY15-16
- CART has provided 172 rides from various local hospitals and locations
- 87 transported to Modesto
- 70 Transported to Ceres
- 1 Transported to Salida
- 9 transported to Turlock
- 2 transported to Empire
- 1 transported to Waterford
- 1 transported to Newman
- 1 transported to Riverbank

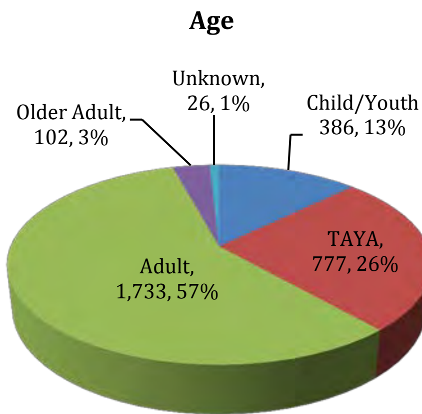
Challenges:

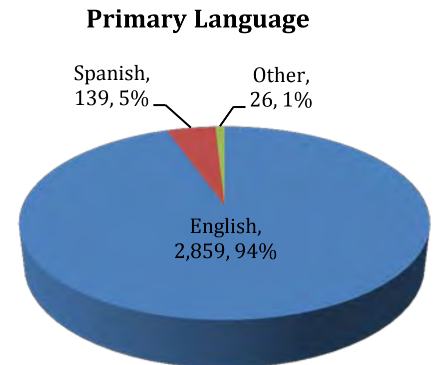
- The need for mental health crisis services has increased rapidly due to a variety of factors across all counties in California. CERT/Warm Line services are stretched to the limits of time and budget to provide 24/7 coverage that includes an immediate response to all who need crisis interventions and the needs of the Modesto Police Department.
- The CERT/Warm Line program has moved to a new location in Ceres. Public transportation is an issue. Connections to major transportation hubs are not nearby and cause difficulty to those who have medical issues.

CSS – Community Emergency Response Team & Warm Line
GSD- 02 FY 2015 - 2016

3,024 Individuals Served







Program Results for GSD Level of Care

How Much?

- 3,024 individuals were served (combined)
- 1.5 – average number of clinical services per individual (CERT)

How Well?

- 100.8% of annual target of individuals served was met (Target: 3000)
- 1 day – average length of GSD services (CERT)
- 100% (2/2) of surveyed individuals were satisfied with services* (CERT)
- 100% (2/2) of surveyed individuals said that “Staff believed I could change” (CERT)

Better Off?

- 50% (1/2) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems*
- 100% (2/2) of surveyed individuals indicated that as a results of services, they feel they belong to their community
- 100% (11/11) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, or decreased need for extensive and expensive services*

** Mental Health Statistics Improvement Program (MHSIP) Consumer Survey*

CSS – Families Together (GSD-04)

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

Program Description

This program provides mental health services to families in a one-stop shop experience. The Parent Partnership Project promotes collaboration between parents and mental health providers. Kinship Support provides services to caregivers, primarily grandparents raising grandchildren. The Family Partnership Mental Health Team provides mental health and psychiatric services and linkages to other programs.

Target Population

Families and caregivers who have children with Serious Emotional Disturbance (SED).

Services and Activities

Together, the Parent Partnership Project, Kinship Support Services, alongside the Family Partnership Mental Health Team, provides a wide variety of support services to meet the need of diverse families at the Family Partnership Center. Services include peer group and individual support, family education, guardian workshops, and help with navigating mental health, Juvenile Justice, and Child Welfare systems. Services include peer group support and help with navigating mental health, Juvenile Justice, and Child Welfare systems.

In FY 17-18, there are no proposed changes in the population to be served. The estimated number of individuals projected to be served is 80. The estimated number of individuals to be served in FY 18-19 and FY 19-20 will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2015-16

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$612,352	***$275,871***	***102***	***$2,705***

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$587,895	***$482,245***	***$627,380***	***$632,851***	***$638,377***

Highlights:

- Family Partnership Center Volunteer program: Implementation work began in FY 14-15 to develop the program which had been a long standing item on the centers advisory committee goal agenda.
- Formation of a Steering Committee with parents and caregivers to generate interest in volunteering and provide community outreach.

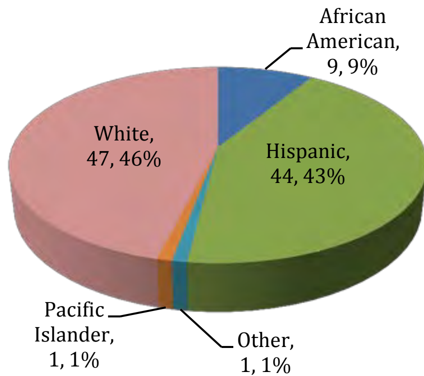
Challenges:

- Recruitment and hiring of individuals with appropriate lived experience.

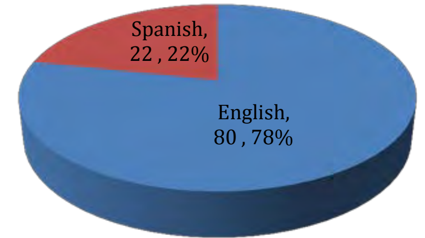
CSS – Families Together
GSD-04 FY 2015 - 2016

102 Individuals Served

Race/Ethnicity



Primary Language



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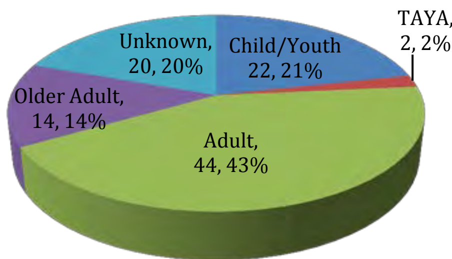


Program Results for GSD Level of Care

How Much?

- 102 individuals were served

How Well?

- 127.5% of annual target of individuals served was met (Target: 80*)*

Better Off?

- Staff has participated in orientations and trainings to provide support to families

CSS – The Consumer Empowerment Center (GSD- 05)

Operated by Turning Point Community Programs in the Behavioral Health and Recovery Services Consumer and Family Affairs System of Care

Program Description

The Consumer Empowerment Center (CEC) is a culturally diverse place where behavioral health consumers and family members gain peer support and recovery-mind input from others to reduce isolation, increase the ability to develop independence, and create linkages to mental health and substance abuse treatment services. It's a safe and friendly environment where they can flourish emotionally while developing skills.

Target Population

Transition Age Young Adults 18-25, Adults 26-59, and Older Adults 60+.

Services and Activities

CEC is 100% staffed by behavioral health consumers and family members. A culinary training program called "The Garden of Eat'n" is part of the center. This program provides an opportunity for people to learn 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 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.

In FY 16-17, there are no proposed changes in the population expected to be served or the strategies to be used. There are no expected changes in the contractual number of individuals that will be served, which is to be no less than 500 individuals. Currently, on average, 88 individuals receive services each month and it is estimated at that rate; 1,056 individuals will be served for the FY 16-17.

FY 2015-16

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$549,686	***$528,378***	***856***	***$617***

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$550,112	***$557,941***	***$509,377***	***$509,377***	***$509,377***

Highlights:

- Development of a "leaderful" group of members that have learned to advocate in community forums and encourage other consumers to share their lived experience alongside their modeling.
- Monthly Advisory Council meetings take place to focus on issues of importance and current community trends that affect consumers and their family members.
- Maintain community partnerships including the Stanislaus County Focus on Prevention Initiative.
- CEC members actively participate in community events, galleries, and panels to present their experiences and support other opportunities surrounding mental health and substance abuse.

- Members are active in local boards and committees and collaborate with service providers to enhance service knowledge and ease in navigating the mental health system.

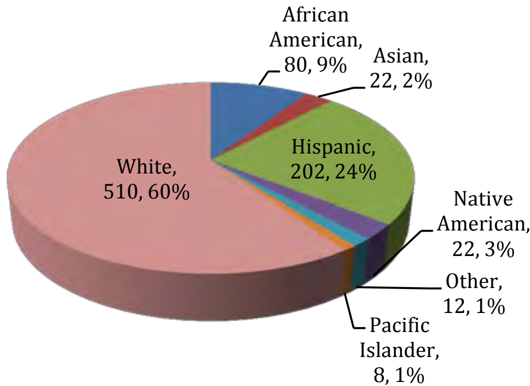
Challenges:

- Transportation continues to be a challenge as EC does not have a vehicle for transportation which limits participation from people outside Modesto.
- CEC relies heavily on fundraising efforts to help pay for activities and supplies as program funding is limited; CEC is a non-profit organization that accepts donations.
- As many members face cycles of homelessness due to their mental health instability, focusing on mental health needs vs housing needs can be difficult to separate.
- Limited services for the substance-use disorder community continues to present challenges in connecting individuals to treatment or establishing healthy relationships with others.
- In some response to California's Public Safety Realignment Act, an increase of individuals released from prisons and jails have presented their need to Mental Health services and support.
- Continue to offer education and combat stigma to the community and its service providers while appropriately representing our varying population's needs.
- Partnerships with community vendors that offer employment continues to be a limited resource for the population we serve.

CSS – The Consumer Empowerment Center
GSD-05 FY 2015 - 2016

856 Individuals Served

Race/Ethnicity



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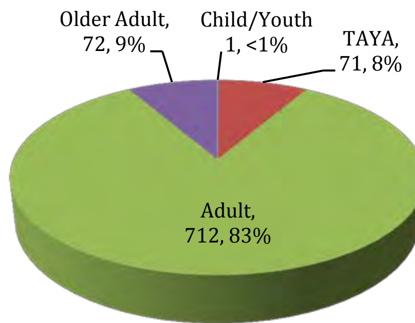
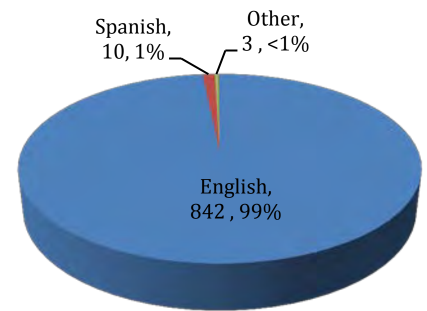


Primary Language



Program Results for GSD Level of Care

How Much?

- 856 individuals were served

How Well?

- 214% of annual target of individuals served was met (Target: 400*)*
- 92.6% (150/162) of surveyed individuals were satisfied with services*
- 89.17% (140/157) of surveyed individuals said that “Staff believed I could change”

Better Off?

- 77.78% (119/153) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems*
- 58.13% (93/160) of surveyed individuals indicated that as a result of services, they feel they belong to their community.
- 81.22% (735/905) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, or decreased need for extensive and expensive services*

** Mental Health Statistics Improvement Program (MHSIP) Consumer Survey*

CSS – Crisis Stabilization Unit (GSD- 06)
Operated by Behavioral Health and Recovery Services

Program Description

The Crisis Stabilization Unit (CSU) provides clinical and psychiatric services and more intensive levels of care, including the ability to provide medication. The CSU opened in February 2016 and is co-located with the county's Community Emergency Response Team known as CERT and its WarmLine. The CSU's goal is to focus on recovery-centered care and create an opportunity for each consumer to be treated in a less restrictive setting.

Target Population

Transition Age Young Adults 18-25, Adults 26-59, and Older Adults 60+.

Services and Activities

The CSU provides up to 23 hours of crisis stabilization services to provide mental health care to residents in crisis and keep them out of area hospitals. In addition, the facility provides group interventions as necessary. The CSU is a one-stop shop for people in crisis. CERT provides most of the county's crisis assessment services so having a CSU in the same building allows the CERT team to give a warm hand off to CSU staff, ensuring that interventions are seamless. The building is also home to Peer Navigators who help guide consumers through the mental health system and provide more follow-up and early intervention services.

The CSU was a Capital Facilities project funded through MHSA. The project is now funded under General System Development (GSD) dollars for operational costs. A total of 150 individuals were served in the first four months of providing services.

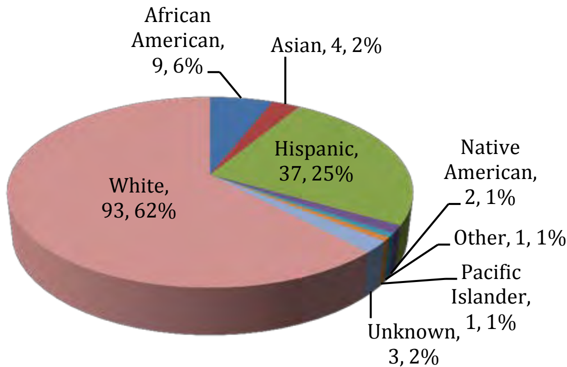
FY 2015-16

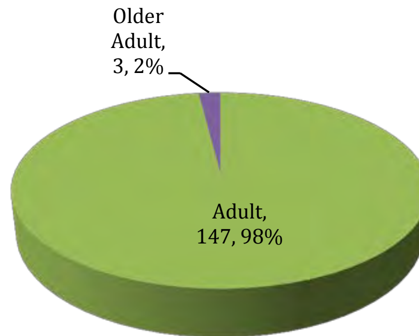
Total MHSA Budget	***Actual***	***Total Number Served***	***Estimated MHSA Cost Per Participant***
$1,164,000	***$316,692***	***150***	***$2,111***

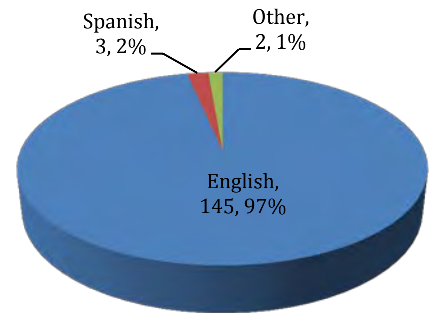
FY 16-17 Budgeted	***FY 16-17 Projected***	***FY 17-18 Projected***	***FY 18-19 Projected***	***FY 19-20 Projected***
$1,070,478	***$674,572***	***$1,088,450***	***$1,088,450***	***$1,088,450***

CSS – Crisis Stabilization Unit
GSD-06 FY 2015 - 2016

150 Individuals Served







Program Results for GSD Level of Care

How Much?

- 150 individuals were served
- 1.10 – average number of clinical services per individual

How Well?

- 135% of annual target of individuals served was met (Target: 110*)*
- 1.83 day – average length of GSD services

Better Off?

- 77.78% (119/153) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems*
- 58.13% (93/160) of surveyed individuals indicated that as a result of services, they feel they belong to their community*

** Mental Health Statistics Improvement Program (MHSIP) Consumer Survey*

CSS – Garden Gate Respite (O&E - 02)
Operated by Turning Point Community Programs

Program Description

Garden Gate Respite (GGR) is a residential based program that introduces individuals from unserved and underserved populations to mental health services through a welcoming and engaging environment in the context of a home-like setting. The 11-bed facility is open 24 hours a day, seven days a week, and 365 days a year. It provides each referred guest an individual "needs assessment" to facilitate access to mental health case management and other outreach/engagement services within the system of care.

Target Population

Transition Age Young Adults (age 18 minimum), Adults, and Older Adults from diverse and/or underserved populations who are either known or suspected to experience mental illness, and are either homeless or at risk of homelessness, at risk of incarceration, victimization, and/or psychiatric hospitalization.

Services and Activities

The program provides crisis intervention in basic needs (Food, Clothing, Shelter) and individual "Need Assessments" to facilitate targeted crisis intervention case management/support services and direct linkage to outreach and engagement services. The facility is situated in a residential neighborhood adjacent to the BHRS Housing First Transitional program apartment complex for which GGR provides limited ancillary support. Staff members of GGR represent diverse cultures, including individuals with lived experience as consumers or family members of mental health service consumers. Each guest at the program is offered 1:1 peer support, and groups that encourage leisure activities/stress reduction (i.e. Dual Recovery Anonymous, Arts & Crafts, Game Night, Movie Night, & Poetry Night).

It works closely with community partners who perform Case Management, Crisis Assessments, and other mental health services. Referrals are made by several groups including the Modesto Police Department, Community Emergency Response Team (BHRS-contracted service providers who perform crisis assessments), and Telecare Transition TRAC (BHRS-contracted outreach and engagement program providing time-limited case management to prevent hospitalization/re-hospitalization).

In FY 17-18, there are no proposed changes in the population to be served and strategies to be used. The estimated number of individuals projected to be served in FY 17-18 is expected to be more than the required 97, as FY 15-16 GGR served 348 unduplicated individuals. The estimated number of individuals to be served in FY 18-19 and FY 19-20 will be based on approved program targets, fiscal sustainability, and stakeholder input.

The following budget includes Supportive Housing Services (also O&E 2).

FY 2015-16

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$2,160,728	***$1,750,624***	***568***	***$3,082***

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$3,309,547	***$2,607,993***	***$3,608,919***	***$3,625,424***	***$3,642,093***

Highlights:

- Proactive and collaborative site-based case management & linkage, on-site presentations (NAMI), process support groups (Dual Recovery Anonymous-3 nights per week), and pro-social activities (Cooking, Games, Movies, Poetry, and Stress Reduction), Identification in immediate need assessments

in food, clothing, & long-term shelter through peer support/navigation, and result-based outcomes reporting arising from intensive data collection.

- Initiative to build program value in the community and create areas for new referrals and linkages through presentations, site tours, collaborative partnerships, and participating in local interest-based non-profit groups such as the Homeless Action Council, Stanislaus Housing and Supportive Services Collaborative, Faith Sector Homelessness Action Council, Housing Innovation Workgroup, Boots on the Ground homeless outreach, and other community stakeholders.
- Continue collaborations to support our continuing mission at Garden Gate Respite such that as guests stabilize, there will continue to be a reduction in their experience of homelessness, incarceration, psychiatric hospitalization, and community victimization.

Challenges:

- Challenges in scheduling trainings, staff meetings, maintaining 24/7 on site staffing, and developing an adequate number of trained staff members for a residential based 24/7 program.
- Changing community perceptions about our work; Educating external service providers who have become accustomed to a previous model of service delivery, or with new service providers who may believe we are a traditional crisis residential program providing treatment rather than a short term crisis intervention respite program that provides data-rich linkage services to local outreach & engagement programs.
- Gaps in service in areas such as family support (our community lacks transitional family housing), outpatient mental health and SUD assessments (often experiencing a 4-week wait for an assessment at SRC or BHRS services), and transportation (we have limited bus tickets and guests who may experience functional deficits which significantly impair their independent navigation in the community).
- Collaboration with new homeless outreach agencies to look for ways in which service partners can support each other and our program participants in the present, but also forward over the next 10 years, across sectors and public-private partnerships.

CSS – Supportive Housing Services (O&E - 02)

Program Description

This program provides supportive housing and housing services to homeless and mentally ill residents of Stanislaus County. An integral part of Supportive Housing Services is community partnerships. BHRS partners with the Stanislaus County Housing Authority, city of Modesto, and Stanislaus County Affordable Housing Corporation (STANCO) to provide housing to this population. Another important partner is the California Department of Rehabilitation.

Target Population

Transition Age Young Adults (TAYA) 16-25, Adults 26-59, and Older Adults 60+.

Services and Activities

Supportive Housing Services include Garden Gate Respite, Intensive Transitional Housing, Vine Street Emergency Housing, and Supportive Housing Services/Transitional Board and Care. The program includes Transitional Housing, Permanent Housing, and outreach and employment opportunities for homeless and mentally ill residents of Stanislaus County.

In FY 15-16, a total of 568 individuals (combined and unduplicated) were served through this Outreach and Engagement program (347 Garden Gate Respite; 184 Housing; and 93 Employment). The estimated number of individuals to be served in FY 18-19 and FY 19-20 will be based on approved program targets, fiscal sustainability, and stakeholder input.

Highlights:

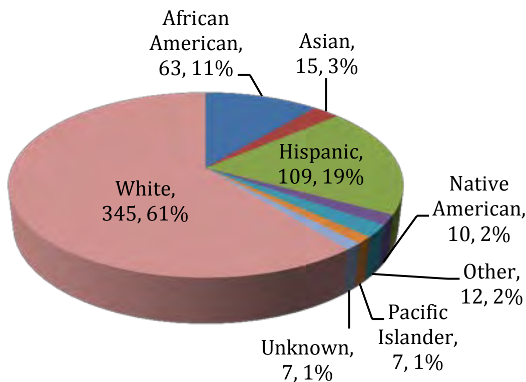
- Supportive Housing Services/Transitional Board and Care contract awarded to Turner Residential, Inc.
- A Permanent Supportive Housing and Community Resource Center Project was approved by the Stanislaus County Board of Supervisors on September 29, 2015/Use of $490,000 of the county's California Housing Finance Agency funds.
- Granger Avenue project is a partnership with the city of Modesto, STANCO, and Community Transitional Resources, a local non-profit organization.

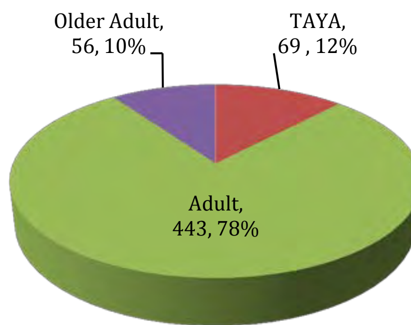
Challenges:

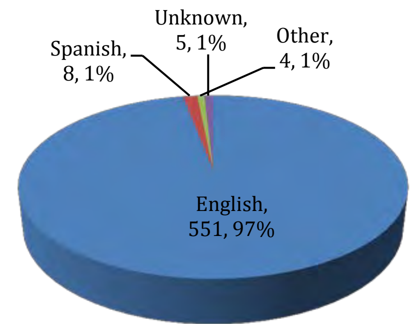
- Lack of funding designated for affordable housing continues to be a challenge.
- Housing funds have strict program rules and limited flexibility; this can cause barriers to medium and small counties that have limited resources.
- Staffing a growing Housing and Support program.

CSS – Garden Gate Respite Center and Supportive Housing Services
O&E - 02 FY 2015 - 2016

568 Individuals Served







Program Results for O&E Level of Care

How Much?

- 568 individuals were served (347 for Garden Gate; 184 for Housing; 93 for Employment)
- 0.06 – average number of clinical services per individual (0.06 from Housing; 0.06 from Employment)
- 0.01 – average number of support services per individual (Housing)

How Well?

- 308.69% of annual target of individuals served was met (Target: 184; 96 Garden Gate, 88 Housing & Employment*)*
- 3.08 days – average length of O&E services (4.33 for Garden Gate; 1079.06 for Housing; 396.34 for Employment)
- 95.46% (42/44) of surveyed individuals were satisfied with services*
- 93.02% (40/43) of surveyed individuals said that "Staff believed I could change"

Better Off?

- 86.05% (37/43) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems*
- 80.49% (33/41) of surveyed individuals indicated that as a result of services, they feel they belong to their community.
- 88.33% (227/257) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, or decreased need for extensive and expensive services*

** Mental Health Statistics Improvement Program (MHSIP) Consumer Survey*

CSS – Rural Access and Assessment (O&E-03)

Operated on Contract to Telecare Corporation within the Behavioral Health and Recovery Services Adult System of Care

Program Description

Program provides brief counseling intervention and engagement services that actively seek out, engage, assess, and refer individuals with serious mental illness to appropriate service providers and community supports within rural communities of Stanislaus County.

Target Population

- Underserved community members; Adult clients (26-59) who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services, but are not provided the necessary or appropriate opportunities to support their recovery, wellness, and/or resilience.
- Adult individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services.
- Adult individuals who may have had only emergency or crisis oriented contacts and/or services from the county may also be considered unserved.

Services and Activities

Services include brief counseling, behavioral health screening/assessment, referrals to BHRS and community partners, peer support group facilitation and transportation that help individuals engage and access services or peer/community supports. Through promotion and outreach, the program team designs and implements activities to inform the wider community about behavioral issues, services, and community support.

In FY 17-18, there are no proposed changes in the population to be served. The estimated number of individuals to be served in FY 18-19 and FY 19- 20 will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2015-16

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$140,000	***$139,218***	***695***	***$200***

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$140,000	***$138,809***	***$140,000***	***$140,000***	***$140,000***

Highlights:

- Program provided services including case management and screening/assessments to individuals living in rural communities of Patterson, Newman, Denair, Hickman and Waterford.
- Program has two Spanish speaking staff that assisted individuals in their primary language of Spanish
- Program linked individuals with mental health and SUD services.
- Development of a “leaderful” group of members that have learned to advocate in community forums and encourage other consumers to share their lived experience alongside their modeling.

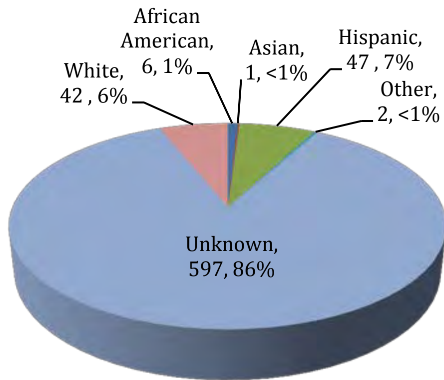
Challenges:

- Scarcity of mental health services/resources in rural communities and for uninsured individuals
- Limited free resources for individuals needing mild to moderate level of care.
- Cultural concerns in individual counseling and support groups focusing on mental health were identified as a barrier for individuals seeking mental health treatment.
- For homeless individuals, the lack of resources to leave their belongings or pets was a challenge to obtaining treatment.

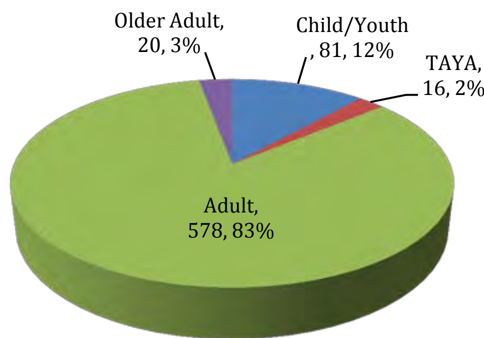
CSS – Rural Access and Assessment
O&E-03 FY 2015 - 2016

695 Individuals Served

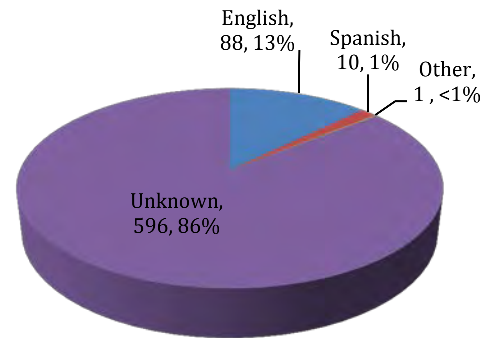
Race/Ethnicity



Age



Primary Language



Program Results for O&E Level of Care

How Much?

- 695 individuals were served
- 0.01 – average number of clinical services per individual

How Well?

- 631.82% of annual target of individuals served was met (Target: 110)
- 88.4% (40/43) of surveyed individuals said that “Staff believed I could change”

Better Off?

- 76.2% of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems*
- 60.9% of surveyed individuals indicated that as a result of services, they feel they belong to their community.

** Mental Health Statistics Improvement Program (MHSIP) Consumer Survey*

PREVENTION EARLY INTERVENTION (PEI)

PEI programs are restructuring the mental health system in Stanislaus County to embrace a "help first" paradigm in partnership with the community. The aim is to promote prevention and early intervention. It's the second largest component of MHSA and represents 20% of MHSA funding.

The programs are designed to prevent mental illness from becoming severe and disabling by recognizing the early signs and symptoms, and improving access to services and programs. With the help of diverse groups and neighborhood based organizations, residents learn how to support each other. This strengthens the capacity of communities to reduce the stigma and discrimination of mental illness, and develop and/or strengthen protective factors.

As noted in the FY 15-16 Annual Update, BHRS revisited its PEI Plan and began the process of revising it to be in alignment with proposed PEI statewide regulations and to address anticipated MHSA future growth funding.

The proposed changes included a PEI structure redesign that focused on coordinated and consistent program results and outcomes to strengthen all MHSA PEI programs. The restructuring plan also included changes on how programs report data.

There were also changes to existing programs to better serve the needs of those at risk of or with mental illness in Stanislaus County. On February 27, 2015, the BHRS Leadership Team presented the PEI Restructuring plan to the MHSA Representative Stakeholder Committee and it was approved by stakeholders.

The following illustrates how PEI programs will be structured and categorized in the new PEI redesign and presented in this FY17-18 Annual Update:

- Prevention
- Early Intervention Programs
- Outreach Programs for Increasing Recognition of Early Signs of Mental Illness
- Stigma Discrimination Reduction Programs
- Suicide Prevention Programs

Previous Structure	2015/2016 Revised Structure
• Community Capacity Building • Emotional Wellness Behavioral Health Education/Community Support • Childhood Adverse Experience Intervention • Child and Youth Resiliency and Development • Adult Resiliency and Social Connectedness • Older Adult Resiliency and Social Connectedness • Health-Behavioral Health Integration • School-Behavioral Health Integration	• CalMHSA Statewide Initiative • Prevention Programs • Early Intervention Programs • Outreach Programs for Increasing Recognition of Early Signs of Mental Illness • Stigma Discrimination Reduction Programs • Suicide Prevention Programs

Stanislaus County has six (6) PEI categories that include eighteen (18) overall program areas. Many have more than one contracted agency to implement the program in communities across Stanislaus County that result in 39 programs across the county. Each 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 service experience.

PEI Budget

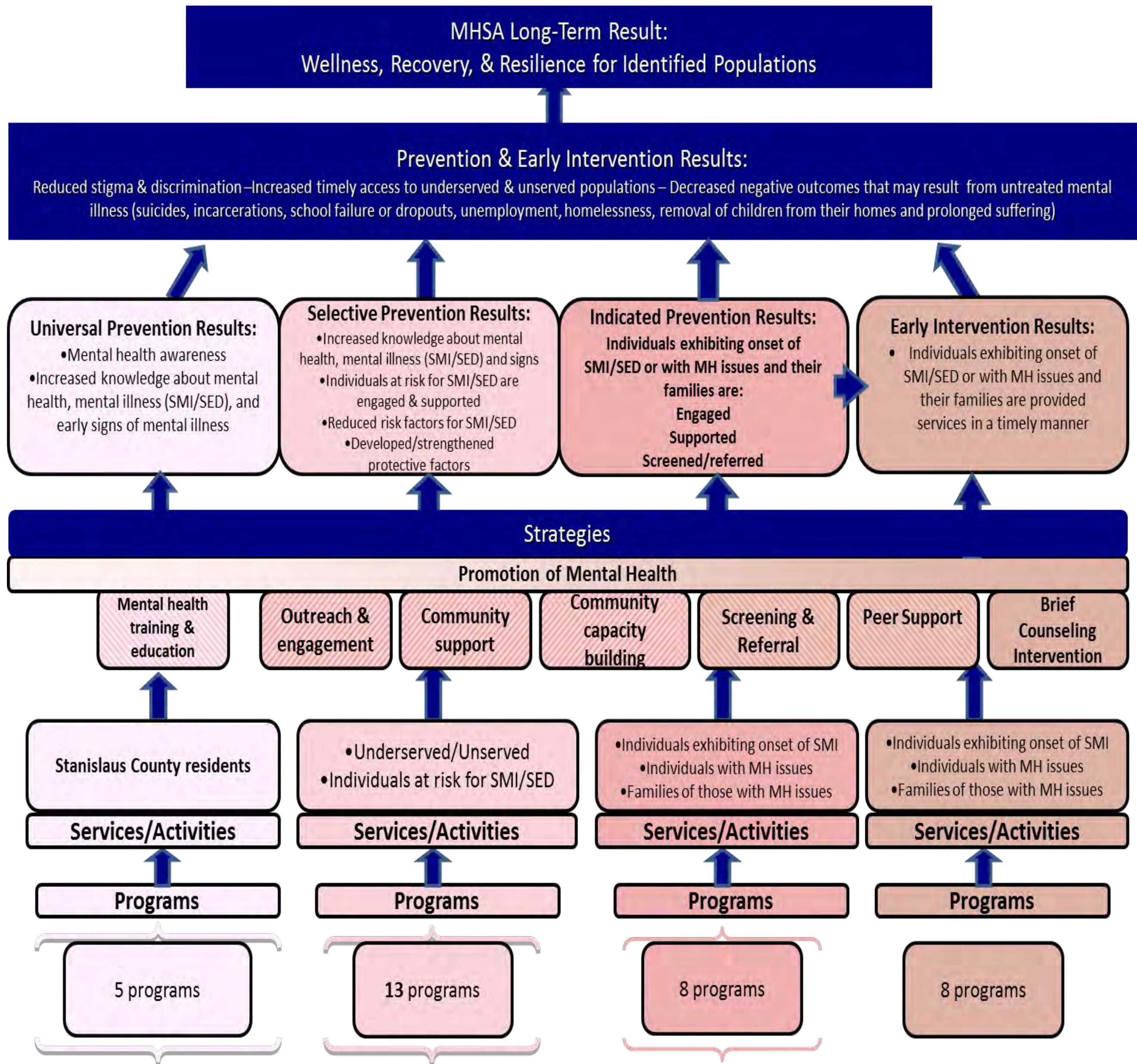
FY 2015-16

Total MHSA Budget	***Actual***	***Total Number Served***	***Estimated MHSA Cost Per Participant***
$5,572,528	***$4,490,262***	***68,772***	***$65***

*Not unique count due to some types of services (outreach, presentations, trainings, etc.)

FY 16-17 Budgeted	***FY 16-17 Projected***	***FY 17-18 Projected***	***FY 18-19 Projected***	***FY 19-20 Projected***
$5,263,610	***$4,942,010***	***$4,980,596***	***$4,976,860***	***$4,994,700***

Theory of Change



Note: Since there is an overlap of strategies within programs, the total program sum does not equal 18.

Early Intervention Programs

Program Description

Early Intervention programs provide treatment and other services and interventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence. The services can include relapse prevention and outcomes encompass the applicable negative outcomes that may result from untreated mental illness such as suicide, incarcerations, school failure or dropout, unemployment, homelessness, and removal of children from their homes.

Early Intervention Programs:

- **Aging and Veteran Services - Older Adult Services** *(adults and older adults, age 60+, including Spanish speaking)
- **Catholic Charities – Brief Counseling Intervention** *(adults and older adults, age 60+, including Spanish speaking)
- **El Concilio – Brief Counseling Intervention** *(adults and older adults, age 60+, including Latino and Spanish speaking)
- **Golden Valley Health Center – Brief Counseling Intervention**
  - Integrated Behavioral Health *(adults and older adults, age 60+, including Spanish speaking)
  - Corner of Hope *(homeless adults and older adults, age 60+, including Spanish speaking)
- **Parents United- Child Sexual Abuse Treatment Services** *(trauma exposed individuals, adults sexually abused as children, and sexual abuse offenders, including Latino and Spanish-speaking)
- **Sierra Vista Child and Family Services - LIFE Path, Early Psychosis** *(youth and TAYA exhibiting signs of early psychosis and potential responders)
- **School Behavioral Health Integration**
  - Center for Human Services - Resiliency and Prevention Program (RaPP) *(youth and potential responders in underserved Modesto schools, including Spanish-speaking)
  - Sierra Vista Child and Family Services - Creating Lasting Student Success (C.La.S.S) *(youth and potential responders in underserved Modesto schools, including Spanish-speaking)
  - BHRS - School Based Services, School Consultation *(youth and potential responders in underserved schools, including Spanish-speaking)
  - BHRS - Aggression Replacement Training (ART) *(youth and TAYA, including Spanish-speaking)
- **West Modesto King Kennedy Center – Brief Counseling Intervention** *(adults and older adults, age 60+, including Spanish speaking)

Target Population

All Early Intervention programs target Stanislaus County's underserved/unserved populations in the following categories:

- Individuals at-risk or exhibiting onset of serious mental inllness
- Individuals displaying mental illness early in its emergence
- Families of individuals in the above populations

Some Early Intervention programs target specific age, cultural, and geographic communities within the underserved/unserved populations as specified above by programs with asterisks.

Services and Activities

Early Intervention services do not exceed 18 months, with the exception of first onset of SMI/SED with psychotic features (4 years). Early Intervention can also include services to parents, caregivers, and other family members of the person with early onset of a mental illness. In addition, all Early Intervention programs are designed and implemented to help create access and linkage to treatment and improve timely access to mental health services for individuals and families from underserved populations when appropriate. Services are provided in convenient, accessible, and culturally appropriate settings using strategies that are non-stigmatizing and non-discriminatory.

One of the primary services in all of the Stanislaus County Early Intervention programs is Brief Counseling Intervention (BCI). Brief Counseling Intervention is short duration and low intensity, and can be provided via individual sessions or group sessions. Collateral services to parents or other family members may also be part of BCI.

Outreach, engagement, and access and linkage activities are also integrated into Early Intervention programs to increase the effectiveness of the services.

FY 2015-16

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$2,689,651	***$2,144,365***	***1,686****	***$1,272***

*Unduplicated served

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$2,477,069	***$2,443,785***	***$2,455,420***	***$2,459,978***	***$2,464,582***

Highlights for Early Intervention

- Stigma Reduction presentations
  - Partnering programs who are providing early intervention brief counseling services had requested to also provide a level of prevention services to the community which included stigma reduction presentations. Partners have now reported that providing such presentations has served to support family members who are providing peer support to individuals who are receiving brief counseling intervention services.

- Access and Linkages
  - Parents of children receiving mental health services at school sites have reported to benefit from BCI support as a way to support the overall wellbeing of families. Specifically, with regard to access and linkage to other formal and "non- formal" support services. BCI service providers have begun to screen parents for mental health support and have found that an overwhelming number of them do not require clinical services but in fact are benefiting from lower level of support services such as parenting support/skill classes, community supports and broader community resources they weren't originally aware of.
  - Brief Counseling Intervention Services have been well received by community at six (6) church sites throughout Stanislaus County.

Challenges for Early Intervention

- Timely Access to Services for Underserved Populations
  - Partners have shared there is constant difficulty of employing and/or retaining full-time bilingual counselors who can provide services to those in the threshold language of the community.
  - Ongoing requests of 1-1 psychiatric support/time are a constant request from the community to BIC partners.
  - A local mental health clinician shared that the lack of psychiatry services within Stanislaus
  - County means that clients have to be put on a 5150 or present at the emergency room for psychiatric support.
  - Currently there is a low utilization of BCI services for the hard-to-reach homeless population. The current service location/model may not be near enough adequate to reflects the needs or demands necessary to reach the homeless population. A variety of alternate strategies are being explored to successfully reach the target population.
- Stigma Reduction/Culturally appropriate practices
  - Partners have shared that providing culturally appropriate support for African-American populations is crucial. African-American clients participating in BIC services have expressed to typically receive mental health and emotional support from their faith communities/elders and this year this particular community had a slight increase in African American community members who utilized BIC services, specifically when agency programs employed an African-American counselor.

Prevention Programs

Program Description

Prevention programs provide a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of prevention programs is to bring about mental health including reduction of the applicable negative outcomes as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is significantly greater than average and, as applicable, their parents, caregivers, and other family members.

Prevention Programs:

- **NAMI – Training and Education** *(culturally diverse communities and potential responders)
- **Peer Recovery Art Project – Adult & Social Connectedness**
- **RAIZ Promotoras Program** *(Latino community in each of the dedicated cities/regions)
    - AspiraNet – Turlock
    - Center for Human Services – Ceres, Newman, Patterson
    - Oak Valley Hospital District – Oakdale
    - Riverbank Unified School District – Riverbank
    - Sierra Vista Child and Family Services – North Modesto/Salida, Hughson/Waterford/Denair/Empire/Hickman
    - West Modesto King Kennedy Center – West Modesto
- **Stanislaus County Office of Education – Training and Education** *(potential responders)
- **Youth Leadership Initiative**
    - Center for Human Services – My Life Plan *(at-risk youth and TAYA in Ptterson, Wesley, Grayson areas)
    - Sierra Vista Child and Family Services – The BRIDGE *(at-risk South East Asian youth and TAYA in West Modesto area)
    - Sierra Vista Child and Family Services – Hughson Youth Leadership *(at-risk youth and TAYA in greater Hughson Unified School District area)
    - BHRS – South Modesto Youth Leadership *(at-risk youth and TAYA in South Modesto area, including Spanish-speaking)
    - West Modesto King Kennedy Center – Leadership for the Future *(at-risk youth and TAYA in West Modesto area, including Spanish-speaking)
- **BHRS – Friends are Good Medicine**
- **BHRS – Prevention Community Trainings**
    - Mental Health First Aid
    - ASIST (Applied Suicide Intervention Skills Training)

Target Population

All prevention programs target Stanislaus County's underserved/unserved populations in the following categories:

- Individuals at-risk or exhibiting onset of serious mental inllness
- Individuals displaying mental illness early in its emergence
- Families of individuals in the above populations

Some Prevention programs target specific age, cultural, and geographic communities within the underserved/unserved populations as specified above by programs with asterisks.

Services and Activities

Prevention programs provide services that reduce risk factors and increase protective factors. These services include one-to-one support, screenings, referral and behavioral health navigation assistance, presentations, trainings, and other engagement and outreach activities. Like early intervention programs, all prevention programs are designed and implemented to help create access and linkage to treatment and improve timely access to mental health services for individuals and families from underserved populations when appropriate. Services are provided in convenient, accessible, and culturally appropriate settings using strategies that are non-stigmatizing and non-discriminatory.

FY 2015-16

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$1,394,279	***$1,094,983***	***3,037****	***$361***

*Unduplicated served

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$1,420,236	***$1,364,204***	***$1,277,214***	***$1,281,265***	***$1,285,357***

Highlights for Prevention

- The ***RAIZ Promotora Mental Health Prevention Program*** continued to have a strong presence within the Spanish speaking communities of 9 cities throughout Stanislaus County with 123 community promotores who organized mental helath awareness and well-being activities throughout the county.

  - 68 community-wide events were organized by community promotores.
  - 35 community promotores lead and/or co-facilitated mental health well-being groups in 9 regions of Stanislaus County.
  - Many individuals engaged through the networks of promotores for MH prevention are now engaged in ESL classes, GED classes, and others have obtained employment.

- ***NAMI*** has had success in reaching school populations that were difficult to reach in previous years. The program has now experienced requests from communities and schools asking the program to return and/or recieving refferals to other school sites.

- ***Peer Recovery Art Project** has* created a great welcoming peer-based environment that provides a place for all participants to engage in a local and strong peer-based movement where individuals with lived experience can utilize their personal gifts and talents in a positive and effective way. For some, using their lived experience with mental health has allowed participants to provide support and/or receive support from other peers. Many expresses that entering this program helps them feel valued and encouraged to participate in positive peer based community efforts.

- ***Stanislaus County Office of Education*** has experienced strong growth in collaborations with K-12, Community College and University partnerships. Creative ideas have been developed to engage the different student/family populations to reduce stigma and discrimination when mental health and well-being is addressed on their campuses.

- ***Youth Leadership and Resiliency Programs*** have dedicated time to find strategies that include dialogue opportunities in the areas of mental health and suicide awareness and prevention. Adults that directly support the youth programs have worked alongside youth to present material and information that is relevant and of interest to the community they practice and/or live in. Programs have invited other adults from the community, as guest speakers, and they have offered information, resources and served as additional adult support for youth within these groups. Programs have incorporated activities that are tailored to engaging youth to first-hand experience factors that improve mental health and decrease risk factors for the onset of mental health issues. Some examples include: creating care packets and then disseminated to community members, visiting the Golden Gate Bridge and having a discussion on the signs of suicide and how to reach out for support, engaging with other community members in neighborhood beautification projects. Additional highlights include:

    - Intentional discussions and activities focused on addressing mental health, suicide prevention and emotional wellbeing
    - Developing and strengthening supports with adults and systems.
    - Activities that promote resiliency builders; strengthened positive relationships, encouraging view of personal future, increased confidence and self-worth and meaningful opportunities to serve in their community.

- The ***Resiliency and Prevention Program (RaPP)*** established community connectedness within classrooms and the broader school system. Strategies include the development and strengthening of peer and student/teacher relationships, establishing the classroom as a natural system of support. This results in increased levels of engagement of both students and staff. It also results in increased engagement and connection to school community (for both students and staff).

Challenges for Prevention

- The ***RAIZ Promotora Mental Health Prevention Program*** experienced some challenges regarding linkage and referrals and access.
    - Possible stigma and fear of discrimination from family members realizing that individuals are in need of mental health professional services continues to be a barrier expressed by the Spanish speaking communities. Therefore, individuals continue to be hesitant of following through with mental health referrals made by a Promotora(s).
    - The fear of losing rights over family and/or children if individuals participate in mental health services continues to be another challenge related to linkage and referrals.
    - Participants continue to express that language is a barrier when attempting to navigate formal systems.
    - Participants have shared time duration from initially requesting services to first appointment averages 2 weeks. The Latino community has expressed the need to find other alternatives to dealing/coping with their issues when this this wait time is experienced.
    - 5 out of the 9 cities are mainly rural communities. Space available to hold large groups or large events is a challenge in these rural cities. Uses of open public spaces like parks are available to use except during winter months. Partnerships with local parishes/churches during winter months have been supportive.
    - Seasonal work in agriculture and food packaging/processing reduces attendance to groups – many promotores work in these industries.

- ***NAMI*** is challenged with the continued need for bilingual English/Spanish presenters. Additionally, engaging with the underserved Spanish-speaking population has been a goal of the program and

hopes to see a higher engagement in the next year. Lastly, retaining NAMI volunteers and speakers for a long periods of time is an ongoing challenge and therefore is constantly facing transition.

- ***Stanislaus County Office of Education*** has been challenged withengaging the academic lay population within the K-12 system to learn about Mental Health First Aid. Each time the program offers the training, each campus sends their clinicians but not broader staff and administration as was the original focused population.

- ***Youth Leadership and Resiliency Prevention Programs*** have found that, while youth from these programs have outlets and supports for discussing and learning about mental health awareness, when referrals are offered for either youth or their families, the stigma that is associated with reaching out to formalized levels of support is very evident. When youth have established relationships with the adult support of their program they are more open to sharing information and seeking resources they can connect with. With any level of turn-over the establishing of the relationship takes time, which in turn affects how likely individuals are to reach out when in need of additional support. Another area that frequently is voiced by youth participants is that families often times speak of mental health challenges with shame, predominately with ethnic culturally diverse groups (Latino, African-American, and South East Asian).

- ***RaPP*** takes place during the school day/instructional time, so finding time during the instructional day for the program becomes increasingly difficult (especially in classrooms where there are numerous transitions based on English Language Learner curriculum/adaptations, etc). When circle time (RaPP) and wellbeing discussion lead to students seeking peer/teacher support, this can extend beyond the allocated time, either requiring the time to continue and interfere with instructional time or bringing the classroom discussion for support to a close and find alternative individualized levels of support for the student sharing.

Outreach Programs for Increasing Recognition of Early Signs of Mental Illness
Stigma and Discrimination Reduction Programs
Suicide Prevention Programs
Statewide Initiative - CalMHSA

Program Description

The PEI programs in these four categories are overlapping, and are also addressed by multiple programs categorized as Early Intervention and Prevention.

- Programs and strategies focused on ***outreach for increasing recognition of early signs of mental illness*** utilize ***Outreach,*** which is a process of engaging, encouraging, educating, and/or training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness.
- ***Stigma and discrimination reduction programs*** encompass the direct activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or to seeking mental health services and to increase acceptance, dignity, inclusion, and equity for individuals with mental illness, and members of their families.
- ***Suicide prevention programs*** are those that organize activities to prevent suicide as a consequence of mental illness. This category of programs does not focus on or have intended outcomes for specific individuals at risk of or with serious mental illness.
- The ***statewide initiative*** is a contribution to CalMHSA, the statewide organization that provides support and liaison activities across counties.

Outreach Programs for Increasing Recognition of Early Signs of Mental Illness

- Each Mind Matters Campaign/Know The Signs
- Gallo Center for the Arts Stigma Reduction
- Imagen, LLC – Mental Health Promotion Campaign

Stigma Discrimination Reduction Programs

- Each Mind Matters Campaign/Know the Signs
- Imagen, LLC – Mental Health Promotion Campaign

Statewide Initiative

- CalMHSA Contribution

Suicide Prevention Programs

- Each Mind Matters Campaign/Know the Signs
- Imagen, LLC – Mental Health Promotion Campaign
- Kingsview – Central Valley Suicide Prevention Hotline *(individuals with suicidal ideation or at-risk)

Target Population

All PEI programs target Stanislaus County's underserved/unserved populations in the following categories:

- Individuals at-risk or exhibiting onset of serious mental inllness
- Individuals displaying mental illness early in its emergence
- Families of individuals in the above populations

Some PEI programs target specific age, cultural, and geographic communities within the underserved/unserved populations as specified above by programs with asterisks.

Services and Activities

- Outreach includes such activities as presentations, trainings, and events that encourage, educate, or train individuals and potential responders about ways to recognize and respond effectively to early signs of mental illness. Outreach services are provided throughout all PEI programs at varying degrees.

- PEI staff and contracted partners are trainers for the following trainings that are provided free of cost to the community and targeted populations across the county:
  - Mental Health First Aid (MHFA)
  - Youth Mental Health First Aid
  - Applied Suicide Intervention Skills Trainings (ASIST)
  - NAMI Provider Education Course
  - Toward Effective Self Help Group Facilitator training

- PEI also provides staff support to several cross-cultural community-based collaboratives/partnerships that help promote emotional health and wellbeing by decreasing stigma, disparities, and barriers to mental health resources. The collaboratives include the Assyrian Wellness Collaborative, Stanislaus Asian American Community Resource (SAACR), and Lesbian Gay Bisexual Transgender Questioning Ally (LGBTQA) collaborative.

- Stigma and discrimination reduction activities also include presentations, trainings, and events, and also include marketing campaigns, speakers' bureaus, and efforts to encourage self-acceptance for individuals with a mental illness. All PEI programs integrate one or more of these activities in their program delivery.

- A primary suicide prevention service offered through PEI is the suicide hotline provided by the Central Valley Suicide Prevention Hotline (CVSPH). CVSPH is nationally accredited by the American Association of Suicidology and operates the hotline 24 hours a day, 7 days a week, ensuring that our county residents have access to suicide prevention support and emergency services when appropriate.

- Other suicide prevention activities include campaigns, training, and education focused on suicide information and prevention.

- CalMHSA provides support in the areas of suicide prevention and stigma and discrimination reduction, and also is the fiscal agent for CVSPH.

FY 2015-16

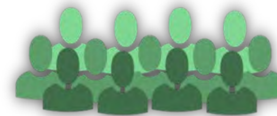
Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$452,782	***$350,148***	***64,049****	***$5***

*Not unique count due to type of services (outreach, presentations, trainings, etc.)

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$381,453	***$287,775***	***$223,843***	***$245,680***	***$245,917***

Highlights

- 445 BHRS and partner staff attended trainings focused on stigma and discrimination reduction or suicide prevention
    - 330 trained in Mental Health First Aid
    - 74 trained in Applied Suicide Intervention Skills Training
    - 20 attended NAMI Provider Education Course
    - 21 trained as Self-Help Group Facilitators



- ***The Mental Health Promotion Campaign (Imagen, LLC)*** has taken the state suicide prevention video message, know the Signs/Reconozca Las Señales, and saturated it throughout all major movie theaters in Stanislaus County during high viewing population attendance. Additionally, this campaign was able to secure prime time radio stations ad cycles in both English and Spanish. The campaign provides updates to a county-wide mental health support directory twice a year. This directory is also updated on a separate website from the county where the community can access all prevention county service information.

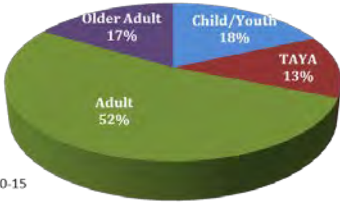
Challenges

- It has been difficult to engage contracted partners to share information about their programs on a more frequent basis. Continued attempts are made to encourage partners to engage in this effort to increase campaign awareness as well as prevention services available to the community.

Prevention and Early Intervention (PEI)
FY 2015-2016

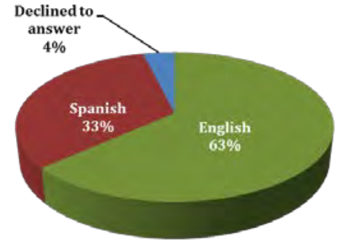
4,549 Individuals Served
(Unduplicated)

Age*

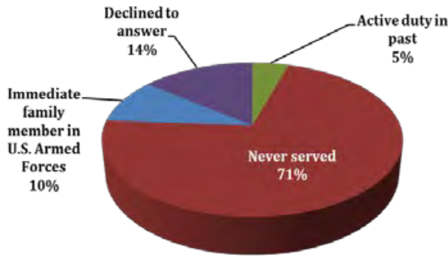


*
Child/Youth: 0-15
TAYA: 16-25
Adult: 26-59
Older Adult: 60+

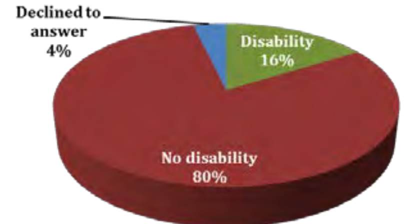
Primary Language



Military Service

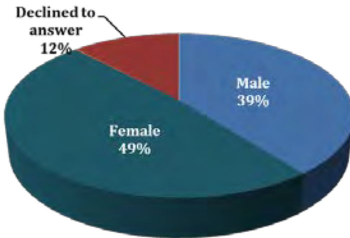


Disability*



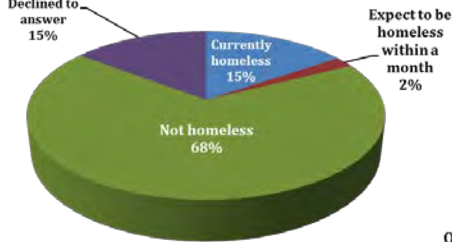
*Defined as a physical or mental impairment or chronic medical condition (not a result of SMI)

Current Gender

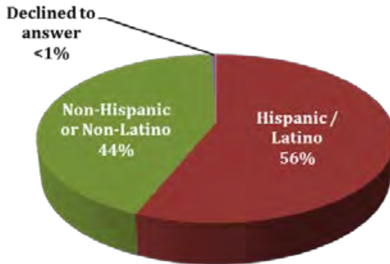


*Transgender, Genderqueer, Questioning/Unsure, and Another Gender Identity are together <1%

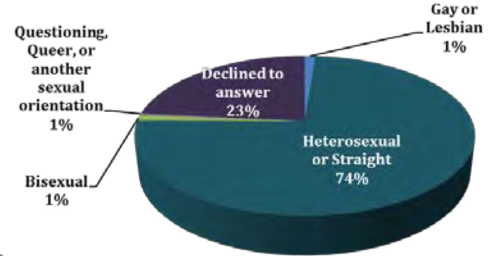
Homelessness



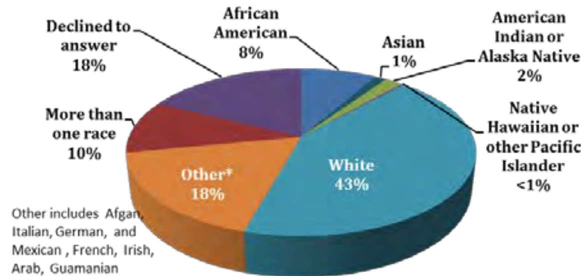
Ethnicity



Sexual Orientation



Race



Other includes Afgan, Italian, German, and Mexican , French, Irish, Arab, Guamanian

Demographic percentages are based on n=2,877 due to missing demographic information.

Program Results for PEI Programs

How Much?

- 1,686 – unduplicated individuals who received Brief Counseling Intervention services
- 3,037 – unduplicated individuals engaged in prevention services
- 834 – potential responders* trained to recognize and respond effectively to early signs of mental illness
- 484 – engagements with family members
- 20,579 – services provided**
- 232 – referrals provided***
- 1,968 – number trained in stigma and discrimination reduction, suicide prevention, or recognizing mental illness

*includes families, employers, school personnel/teachers, leaders of faith-based organizations

**includes screenings, support, peer and volunteer development, brief counseling, groups, and other engagement

***includes referrals to treatment, community-based programs, and other prevention and early intervention programs

How Well?

- 72% of the unduplicated individuals served were at risk of developing a mental illness
- 14% of the unduplicated individuals served displayed early onset of mental illness
- 19% of the individual services were brief counseling intervention
- 38% of the services were groups that engaged at-risk individuals
- 26% of the referrals resulted in a successful linkage
- 4.6 – average number of brief counseling intervention services per participant
- 5.9 – average number of total services per participant
- 96% of all services were provided in the community* while just 4% were in an office

*includes homes, schools, places of worship, community-based organizations, and Family Resource Centers

Better Off?

The ultimate goal of PEI is to increase wellness, recovery, and resilience through various strategies, services, and activities that decrease risk factors and increase protective factors which serve to reduce or buffer risk factors. The Stanislaus County BHRS/PEI Wellbeing Survey was developed to measure wellbeing across PEI program and event participants. The majority of PEI programs (30) administered the survey in FY15-16, resulting in 3,342 surveys completed by 2,841 individuals.

FY2015-2016 Wellbeing Survey Results

Relationships, Community, Connection, and Support (protective factors)

- 73% of respondents agreed or strongly agreed that they support each other
- 70% felt they offered support to other community members
- 73% agreed or strongly agreed that they acted together to make positive change
- 80% reported they had someone to talk to when they needed support

Engagement, Involvement and Spirituality (protective factors)

- 80% participated in one or more faith/spiritual events within the past 3 months
- 66% volunteered at a local service organization
- 77% attended a meeting or event at school
- 79% tried something new or challenging within the week
- 90% exercised within the week

Isolation (Risk Factor)

- 91% socialized with people outside of their homes
- 90% have relatives or friends they can count on if they need them

Meaning and Accomplishment (protective factors)

- 86% reported a high level of agreement that they have goals or plans for the future
- 80% feel valued by others
- 79% feel that most days they have a sense of accomplishment

Involvement in PEI programs made a difference

- Because of their involvement in a PEI program:
    - 73% know how to talk to others about important things
    - 73% did things they didn't think they could do
    - 83% of those participating 2 or more years now know how to ask for help compared to 55% of those who had participated for less than one month, illustrating how program involvement correlates with the degree to which participants know how to ask for help
    - 80% have meaningful relationships, suggesting that program involvement increases support and decreases social isolation

WORKFORCE EDUCATION & TRAINING (WE&T)

The Workforce Education and Training (WE&T) component of MHSA provides funding to help improve and build the capacity of the mental health workforce. It is designed to help counties develop and maintain a competent and diverse workforce capable of effectively meeting the mental health needs of the public. WE&T funds are a one-time allocation and do not provide direct service.

The goal is to develop a diverse and well-trained workforce skilled in delivering a culturally competent integrated service experience to clients and their families. Equally important are community collaboration efforts to increase protective factors.

Stanislaus County had 6 programs operating during FY15-16:

- Workforce Development
- Consumer Family Member Training and Support
- Expanded Internship and Supervision
- Outreach and Career Academy
- Consumer and Family Member Volunteerism
- Targeted Financial Incentives to Increase Workforce Diversity

WE&T Budget:

FY 2015-16

Total MHSA Budget	***Actual***
$713,960	***$531,346***

FY 16-17 Budgeted	***FY 16-17 Projected***	***FY 17-18 Projected***	***FY 18-19 Projected***	***FY 19-20 Projected***
$763,395	***$545,053***	***$657,326***	***$536,027***	***$539,766***

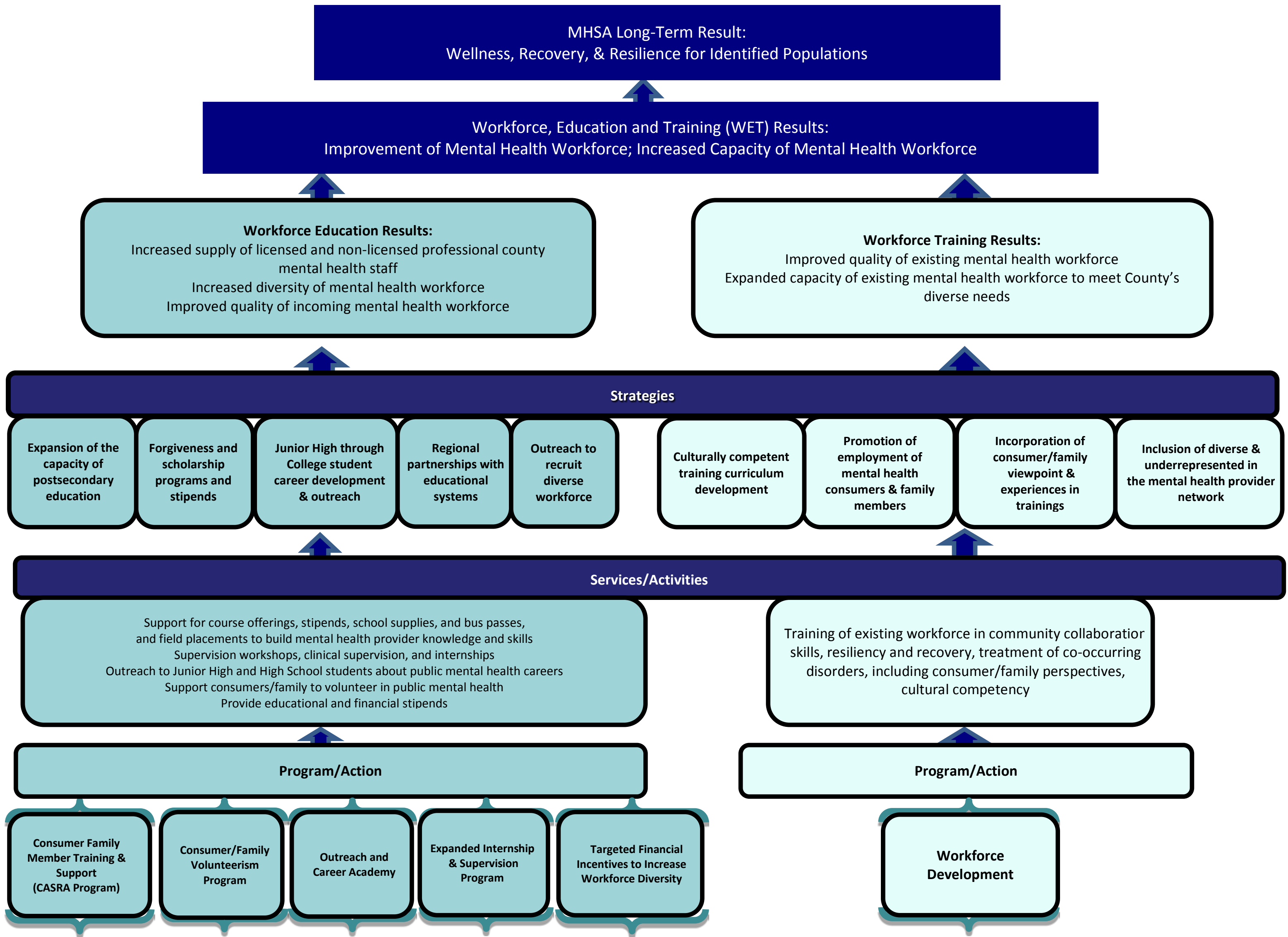
Highlights:

- Two day Trauma Competency Conference provided valuable information for staff; Trauma Learning Groups were formed for mental health clinicians and BHRS staff
- A total of seven (7) CASRA Based Stipend Program participants received their Associate of Arts Degree in Human Services at Modesto Junior College (MJC)
- Twenty-three (23) CASRA Based Stipend Program participants completed the academic requirements and volunteer hours to receive their Skills Recognition Certificate for completion of the MJC 9-Unit Psychosocial Rehabilitation Program.
- A total of 118 individuals volunteered during FY 15-16, an increase from FY 14-15 where 110 people volunteered their services.

Challenges:

- Maximizing one-time WE&T funds to invest in quality trainings
- Ability to offer trainings to the larger BHRS workforce to include clerical, administrative staff, and support staff
- Providing clinical supervision to field placement students and unlicensed staff due to not having enough fully licensed and qualified staff to provide appropriate supervision

Theory of Change:



WE&T – Workforce Development

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

Trainings are at the core of Workforce Development. The goal of the training program is to increase overall and specific competencies in staff throughout the public mental health workforce and expand capacity to implement MHSA essential elements in the existing workforce. The trainings address a variety of key content identified during the stakeholder planning process. Among them:

- 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 uses consumer and family member trainers when appropriate. Training was offered to BHRS and organizational provider staff to enhance knowledge and skills, especially in the areas of recovery and resilience and evidence-based practices.

Highlights:

- Brought in Trauma Competency Expert for a two day Trauma Competency Conference which received excellent reviews from staff; Staff reported ow valuable they felt the training was to their work with BHRS consumers.
- Trauma Learning Groups were formed and facilitated by the Training Program based on the two-day Trauma Competency Conference; one consisted of Mental Health Clinicians and the other was for BHS staff. Groups formed in late spring through December 2017; a report on this is currently being developed to look at outcomes.
- Continued focus on increasing a variety of cultural competency training topics such as LGTBQ Older Adult, Understanding and Addressing Self Harm, Advance Your Cultural Competency in the Clinical Setting along with the California Brief Multicultural Scale training.

Challenges:

- Trainings filled up quickly; this necessitated the need to provide several offerings in order to meet the need of BHRS staff and our various partner agency staff.
- Working to maximize the one time money in the effort to invest in quality trainings.
- Maintaining enough offerings that meet the criteria needed to be counted for continuing education hours towards staffs licensure or certification.
- Ability to offer trainings to the larger BHRS workforce which would include clerical, administrative staff, and support staff.

WE&T Workforce Development

2,385 Individuals Served

Program Results

How Much?

- 87 trainings were provided in FY 2015-16
- 2,385 BHRS, contractor staff, and community members attended trainings
- 14 trainings were paid for through WET funds (n=877)
- 19 trainings were sponsored by MHSA Prevention and Early Intervention (PEI) Program (n-445)

How Well?

- 94% of participants reported improved understanding and knowledge of the subject (n=674)
- 88% of participants reported that they felt their skills on the subject improved as a result of the training (n=672)
- 88% of participants reported that the course included content related to diverse populations/cultural competency (n=656)

Better Off?

- Two-day Trauma Competency Conference/Participant Comment - Great training. Lots of useful information!
- Understanding and Addressing Self Harm/Participant Comment – Spectacular and thought provoking. Awesome!

WE&T Consumer Family Member Training & Support

Operated by Human Resources and Training Division of Behavioral Health and Recovery Services in Partnership with Modesto Junior College and Community-Based Organizations

In partnership with Modesto Junior College (MJC), the California Association of Social Rehabilitation Agencies (CASRA) based program provides a structure to integrate academic learning into real life field experience in the adult public mental health system. Before this partnership, MJC did not have a Psychosocial Rehabilitation curriculum. The initiative taken by BHRS to purchase the CASRA curriculum signifies the efforts to fill the gaps for employment of consumers and family members. Students who have received their Skills Recognition Certificate also have the opportunity to become eligible for the National CASRA certification after completing a minimum of 2,500 field experience hours.

The Psychosocial Rehabilitation Program at MJC is a nine (9) unit curriculum that provides individuals with the knowledge and skills to apply goals, values, and principles of recovery oriented practices to effectively serve consumers and family members. The certificated units also count towards an Associate of Arts Degree in Human Services at MJC.

The CASRA Based Stipend Program includes stipends to assist with school fees, bus and parking passes, and school supply vouchers, as needed to participants. There is also a textbook loan program. In addition, CASRA Program participants receive ongoing peer support and academic assistance to maximize their opportunities for success.

Highlights:

- Hiring of a part time Facilitator to manage and assist the CASRA Based Stipend Program participants with stability and reliability to ensure the needs of the program and the participants are being met.
- Hiring of a part-time assistant to help both the CASRA and Volunteer Programs.
- A total of 35 of our participants were placed in volunteer positions that allowed them to meet the specified hour requirements for each MJC Psychosocial Rehabilitation Program course.
- Maintaining a steady increase in the recruitment of several other ethnicities into the behavioral health field. All CASRA Based Stipend Program participants are either consumer/family members or come from a diverse and underserved community.
- A total of 117 students received CASRA stipends in FY 15-16. Twenty-three (23) CASRA Based Stipend Program participants completed the academic requirements and volunteer hours to receive their Skills Recognition Certificate for completion of the MJC 9-Unit Psychosocial Rehabilitation Program.
- Seven (7) additional CASRA Based Stipend Program participants received their Associate of Arts Degree in Human Services at MJC; Sixteen (16) CASRA Based Stipend Program participants serving as volunteers have been hired in the public mental health system; Eight (8) by BHRS and eight (8) by community partner agencies.
- A total of twenty-eight (28) CASRA Based Stipend Program participants are bilingual or multi-lingual.

Challenges:

- Cost of textbooks to provide for a growing number of program participants; the program is exploring alternatives to purchase textbooks at a lower cost.

WE&T Consumer Family Member Training and Support

117 Individuals Served

Program Results

How Much?

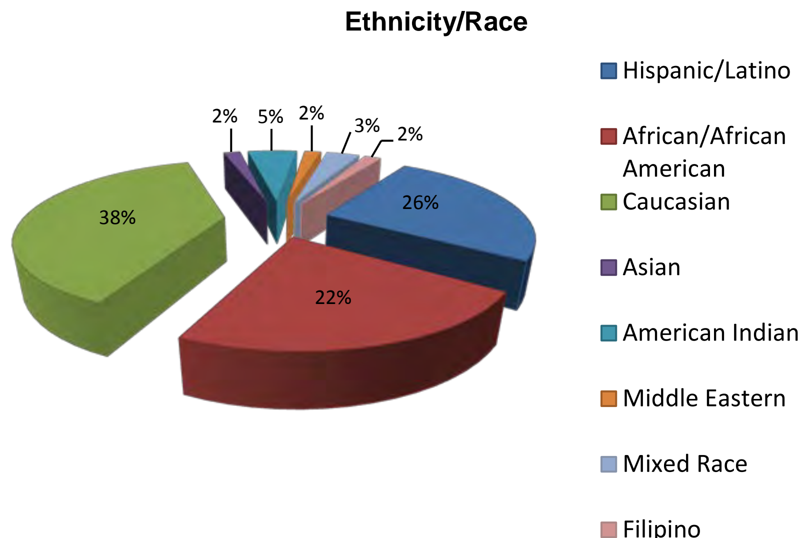
- 117 CASRA Based Stipend Program participants representing diverse ethnicities/cultures received education stipends
- 21 participants received field placement with BHRS or community partner agencies
- 2 CASRA Based Stipend Program orientations and 2 classroom presentations were held at Modesto Junior College (MJC) to raise awareness about the program
- Collaboration with the Behavioral and Social Science departments at MJC

How Well?

- 100% of CASRA Based Stipend Program recipients have lived experience as consumers, family members of consumers, or are from diverse cultural backgrounds
- 28 CASRA Based Stipend Program recipients are bilingual or multi-lingual

Better Off?

- 23 CASRA Based Stipend Program participants completed the academic requirements and volunteer/internship hours needed to receive their Skills Recognition Certificate for the MJC 9-Unit Psychosocial Rehabilitation Program
- 7 CASRA Based Stipend Program participants have received their Associate of Arts Degree in Human Services
- 4 CASRA Based Stipend Program participants have chosen to continue their education at California State University, Stanislaus
- 16 CASRA Based Stipend Program participants were hired in the public mental health system; 8 by BHRS and 8 by partner agencies



WE&T Expanded Internship & Supervision Program

Operated by Human Resources and Training Division of Behavioral Health and Recovery Services in collaboration with CSU, Stanislaus

This program addresses the challenges of identifying internships and providing clinical supervision in the mental health field.

Highlights:

- In order to meet the BHRS staffing needs, three (3) PSC staff with expertise in clinical supervision had to be hired to provide individual and group supervision to those working towards licensure due to not have enough licensed staff within BHRS to do so.
- Advanced group supervision was formed to focus on the BBS licensure exam for mental health clinicians in an effort to help support BHRS staff in attaining their goal of licensure.
- With the remaining $23,000 of the one-time monies for stipends, 2 stipends at $11,500 a piece were awarded to CSUS students; One to an MSW student in the Masters of Social Work program and another to an MFT student in the Psychology program. Both successfully completed their year of field placement/practicum placement.

Challenges:

- Continued challenge to provide clinical supervision to field placement students and unlicensed staff due to the fact of not having enough fully licensed and qualified staff to provide the appropriate supervision.
- No Student placements offered this fiscal year due to the influx of hiring of non-licensed staff at BHRS.

WE&T Expanded Internship & Supervision Program Results

2 Individuals Served

Program Results

How Much?

- 2 stipends
- 1 MSW program
- 1 MS Psychology program

How Well?

- Both students successfully completed their internships and were satisfied with their placements

Better Off?

- 100% of MSW internship students completed their internship hours.

WE&T - Outreach and Career Academy

Operated by West Modesto King Kennedy Neighborhood Collaborative through contract with Behavioral Health and Recovery Services /Workforce Education & Training

Outreach and Career Academies were established in response to strong community input to outreach to junior high and high school students to raise awareness about behavioral health and mental health careers. One community-based organization participated in the project.

The West Modesto King Kennedy Neighborhood Collaborative (WMKKNC) sponsored the Mark Twain Junior High Wellness Project. As part of their learning, students participated in skits, scenarios, and discussions on issues important to them such as stress, self-esteem, and healthy relationships. They also learned how these issues can affect their physical and mental well-being. A total of six (6) students participated in the project which also introduced them to career opportunities in mental health.

Highlights:

- Students planned “Day of Hope” celebration held at Peer Recovery Art Center/The Mod Spot on May 18, 2016.
- Students created individual art pieces that reflected their idea of Hope.
- Students participated in “Positive Affirmation Pencils” project, designing and handing out pencils with positive messages about mental health.
- Students heard about mental health careers from medical interns from the Paradise Medical Office in West Modesto.

Challenges:

- Mark Twain Junior High is home to the only program in the Outreach and Career Academy. Strategic planning continues to explore ways to re-introduce the program into other area schools.

Outreach and Career Academy Program Results

6 Individuals Served

Program Results

How Much?

- A total of six (6) students from Mark Twain Junior High School participated in the wellness project
- Students were actively engaged in activities to learn about mental health and stigma reduction, and mental health careers

How Well?

- Student feedback was extremely positive about their participation in community activities related to mental health awareness

Better Off?

- Students received certificates of recognition and increased knowledge of mental health, stigma reduction, and mental health careers
- Three (3) of the six students in the program are interested in participating in the program again next year

WE&T - Consumer and Family Member Volunteerism
Operated by Human Resources and Training Division of Behavioral Health and Recovery Services

This program addresses the needs of consumers, family members, and diverse community members who wish to volunteer in the public mental health system. It also provides an opportunity to give back to the community as part of their recovery. Volunteers provided an important and valuable service as they worked in countywide BHRS programs.

Volunteer opportunities also continued for California Association of Social Rehabilitation Agencies (CASRA) students from Modesto Junior College, referred to as “field placements.” Volunteers were placed in BHRS programs as well as community-based organizations.

Highlights:

- The CASRA based program volunteer transitioned to a part-time Clerical Community Aide (CCA) on July 1, 2015. The Volunteer/CASRA Support Team became a placement site for a part-time Clerical Community Aide CCA on April 18, 2016.
- A successful BHRS Volunteer celebration took place on April 26, 2016. There were 140 invitations sent and 70 individuals attended this event. The venue was changed as well and the feedback on this event was excellent.
- A survey using Survey Monkey was launched for the volunteer program in March 2016. The response rate was 50% and the feedback initiated action items for more process improvements for the volunteer program.
- Utilizing program contacts we continue to assist with completing all required forms.
- The BHRS Intranet link was expanded to include information about the Volunteer program and this link is under the HR tab.
- In all, there were 118 volunteers during FY15-16. This is an increase from the 14/15 total of 110. There were Nineteen (19) unique volunteers that were CASRA.

Challenges:

- Increase communication with MJC to coordinate BHRS presentations and to make sure that updated procedures and protocols are followed.
- Increase communication between volunteers and their BHRS program contacts, with a focus on timely timecard submission.

WE&T Consumer and Family Member Volunteerism

118 Individuals Served

Program Results

How Much?

- A total of 118 volunteers participated in program
- A total of 7 volunteers were hired by BHRS
- A total of 23,712.36 volunteer hours were accumulated

How Well?

- The total dollar value to the department (at $23.07 an hour) equaled $547,044
- Twelve (12) BHRS sites participated in using volunteers

Better Off?

- Volunteers reported satisfaction in participating in program

WE&T - Targeted Financial Incentives to Increase Workforce Diversity

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

This program provides educational stipends to students in Master's level Social Work and Psychology programs at CSU, Stanislaus. The scholarships are awarded to potential recruits who meet established criteria based on the ongoing assessment of "hard to fill or retain" positions. Such positions include those related to language, cultural requirements, and special skills.

MS and MSW stipends were provided to students through an existing contract with CSU, Stanislaus. BHRS awarded a total of 2 stipends this year and all recipients met desirable classifications for hard to fill positions identified in the WE&T plan workforce needs assessment.

BHRS assisted in submitting applications to the Mental Health Loan Assumption Program (MHLAP) funded by Proposition 63 and administered through the Office of Statewide Health Planning and Development (OSHPD). MHLAP is a loan forgiveness program designed to retain qualified professionals working within the public mental health system.

In FY 15-16, a total of thirteen (13) individuals received awards in Stanislaus County for a total award amount of $127,644.

Highlights:

- $23,000 in the WE&T budget remained which allowed 2 stipends to be awarded.
- 2 stipend recipients received a student placement for their internship within Stanislaus County and successfully completed their internships.
- Both recipients received employment within Stanislaus County contracted agencies upon completion of their internships.
- In FY15-16, more new positions were developed for mental health clinicians within BHRS and contracted partners.
- Presentations to students in CSU, Stanislaus MSW and MFT programs resulted in a dramatic increase in applicants applying for stipends.

Challenges:

- A number of exceptional candidates applied for stipends so it was hard to only have 2 stipends to offer.

Targeted Financial Incentives to Increase Workforce Diversity

2 Individuals Served

Program Results

How Much?

- 2 stipends were awarded in FY 15-16
- 1 student in the MSW program;1 student in the MS program received stipends
- $23,000 in funding was awarded

How Well?

- Both recipients came from low socio-economic backgrounds
- Both recipients had a family history of mental health issues which necessitated the use of public mental health services in the past
- 1 recipient was bilingual Spanish speaking

Better Off?

- Both were offered employment within Stanislaus County contracted agencies at the end of their internships

CAPITAL FACILITIES

The Capital Facilities (CF) component of MHSA provides funding for building projects.

CF funds were used for the construction of the Crisis Stabilization Unit (CSU) which opened its doors in February 2016 to provide clinical and psychiatric services and more intensive levels of care, including the ability to provide medication.

The CSU is co-located with the county's Community Emergency Response Team known as CERT and its WarmLine. The CSU's goal is to focus on recovery-centered care and create an opportunity for each consumer to be treated in a less restrictive setting. The project is funded through General System Development (GSD) dollars for operational costs. Highlights of this program were included in the CSS section of this Annual Update.

Design and construction work on a countywide CSU began in FY 13-14 to address a significant increase in the number of acute psychiatric inpatient hospitalizations. As highlighted in the June 2014 Annual Update, the project was the third piece of a strategic planning process by the Stanislaus County Chief Executive Office and BHRS to enhance secure mental health services.

In the MHSA FY 14-15 Annual Update and Three Year Program and Expenditure Plan approved by community stakeholders and the Board of Supervisors on June 17, 2015, the development of a Crisis Stabilization Unit (CSU) represented the first Capital Facilities project to receive MHSA funding.

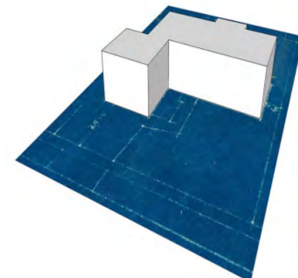
A CSU is a critical need in Stanislaus County. This strategic planning effort focused on 24/7 secure mental health services as well as the services preceding and following the inpatient services.

Former BHRS Director Dr. Madelyn Schlaepfer shows the CSU under construction to members of the MHSOAC during their visit to Modesto on August 27, 2015.

Three goals were identified: Development of a new Psychiatric Health Facility, creation of a Discharge Team that would follow up with all discharges of county patients from the inpatient psychiatric hospital, and the development of a CSU.

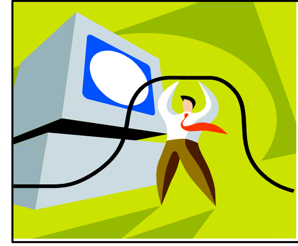
This process included input from a wide variety of stakeholders, including member of the MHSA Representative Stakeholder group. The first two goals have been implemented. The CSU was the last outstanding goal to be accomplished to provide the continuum of services.

A temporary Crisis Intervention Program (CIP) was instituted in October 2013 and has shown promise in diverting individuals from hospitalization. A CSU provides a higher, more intensive level of care, including the ability to provide medications, which the CIP cannot. The expectation is that a significant number of individuals in crisis would be appropriately diverted from hospitalization through a CSU.



The second phase of the CSU project, approved by stakeholders on July 18, 2014, would provide for the construction in FY 14-15. The estimated additional costs related to this CF expansion are approximately $758,000, bringing the total CSU construction costs to $944,000.

TECHNOLOGICAL NEEDS (TN) PROJECTS



Technological Needs (TN) Projects provide the tools for secure access to help transform how health and wellness information is used and stored. But most importantly, it supports the empowerment for behavioral health service recipients, their families and providers. By modernizing information systems, the hope is to create greater access to technology, improve the quality and coordination of care, operational efficiency, and cost effectiveness.

BHRS has four TN projects in various stages of implementation.
1) Electronic Health Record
2) Consumer Family Access to Computing Resources
3) Electronic Data Warehouse
4) Electronic Document Imaging

Services and Activities

Electronic Health Record

- Installed four major upgrades in our production system. One of them related to security, another one related to the medication module, patient portal and improved filtering and navigation.
- Provided training to 114 staff, 83 BHRS and 31 contract providers, regarding EHR navigation.
- Started to install additional components.

Consumer Family Access to Computing Services

- Hired a second technician.
- Started to show Network of Care (NOC) to consumers and/or family members.
- Initiated the process to replace old computers with new ones. During this fiscal year, we were able to replace 25% of them; the rest will get replaced next fiscal year.
- Upgraded Internet service for each site. We upgraded to U-Verse, ranging in speeds from 12 to 45 Mbps depending on availability.

Electronic Data Warehouse

- Created additional views for different reporting requirements and for department dashboards.
- Started the transition of the Data Warehouse to a new computer server to increase performance.

Electronic Document Imaging

- Started to scan and attach Mental Health Plan referrals to client's chart.
- Increased the number of lab results scanned and attached to client's charts.

TN Budget:

FY 2015-16

Total MHSA Budget	*Actual*
$1,459,349	***$892,458***

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$1,243,702	***$1,070,001***	***$1,076,325***	***$1,084,644***	***$1,093,244***

Highlights:

- Having two technicians has helped covered the needs on the different sites.
- The increase of both scanned lab results for clients and the provision of tele psychiatry services.

Challenges:

- While not a major challenge, when hiring new staff, we always experience a learning curve. This does not only applies to service providers but also to support staff working with the EHR system and other TN projects.
- Consumers and family members engaging in the use of the Network of Care as a great resource to Stanislaus County residents.

Technological Needs Project Results

How Much?

- 667 staff utilized the EHR in multiple capacities.
- 114 staff (83 BHRS and 31 contracts) was trained to effectively use the EHR.
- 74 appointments were made to assist consumers in accessing computing resources.
- 1,040 electronic documents were attached to clients' EHR charts, allowing more complete electronic access to chart information.

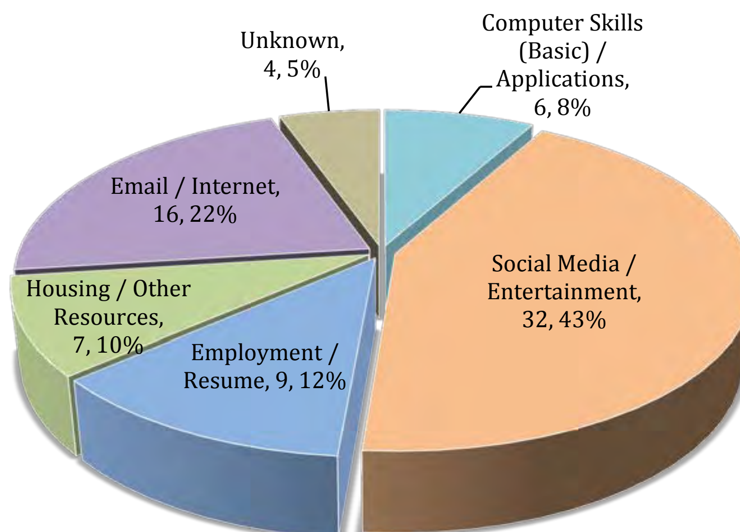
How Well?

- 92.5% of the electronic documents attached to charts were lab results (962/1040), critical documents for treatment.
- 444 medication services were provided via tele psychiatry, improving access and efficiency of services.

Better Off?

- The Data Warehouse continues to be instrumental in the process of data analysis and outcomes reporting for decision making. The data warehouse was utilized for report and dashboard development, including CANS (Child and Adolescent Needs and Strengths) reports, Service Utilization and Access reports, and Consumer Perception Survey dashboards.
- Consumers and families received technical assistance in the following computing resources categories:

Categories of Consumer/Family Computer Technical Assistance
FY 2015-2016
TA sessions = 74



INNOVATION (INN)

Innovation funding is intended for unique, never-before-tried, time-limited programs to develop new and effective practices and approaches to mental health service delivery. The focus is to make a contribution to learning in one or more of the following ways:

- Introduce a new mental health practice/approach that has never been done before.
- Make a change to an existing mental health practice/approach, including an adaptation for a new setting or community
- Introduce a new application to the mental health system of a promising, community-driven practice/approach or a practice/approach that's been successful in a non-mental health context or setting

Innovation projects are guided by MHSA values of community collaboration, cultural competence, a client/family driven mental health system, a wellness, recovery, and resiliency focus, and integrated Service Experiences for clients and family members. The projects must serve one of more of the following purposes:

- Increase access to mental health services
- Increase access to mental health services to underserved groups
- Increase the quality of mental health services, including better outcomes
- Promote interagency and community collaboration related to mental health services, supports, or outcomes

INN Budget:

FY 2015-16

Total MHSA Budget	*Actual*
$2,204,736	***$1,141,556***

FY 16-17 Budgeted	*FY 16-17 Projected*	*FY 17-18 Projected*	*FY 18-19 Projected*	*FY 19-20 Projected*
$1,928,393	***$1,291,794***	***$1,807,884***	***$1,511,319***	***$367,831***

Background:

In FY 15-16, a total of six (6) projects were funded for this MHSA component. Each project reflected an unmet need and was developed through the community planning process.

The projects are as follows:

- INN-11 – Wisdom Transformation Initiative
- INN-12 – Garden Gate Innovative Respite
- INN-13 – Quiet Time
- INN-14 – Father Involvement
- INN-15 – Youth Peer Navigators
- INN-16 – Full Service Partnership (FSP) Co-Occurring Disorders
- INN-17 – Suicide Prevention Community Project

The Wisdom Transformation and Garden Gate Respite projects were completed in June 2016. Final learning reports were forwarded to the MHSOAC on July 22, 2016. Both are attached in this section of the Annual Update.

On June 25, 2016, three Stanislaus County projects were approved by the Mental Health Oversight and Accountability Commission (MHSOAC).

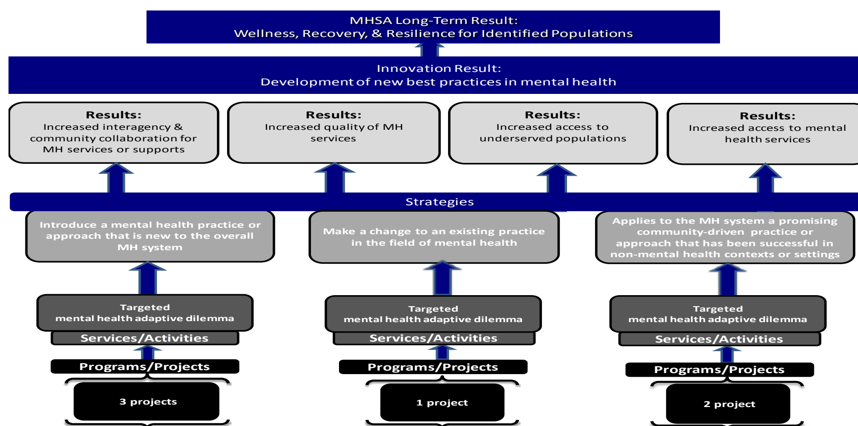
They were as follows: Father Involvement Project/Center for Human Services; Youth Peer Navigators/BHRS; and Quiet Time Project/Sierra Vista Child and Family Services. Reports from these learning projects are included in this section of the Annual Update.

On August 27, 2015, the MHSOAC approved an FSP Co-Occurring Disorders Innovation project operated by Behavioral Health and Recovery Services. And on April 28, 2016, the MHSOAC approved another Innovation project, this one aimed at Suicide Prevention. Information about these projects can be found on the following pages.

Challenges:

Innovation projects can prove challenging because of their newness. Since they are short term demonstration projects, hiring staff on a timely basis and establishing needed infrastructure for evaluation can be potential barriers.

Theory of Change:



* On March 17, 2016, the MHSA Representative Stakeholder Committee (RSSC) approved and prioritized three (3) new Innovation concept ideas: 1) Stanislaus County Probation Department/LGBTQ Youth, 2) Community Outreach and Engagement, 3) Senior LGBTQ Community.

BHRS management held several meetings with probation staff regarding the LGBTQ youth concept idea but it was determined that it did not meet MHSOAC criteria. The Senior LGBTQ community concept also did not meet MHSOAC criteria. The Community Outreach and Engagement concept lacked pertinent information. As a result, no INN applications were submitted to the MHSOAC. Discussions are ongoing regarding next steps for MHSA Innovation funding.

The following Final Reports were submitted to the MHSOAC for the Wisdom Transformation Initiative and the Garden Gate Respite project on July 22, 2016.

BEHAVIORAL HEALTH AND RECOVERY SERVICES
A Mental Health, Alcohol and Drug Service Organization

Madelyn Schlaepfer, Ph.D.
Behavioral Health Director

800 Scenic Drive, Modesto, CA 95350

July 22, 2016

Mental Health Services Oversight & Accountability Commission
1325 J. Street, Suite 1700
Sacramento, CA 95814

Dear Colleagues:

Please find attached Final Learning Reports for two (2) Stanislaus County Mental Health Services Act (MHSA) Innovation Projects that were completed in FY 15-16. They are being submitted separately and were not included in the FY 16-17 Annual Update because of time and logistical constraints.

Working from the BHRS Vision and Mission, MHSA General Standards, input from stakeholders, and in accordance with state guidelines, these projects were developed in FY 2013-14. As three (3) year demonstration projects, they were fully and successfully implemented by two (2) organizations: Turning Point Community Programs and the Center for Collective Wisdom. Each Innovation project ended on June 30, 2016.

We understand that counties must provide the Mental Health Services Oversight and Accountability Commission with a Final Report upon completion of these projects and that the Final Report may be included in the county's Annual Update or its Three-Year Plan, whichever is due during the year the project is completed. The county does not have to provide, but may submit, a separate report.

An acknowledgement that you have received this document is appreciated.

If you have any questions, please do not hesitate to contact me, or Dan Rosas, MHSA Manager, at (209) 525-6225.

Sincerely,

Madelyn Schlaepfer

Madelyn Schlaepfer, Ph.D.
Behavioral Health Director

cc: Dan Rosas

Enclosure

STRIVING TO BE THE BEST COUNTY IN AMERICA

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StanUp for Wellness!

Support Mental & Emotional Health

Stanislaus County
Behavioral Health and Recovery Services

Mental Health Services Act
Innovation Final Reports FY 2015-16
June 2016

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Stanislaus County Behavioral Health and Recovery Services (BHRS)
MHSA Planning Office
800 Scenic Drive
Modesto, CA 95350
Phone: (209) 525-6247 Fax: (209) 558-4323

INNOVATION OVERVIEW

Innovation is one of five components of Proposition 63, the Mental Health Services Act (MHSA), passed by California voters in 2004. It provides funds and evaluates new approaches in mental health. The projects contribute to learning about and addressing unmet need rather than having a primary focus on providing services.

Innovation projects are developed to target a mental health adaptive dilemma, or a challenge that cannot be resolved through habitual or known responses. The result we hope to achieve is the development of new best practices in mental health in Stanislaus County.

Innovation funding is unique and intended for projects that focus on and demonstrate one of the following primary purposes:

a) Increase access to mental health services to underserved groups;
b) Increase the quality of mental health services, including measurable outcomes
c) Promote interagency and community collaboration related to mental health services, supports, or outcomes;
d) Increase access to mental health services

In addition, Innovation projects are expected to contribute to learning in the following ways:

a) Introduce a new mental health practice/approach that has never been done before
b) Make a change to an existing mental health practice/approach, including an adaptation for a new setting or community
c) Introduce a new application to the mental health system of a promising, community driven practice/approach or a practice/approach that's been successful in a non-mental health context or setting

Innovation projects are developed through input from community planning processes and are reflective of the unmet need identified by inclusive and diverse stakeholder input. 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.

Round 1 of Innovation Funding

Since January 2010, Stanislaus County has conducted community planning for Innovation funding that resulted in the development of 17 new projects to date. 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 these community partners may contribute to decision-making.

The project was entitled "Evolving a Community-Owned Behavioral Health System of Supports and Services". Concluding in FY 2012-13, the final report was submitted to the MHSOAC in June 2013.

Round 2 of Innovation Funding

Stanislaus County's second round of Innovation planning began with the BHRS Leadership Team's intention to bring project ideas in behavioral health unique to efforts in the county's commitment to community capacity building, increasing protective factors, and advancing of non-stigmatizing early intervention approaches. On October 26, 2010, the Stanislaus County Board of Supervisors authorized the first Request for Proposals (RFP) process for the Innovation learning projects. It resulted in the selection and funding of nine (9) new projects operated by six (6) unique community based organizations and one county agency for two or three years.

Six final reports were submitted to the MHSOAC in June 2014. The organizations and their projects were as follows:

- Center for Human Services/Building Support Systems for Troubled Children
- Center for Human Services/Civility School Learning Project
- Center for Human Services/Revolution Project
- Stanislaus County Health Services Agency/Integration Innovations
- Sierra Vista Child and Family Services/Connecting Youth to Community Supports
- Tuolumne River Trust/Promoting Community Wellness through Nature

Three additional projects from round two were completed in FY 2014-15.

The organizations and their projects were as follows:

- National Alliance for Mental Illness (NAMI)/Beth and Joanna Friends in Recovery
- West Modesto King Kennedy Neighborhood Collaborative/Families in the Park
- Peer Recovery Art Project/Arts for Freedom

Round 3 of Innovation Funding

A third round of Innovation planning was conducted in FY 2012-13 and resulted in two (2) new projects:

- Stanislaus County Wisdom Transformation Initiative/Center for Collective Wisdom
- Garden Gate Innovative Respite Project/Turning Point Community Programs

The projects were approved in June 2013 and began implementation in FY 2013-14. The final learning reports for these projects can be found on the following pages of this document.

Final reports for these and all Stanislaus County Innovation projects that have ended may be viewed on-line by going to www.stanislausmhsa.com

Round 4 of Innovation Funding

On July 18, 2014, community stakeholders approved a priorities funding plan that included a third RFP process for Innovation. Proposers were asked to select a mental health adaptive dilemma consistent with stakeholders' priorities. The Innovative approach had to include prevention strategies that are known to address similar adaptive dilemmas in other fields such as health.

The prioritized adaptive dilemmas were as follows:

1. Improving parental competency and social support for fathers
2. Improving the well-being of children, Transition Age Youth (TAY), and Transition Age Young Adults (TAYA)
3. Treatment options for people struggling with both substance abuse and mental illness
4. Connecting people receiving services to community based support
5. Honoring and identifying more holistic approaches to well-being
6. Connecting and linking underserved and diverse communities with resources

On September 30, 2014, in conjunction with the county's General Services Agency, the Stanislaus County Board of Supervisors authorized BHRS to issue a Request for Proposals (RFP) for the Innovation learning projects. The RFP was issued on October 3, 2014, and an Evaluation Committee reviewed and scored five submitted proposals.

On December 2, 2014, the GSA issued a Notice of Intended Award to the following two (2) community-based organizations:

- Center for Human Services/Father Involvement Project
- Sierra Vista Child and Family Services/Quiet Time Project

In addition, the BHRS Juvenile Justice program requested to expand its services through a Youth Peer Navigator Innovation project to serve children, Transition Age Youth (TAY), and Transition Age Young Adults (TAYA). The expansion request was reviewed by the Evaluation Committee and recommended for approval by the BHRS Senior Leadership team.

On February 10, 2015, the Stanislaus County Board of Supervisors approved two year agreements with the community-based organizations and BHRS Juvenile Justice contingent on their approval from the MHSOAC. On June 25, 2015, the MHSOAC approved the three projects at its monthly meeting.

Round 5 of Innovation Funding

The next round of funding resulted in the development of two new Innovation projects.

On February 27, 2015, community stakeholders endorsed moving forward with a Full Service Partnership (FSP) Co-Occurring Disorders Innovation project with a focus on adults who have both serious mental illness and co-occurring substance use disorder. The three year project was approved by the Stanislaus County Board of Supervisors on June 2, 2016 and by the MHSOAC on August 27, 2016.

On October 23, 2015, stakeholders endorsed a BHRS funding recommendation for a three year Suicide Prevention Project aimed at decreasing the alarming number of suicides in Stanislaus County. The project was approved by the Stanislaus County Board of Supervisors on March 15, 2016, and the MHSOAC on April 28, 2016.

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CULTIVATING CULTURES OF COLLECTIVE WISDOM

Assessing the Impact and Lessons Learned from The Wisdom Transformation Initiative

June 2016

John G. Ott, J.D. • Rose A. Pinard, Ph.D.
Center for Collective Wisdom • c4cw.org

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EXECUTIVE SUMMARY

Over the last decade, the Stanislaus County Behavioral Health and Recovery Services Department (BHRS) has confronted an increasingly complex and volatile fiscal and policy reality. Between 2006 and 2012, department revenues declined by 18%, from $83 million to $68 million, and the number of staff by 35%, from 516 to 338. These overall reductions in funding and staff happened despite the new funding the department received through the Mental Health Services Act (MHSA).

In this same period, the number of people served by the department declined from 11,000 to 10,000, even as the number of people in the county struggling with behavioral health issues was increasing significantly, caused in part by veterans returning home from Iraq and Afghanistan as well as the fallout from the recession.

Senior leaders began to understand this reality as an *adaptive dilemma,* defined as a challenge that cannot be resolved, or a longing that cannot be realized, through habitual or known responses. After several years of rapidly declining revenues and increasing need, senior leaders became convinced that they could not simply manage their way out of the challenges confronting the department using only the short-term strategies they had relied on in the past.

They committed to undertake a more comprehensive and proactive response: a transformation process, an ongoing process of rethinking the role of the department, and increasing the capacity of staff to learn and adapt together in ways that would improve results even with diminishing budgets.

As designed by John Ott and Rose Pinard, the principals of the Center for Collective Wisdom (C4CW), four commitments defined 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 were called the Wisdom Transformation framework.

With support from Ott and Pinard, senior leaders began laying the foundation for this transformation process, exploring the implications of each of the four commitments for their respective programs and areas of responsibility, and then introducing the framework to managers and coordinators in 2012. Then, in 2013, stakeholders approved an Innovation Project, entitled the Wisdom Transformation Initiative (WTI), to deepen and extend this transformation process into some of the largest community-based partners working with BHRS.

THE IMPACT OF WTI

Over 700 participants from four organizations participated in WTI. From July 2013 through December 2015, C4CW worked intensively with each participating organization through custom-designed and tailored processes grounded in the Wisdom Transformation framework, with a particular focus on the commitment to leadership development.

This project first explored learning questions related to the *impact* of organizations adopting the Wisdom Transformation framework. More specifically, the project assessed whether the adoption of the Wisdom Transformation framework could help participating organizations increase their capacity to:

- Learn to adapt better to the policy and fiscal volatility within the behavioral health system;
- Create a stronger and more positive internal environment for staff and others connected to the organization so they can better support the people they serve; and
- Cultivate more effective collaboration among each other and with BHRS.

The data offer a resounding *yes* to these questions about impact. First, every organization successfully resolved one or more adaptive dilemmas through the Wisdom Transformation process. Examples include:

- Redesigning programs for better impact;
- Making significant progress on team productivity goals;
- Making a shift to embodying a commitment to community to improve impact;
- Developing plans for long-term sustainability; and
- Improving staff recruitment, training, and retention practices.

Moreover, every organization reported and demonstrated ongoing capacity to effectively address new adaptive dilemmas, including:

- Increased capacity to use data to improve program and organizational impact; and
- Increased capacity to use the process of Wisdom Dialogues[1] to address adaptive dilemmas.

Second, every organization also reported more positive internal working environments for staff and others connected to the organization. Data documented improved staff morale, strengthened relationships among staff and others, and a significantly improved capacity to cultivate safe spaces for meaningful conversations among people who had different perspectives.

Third, every organization reported and demonstrated improved capacity to effectively collaborate with each other, BHRS, and communities connected to people receiving services. This was a principal focus of the Innovation project, and the data document numerous examples of improved collaboration among organizations, and between organizations and BHRS.

Beyond these immediate impacts, the project also inquired into whether adopting the framework would help organizations improve outcomes for people suffering from or at risk of mental illness. While the timeframe for this project was too brief to create or document sustained impact on outcomes for people receiving services, the data that did emerge are promising.

Essential to realizing the potential for improved results is the commitment and capacity of organizations to sustain their transformation processes beyond the project. In their final reports, every organization expressed a commitment to continue their particular WTI work beyond the initiative.[2] Different organizations have integrated aspects of the framework into their long-term strategic plans, and have developed staff surveys and other assessment instruments to assess their progress in embodying the framework over time. Moreover, leaders and program managers from several organizations are regularly teaching and modeling the commitments and practices of the framework to other staff, and staff members continue to regularly access online videos and other resources to deepen their understanding and ability to adapt the framework for their programs.

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[1] A process developed by Ott and Pinard to help organizations embody the commitment to leadership when addressing adaptive dilemmas.

[2] Final Organization progress reports, December 2015.

LESSONS LEARNED ABOUT PROCESS

Beyond the question of *impact,* we also explored questions about what *processes* would help organizations successfully adopt the Wisdom Transformation framework. Specifically, we assessed:

- What processes would help community-based organizations—each with different missions, cultures, and histories—successfully adapt the Wisdom Transformation framework within their particular programs and services;

- What processes would help build effective intra-organizational learning communities among staff members, community leaders, family members, and people who receive services; and

- Whether cross-organizational learning communities are promising strategies for sustaining long-term transformation efforts.

We have learned a number of lessons about what helps organizations successfully adopt the framework, including the need for:

- Assessing readiness for undertaking an ongoing transformation process, given the current challenges confronting an organization;
- Regularly assessing the commitment within the organization to continue the process;
- Re-framing and translating the framework to fit each organization's unique culture;
- Engaging senior leaders first, and coaching them as allies, to help sustain the process; and
- Using technology and online resources to support the ongoing transformation.

Beyond these general lessons about helping organizations successfully adopt the framework, several additional lessons arose about how to strengthen *intra-organizational* learning communities, including lessons about data and data capacity, and lessons about process. In particular, as C4CW engaged with teams and programs within participating organizations, patterns became apparent about what can help groups embody the commitments and practices of the framework when tackling complex issues. Ultimately, C4CW created a process called Wisdom Dialogues to capture the learning about these patterns.

The question of *cross-organizational* communities yielded an unexpected result. The design for WTI projected that staff across the participating organizations would form learning communities over time, grounded in a shared commitment to results and the Wisdom Transformation framework. Once implementation began, however, and each organization began to move more deeply into its own transformation process, all of the organizational leaders expressed a strong preference for delving more deeply into their own intra-organizational transformation processes rather than investing time and resources in the cross-organizational work.

BUILDING ON THE PROGRESS OF WTI

WTI created significant positive impacts for participating organizations, and demonstrated a number of promising practices about how to help community-based organizations successfully adapt the framework within their particular programs and services. The organizations showed clear signs of healthier and more resilient cultures, cultures defined by the capacity to cultivate the conditions for collective wisdom. This progress is already paying dividends in improved services and supports for

people struggling with mental health issues, and preliminary data point to improved results over time.

So now what?

The cross-organizational work envisioned within WTI was premature. Organizations prioritized the time within this initiative to focus on their individual transformation processes. Having now made substantial progress on their individual transformation plans, however, leaders of the WTI organizations have proposed a new MHSA project, funded with Workforce Education and Training funds, to address cross-organizational and systemic adaptive dilemmas.

This potential MHSA project, endorsed by stakeholders and included in the proposed FY 2016-17 budget for BHRS, would:

- Address one or more systemic adaptive dilemmas through multi-stakeholder Wisdom Dialogues, focusing particularly on solutions that do not require additional revenue;
- Help selected BHRS and community leaders learn how to design and facilitate multi-stakeholder Wisdom Dialogues to address future adaptive dilemmas; and
- Help selected BHRS and community organization staff members learn how to develop and report data to support multi-stakeholder Wisdom Dialogues.

WTI participants have also recommended that BHRS leaders:

- Strengthen the capacity for mental and behavioral health organizations and providers to work together as a more coherent system; and
- Leverage the lessons of WTI to amplify the larger change agendas unfolding across the County.

Six years ago when BHRS was just beginning its journey of transformation, department leaders were virtually alone in their conviction that a new way was needed.

No longer.

In particular, the Focus on Prevention Initiative provides a unique opportunity for BHRS and its partners to leverage the learning of WTI. Launched by the Board of Supervisors in 2014, the Focus on Prevention Initiative reflects a growing awareness among leaders across the county that what has worked before is no longer enough. Inspired in part by the BHRS transformation process and WTI, this long-term effort has embraced much of the Wisdom Transformation framework, including the commitment to results, and essential aspects of the commitments to community capacity-building and leadership development.

From this perspective, WTI has already succeeded, influencing substantial innovation and learning not only within the behavioral health system, but in sectors and efforts across the county. No small achievement.

ACKNOWLEDGMENTS AND APPRECIATIONS

For all that has been, I say *thank you.*
For all that will be, I say *yes.*
— *Dag Hammarskjold*

For the Center for Collective Wisdom (C4CW), the journey of the Wisdom Transformation Initiative (WTI) began in June 2006, when John Ott facilitated a retreat for senior leaders in the Behavioral Health and Recovery Services Department (BHRS). Denise Hunt was Director then, and she was beginning to sense the scope of the adaptive dilemma confronting the behavioral health system, an array of challenges and changes that ultimately spawned the transformation process within BHRS and the Wisdom Transformation Initiative, this Innovation Project.

We could not have anticipated at the time how this movement would expand within Stanislaus County, or how our own lives would be inspired and transformed by the work we have been invited to support since then: the work with Prevention Services to embody a commitment to community capacity-building; the Alcohol and Other Drug stakeholder process to invite community partners to join with BHRS staff to resolve a substantial budget reduction; the work with Promotoras and the Family Resource Centers to build a movement of wellbeing grounded in community; the work with BHRS senior leaders and mid-level managers as the department launched its transformation process; this Wisdom Transformation Initiative; and now the Stanislaus County Focus on Prevention Initiative, with its profound commitment to effect results that matter for families, and an equally profound commitment to embody a value that *there is no other*.

We first want to thank the hundreds of participants who said *yes* to WTI at every stage of this initiative, from the first exploratory conversations in 2012 to the most recent meeting of WTI leaders earlier this year. We are so grateful for the work you do in the world, and for all that you have taught us. We hope that the insights shared in this document begin to reveal, at least in some small way, how we are now different, and see the world differently, because of you.

We are especially grateful to WTI organization leaders Cindy Duenas, Ron Gilbert, Cle Moore Bell, Carole Collins, Judy Kindle, and Jeff Anderson, for your vision, commitment, and steadfast stewardship of WTI.

We would like to offer appreciation for everyone who has guided and supported us within BHRS during this project, and especially Madelyn Schlaepfer, Ruben Imperial, Karen Hurley, and Dan Rosas for your leadership and counsel. We also offer our deep gratitude to the Mental Health Services Act stakeholders who entrusted us with this exploration. And to Denise Hunt: words cannot convey how grateful we are for the invitation you extended to us those many years ago.

In addition, we are blessed to work, play, and learn alongside our C4CW colleagues Trevor Olwig, Ken Ithiphol, Bert Grimm, and Becky Winslow. Thank you for all you have done for WTI.

For all that has been, we say *thank you.* And we cannot wait to discover what is wanting to happen next. For all that will be, we say *yes.*

—John Ott • Rose Pinard
June 2016

INTRODUCTION

Over the last decade, the Stanislaus County Behavioral Health and Recovery Services Department (BHRS) has confronted an increasingly complex and volatile reality. When we began working with BHRS in June 2006, the department's budget was over $83 million. The department employed 516 staff and provided behavioral health services to over 13,500 people. This was the first year of the Mental Health Services Act (MHSA).

Then the recession happened, and even with the infusion of Mental Health Services Act (MHSA) funding, the overall BHRS budget contracted over the next several years. By fiscal year 2011-12, the budget was $68 million, the number of staff was 338, and the number of people served was just over 10,000.

At the same time, the number of people in the county struggling with behavioral health issues was increasing significantly, caused in part by families and individuals struggling with the fallout from the recession, and veterans returning home from Iraq and Afghanistan.

While revenues and staffing have stabilized and even increased since 2012, the fiscal and policy reality has become even more complex and volatile. To cite just two contributing factors: the passage of the Affordable Care Act has significantly increased the number of people who are eligible for mental health services, while the dismantling of the California Department of Mental Health has created significant instability around state-level regulations.

In 2010, after several years of rapidly declining revenues and increasing need, the department's senior leaders concluded that they needed a more proactive response to the complexity they were confronting. They committed to undertake a transformation process, an ongoing process of rethinking the role of the department, and increasing the capacity of staff to learn and adapt together in ways that would improve results even with diminishing budgets.

A support guide written to help staff understand and embrace this transformation effort explained senior leaders' thinking this way:

> The purpose of this effort is to help us move away from short-term reactions to issues beyond our control, and toward a more proactive and sustainable way of doing our work. We know the word *transformation* can be ambiguous, and is often overused. We use the word purposefully, however, to indicate that this is not a short-term strategy, nor an effort that focuses only on the margins of our work. This is a long-term effort designed to strengthen the health and resiliency of the department's culture, and the wellbeing of our staff members, our partners, and ultimately the people we serve.[3]

As designed by John Ott and Rose Pinard, principals of the Center for Collective Wisdom (C4CW), four commitments initially defined 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 were called the Wisdom Transformation framework.

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[3] John Ott and Rose Pinard. *Help Along the Way: A Guide to Support the Transformation of the BHRS Department.* 2012, pp. 1-2.

As part of this transformation effort, BHRS began its first Innovation Project in 2010. 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 Alcohol and Other Drug (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.

This first Innovation Project, also designed and facilitated by Ott and Pinard, was a marked success. 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. 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.

Given the success of the first Innovation Project, in 2012 BHRS initiated six half-day trainings for department managers and coordinators, helping them explore how to introduce the Wisdom Transformation framework into the day-to-day work of their programs. And then in 2013, MHSA stakeholders approved the current Innovation Project, entitled the Wisdom Transformation Initiative (WTI), to deepen and extend the transformation process into some of the largest community-based partners working with BHRS.

WHY THESE PARTNERS

The six original community-based organizations participating in this project included Aspiranet, Center for Human Services, Sierra Vista Child and Family Services, Telecare, Turning Point Community Programs, and West Modesto King Kennedy Neighborhood Collaborative. Together, these six organizations represent the largest non-profit and community-based contractors working 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.

Leaders from each organization had already demonstrated an abiding commitment to the Wisdom Transformation framework, participating in voluntary training sessions introducing some of the framework's core concepts and practices prior to the start of the Innovation Project. Most of the organizations had already 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.

From July 2012 through June 2013, before the beginning of the Innovation Project, leaders from the six organizations participated in a voluntary learning collaborative to explore how to adapt the Wisdom Transformation framework to support their work in the county. These conversations revealed an array of challenges affecting community-based organizations that support people suffering from or at risk of mental illness.

With increasing demands for services and wildly fluctuating public funding levels, 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 were (and are) approaching retirement age, while many younger staff members are reporting higher levels of stress and lower 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 the fiscal challenges. Representatives from all six organizations helped to develop the initial proposal for the Innovation Project and were eager to engage in the process.[4]

The Learning Questions

The primary purpose of the Innovation Project was to promote interagency and community collaboration. Consistent with Innovation guidelines, this project explored new approaches to collaboration and system transformation to strengthen:

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

Through this project, we explored learning questions related both to the *impact* of organizations adopting the Wisdom Transformation framework, and to the *process* of how to help organizations successfully adopt and apply the framework.

Specifically, we assessed whether and how the adoption of the Wisdom Transformation framework helped participating organizations increase their capacity to:

- Learn to adapt better to the policy and fiscal volatility within the behavioral health system;
- Create a stronger and more positive internal environment for staff and others connected to the organization so they can better support the people they serve; and
- Cultivate more effective collaboration among each other and with BHRS.

[4] Once the initiative began, however, two organizations—Aspiranet and Telecare—chose to withdraw from the initiative, and one other organization—Sierra Vista Child and Family Services—delayed their participation for 18 months. We discuss these developments in greater detail in Section 5.

We also inquired into whether adopting the framework would help organizations improve outcomes for people suffering from or at risk of mental illness. While the timeframe for this project was too brief to create or document sustained impact on outcomes for people receiving services, the data we have collected allows us to offer some beginning reflections about the potential for this lasting impact.

These were the *impacts* we sought to assess through the Innovation Project. In addition, we also explored questions about what *processes* would help organizations successfully adapt the Wisdom Transformation framework into their day-to-day operations and larger cultures. That is, we assessed:

- What processes would help community-based organizations—each with different missions, cultures, and histories—successfully adapt the Wisdom Transformation framework within their particular programs and services;
- What processes would help build effective intra-organizational 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.

Data Sources

In developing the reflections and analyses for this paper, we have relied on a wide array of data sources, including the following.

1. **Organizational learning and progress reports.** These semi-annual reports, completed by senior leaders with input from program staff and others, as appropriate, provided opportunities for each organization to offer reflections about their progress, the challenges they were encountering, and the lessons they were learning. The reports also encouraged feedback about the quality and amount of support they were receiving from C4CW. We used these reports to regularly assess and evolve the initiative as it was unfolding.

2. **Key informant interviews and focus groups.** Applied Survey Research conducted a first round of key informant interviews in June 2014. These interviews included 24 participants from three organizations. C4CW conducted more extensive key informant interviews during the fall of 2015. These interviews included sessions with representative groups of participants from each organization, and separate sessions with each organization's senior leaders. The focus of these interviews was on participants' experiences of the initiative and its impact on their work. C4CW conducted a total of 13 interviews with 64 participants.

3. **Impact assessment survey**. This anonymous online survey, conducted between November and December 2015, was completed by a representative sample of participants from each organization who consistently engaged in the initiative, including senior leaders and program staff. The survey assessed participants' perceptions about the degree to which the initiative impacted their organization and/or program's capacity in key outcome areas. A total of 57 respondents completed this survey.

4. **Self-assessment survey.** This pre- and post-survey instrument was administered online with 11 CHS and TPCP senior leaders who participated in the ally development process, including 1:1 coaching sessions. The purpose of the survey was to assess their perceived

capacity to embody the Leadership for Collective Wisdom framework. Pre-process surveys were conducted in early 2015. Post-process surveys were conducted in December 2015.

5. **Monthly work summaries**. All C4CW team members completed detailed summaries of work performed each month, including the type of work, the number of hours for each task and the total number of hours expended, the program or organization the work was for, and other details.

Beyond these common data sources, we reviewed data unique to each organization, including: specific products developed through their WTI work; summaries from various planning and implementation meetings and wisdom dialogues; feedback summaries from orientations and immersion trainings in the Wisdom Transformation and Leadership for Collective Wisdom frameworks; and others.

Another source of information for this report was our direct observations of each organization while working to support their WTI efforts. Over the course of the initiative, we developed and followed a protocol for regularly recording our observations as process notes for each organization. We regularly reviewed these process notes while working with the organizations, and again during the writing of this document.

Finally, we reviewed the preliminary findings of our data analysis with organizational leaders, inviting their feedback and reflections to help guide the completion of this final report.

A Brief Description of Each Section

Section 1 begins with a brief description of the Wisdom Transformation framework, and a more detailed exploration of the commitment to leadership, which became the starting place for our work with each of the participating organizations.

At the heart of the Wisdom Transformation framework's commitment to results is the discipline of using data to answer three related but distinct questions for any program or initiative:

- How much did we do?
- How well did we do it?
- Is anyone better off?[5]

We use these questions to organize our analysis of the data. Section 2 addresses the *'How much did we do?'* question, reviewing data documenting the number of organizations, programs, and people who participated in WTI, and some of the demographic characteristics of these participants. It also details the types and amount of support provided to participating organizations. Section 3 explores '*How well did we do it?'* by analyzing participant feedback offered over the course of the initiative about what aspects of the initiative worked well, and what could be improved.

The question '*Is anyone better off'* is ultimately about assessing the meaningful impact of any program or initiative. Section 4 analyzes and reflects on the data about the *impact* of WTI on participating

[5] These questions are part of the Results-Based Accountability framework developed by Mark Friedman. See, e.g., *Trying Hard is Not Good Enough*. Book Surge Publishing, 2009. BHRS has adopted this framework as the guiding orientation for its commitment to results.

organizations. Section 5 then delineates the lessons we learned about the *process* of helping organizations adopt the framework in service of improving their capacity to promote recovery and wellbeing for people struggling with mental and behavioral health issues. This section also details a number of the challenges we encountered over the two and a half years of working with the organizations, and describes the adaptations we made to address these challenges.

Finally, Section 6 outlines a series of recommendations for how BHRS can build upon the lessons of WTI to continue advancing the transformation of the department and its community partners.

A Final Note About Data

A major challenge for this report was how to present a coherent analysis of the overall initiative, while at the same time honoring the layers of experience and perspective within and across the four organizations. One way we addressed this challenge was to share extensive quotes from the multiple data sources, both to illustrate the major themes of the report, and to help readers appreciate this diversity of experience and perspective.

For readers who want a more direct experience of participants reflecting on their WTI experience, we have compiled several short video clips of excerpts from interviews conducted in the spring of 2014, about one year into the initiative.

The data collection strategies for this initiative did not originally include video testimonials, but we were able to leverage the videotaping of some early training events to include a series of interviews with a few WTI participants. We interviewed eight people from two organizations, and have included with their permission short excerpts from our conversations with four of the participants. Readers can access these video clips through the following links:

Christina Kenney: https://vimeopro.com/c4cw/wisdom-transformation-initiative-video-clip-1

Cindy Duenas: https://vimeopro.com/c4cw/wisdom-transformation-initiative-video-clip-2

Kate Trompetter: https://vimeopro.com/c4cw/wisdom-transformation-initiative-video-clip-3

Paul Corona: https://vimeopro.com/c4cw/wisdom-transformation-initiative-video-clip-4

These videos include powerful stories of personal and organizational transformation. In future efforts like the Wisdom Transformation Initiative, we recommend including funding to support a more systematic approach to video interviews, ideally including video interviews at the beginning, mid-point, and conclusion of the initiative.

SECTION 1: THE FRAMEWORK(S) AND OUR APPROACH

To understand the Wisdom Transformation Initiative, we must first briefly describe the Wisdom Transformation framework, and the commitment to leadership in particular.

THE WISDOM TRANSFORMATION FRAMEWORK

We detailed the original Wisdom Transformation framework in a support guide produced for BHRS staff in 2012.[6] Before we began WTI, we adjusted the language and created practices and illustrations that were more appropriate for non-profit and community-based organizations. We visually represented the four commitments of this revised framework as follows:

When we invited each organization to decide which commitment(s) they wanted to address first in their internal transformation process, all of them chose to focus on the commitment to leadership. Moreover, as we began working with their senior leadership teams and line staff, we quickly realized that we needed to simplify the conceptual framework to make it more immediately relevant to their work on the ground. That is, while all four commitments resonated with senior leaders and mid-level managers of BHRS, given their responsibility for overseeing a complex behavioral health system, this was not the case for leaders and staff of community-based organizations.

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6 John Ott and Rose Pinard. *Help Along the Way: A Guide to Support the Transformation of the BHRS Department.* 2012.

Our adaptation was to work with senior leaders and all other participants to master the commitment to leadership, integrating the content of the commitment to results within this first commitment. We then worked with the commitments to community and sustainability as appropriate for each program and group of participants we engaged. We discuss this adaptation in greater detail in Section 5.

FOUNDATIONAL CONCEPTS FOR THE COMMITMENT TO LEADERSHIP

The commitment to leadership rests on two foundational concepts: collective wisdom and the four dimensions of change.

Collective Wisdom

In our forthcoming book entitled *Leadership for Collective Wisdom,* we write:

> When human beings gather in groups, a depth of awareness and insight, a transcendent knowing, becomes available to us that, if accessed, can lead to profound action. We call this transcendent knowing *collective wisdom*.
>
> This knowing is not of the mind alone, nor is it of any individual alone. When this knowing and sense of right action emerges, it does so from deep within the individual participants, from within the collective awareness of the group, and from within the larger field that holds the group.[7]

This understanding of collective wisdom is the starting place for the commitment to leadership. Management theorist Margaret Wheatley explains this innate capacity of groups this way:

> [There is a] wisdom we possess [in groups] that is unavailable to us as individuals. The wisdom emerges as we get more and more connected with each other, as we move from conversation to conversation, carrying the ideas from one conversation to another, looking for patterns, suddenly surprised by an insight we all share.
>
> There's a good scientific explanation for this, because this is how all life works. As separate ideas or entities become connected to each other, life surprises us with emergence—the sudden appearance of a new capacity and intelligence. All living systems work in this way. We humans got confused and lost sight of this remarkable process by which individual actions, when connected, lead to much greater capacity. To those of us raised in a linear world with our minds shrunken by detailed analysis, the sudden appearance of collective wisdom always feels magical.[8]

Wheatley's last point may seem surprising: the reason the emergence of collective wisdom can feel magical—somehow extraordinary or even unreal—is because we have become so focused on the

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[7] John Ott and Rose Pinard, manuscript of forthcoming book *Leadership for Collective Wisdom*. Cited with permission from the authors.

[8] Juanita Brown and David Isaacs, *The World Café: Shaping Our Futures through Conversations that Matter,* San Francisco: Berrett-Koehler Publishers, 2009, p. xii.

rational ("our minds shrunken by detailed analysis") that we have lost touch with other ways that bring forth new capacity and intelligence.

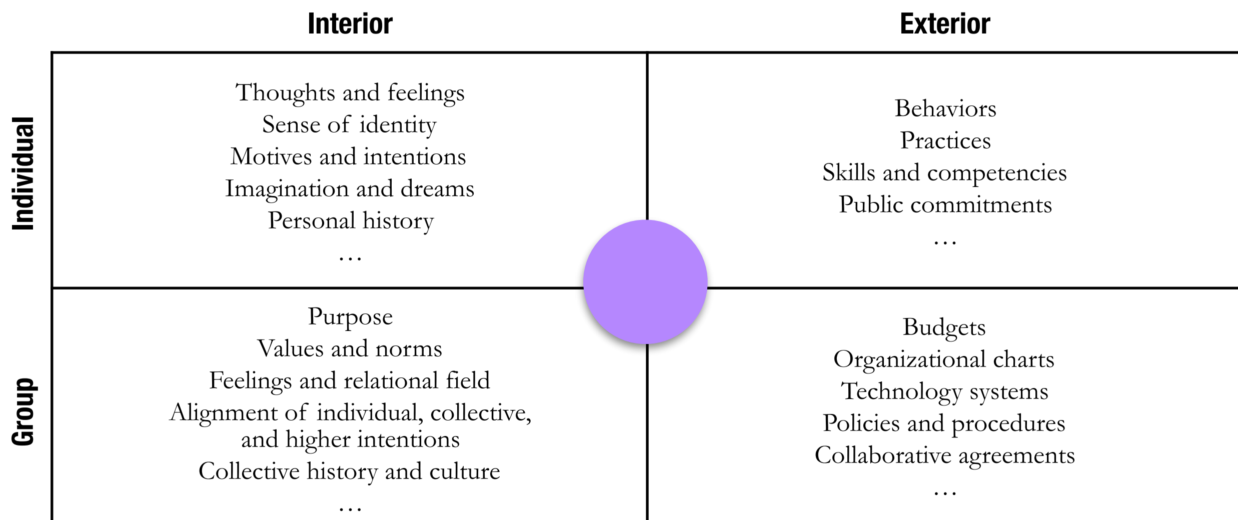
Sometimes conversations and writings about collective wisdom can, perhaps unintentionally, reinforce this perception of the extraordinary nature of the phenomenon, intimating that collective wisdom is only available to the initiated, to the chosen few who have attained an exalted level of consciousness or who faithfully adhere to a particular process or protocol.

The beginning premise of the commitment to leadership is that collective wisdom is a potentiality of *all* groups, not just so-called 'healthy' or 'enlightened' ones. This premise is not a declaration of naïve faith or a wistful prayer. It emerges from decades of experience with the phenomenon, through our work in non-profit organizations, in communities and community-based change efforts, in foundations, in small and large public sector systems, and in small and large-scale private sector organizations.

Moreover, as Wheatley writes, this is how new capacity and intelligence emerges in *all* of life, through new connections: from cell to cell, dendrite to dendrite, human to human, group to group. As extraordinary and mysterious as the experience of profound connection—and of collective wisdom emerging—may feel in the moment, collective wisdom as a phenomenon is natural, even potentially ordinary.

The Four Dimensions of Change

A second foundational concept for understanding the commitment to leadership is the four dimensions of change. Any complex human undertaking involves at least four dimensions of change: the individual and group *interior* dimensions of change, and the individual and group *exterior* dimensions of change.[9] The following diagram graphically represents these four dimensions:



[9] We developed this framework based on Ken Wilber's work on the evolution of consciousness. See, e.g., Ken Wilber, *A Brief History of Everything*, Boston: Shambhala, 1996.

The upper left quadrant represents the individual interior dimension of change, including an individual's thoughts, attitudes, feelings, dreams, sense of purpose, intentions, sense of identity, personal history, and all aspects of an individual's subconscious and unconscious mind. That is, the individual interior dimension of change includes all of those aspects of an individual's interior life that cannot be known by someone else unless the individual chooses to reveal them.

The lower left quadrant is the group interior dimension of change. This quadrant refers to the interior dimensions of a group's experience that are not visible. For example, what feelings or shared history are present within the group? Do people in the group feel safe speaking their truth, or do they feel afraid and anxious? What is the nature of the interaction between members' individual intentions and the group's collective intentions? Are there old wounds or betrayals that continue to undermine trust among members?

The upper right quadrant is the individual exterior dimension of change. This realm involves behaviors, practices, skills, competencies, and other aspects of an individual's life that can be observed by someone else.

The lower right quadrant is the group exterior dimension of change. In addition to group behaviors and skills (paralleling the individual exterior dimension of change), this realm includes the myriad external manifestations of group life: budgets, technology systems, strategic plans, policies and procedures, collaborative agreements, organizational reporting structures, job descriptions, and so forth.

Many organizations fail to achieve or sustain their desired impacts because, over time, they become so focused on the group exterior dimensions of change that they forget to continue engaging the other dimensions of change. An underlying premise of the four dimensions of change, supported by our experience and research, and that of many others, is that groups are more likely to experience collective wisdom arising to support their efforts when they engage all four dimensions of change. That is, when groups engage all four dimensions of change in a disciplined and sustained way, we open a portal for collective wisdom to arise and guide our efforts in the world.

Leadership for Collective Wisdom

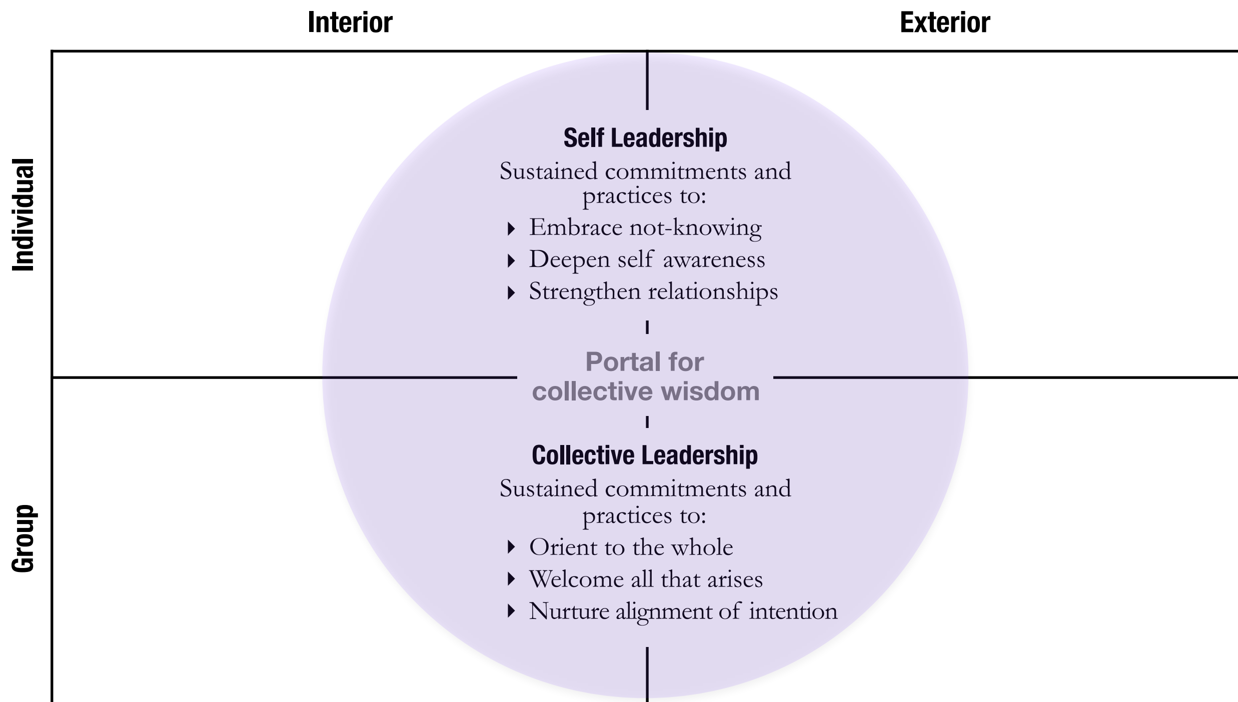
But how do we do this? How do we engage all four dimensions of change in a disciplined and sustained way to open a portal for collective wisdom to arise? One answer to this question is the Leadership for Collective Wisdom (LfCW) framework.

No group can simply decide to be wise, just as no gardener can decide to *make* a tomato. If a gardener longs for tomatoes, she must plant the seeds, and then carefully tend to the conditions that support their growth. She waters; she weeds; she protects; she waits. The better she is at sustaining the conditions that nurture tomatoes, the more likely she will be graced with an abundance of ripe, juicy fruit.

So it is with collective wisdom. The seeds of collective wisdom are always present whenever two or more of us gather, but to realize this potential, we must nurture the conditions that make it more likely for collective wisdom to arise among us. Engaging the four dimensions of change in a disciplined and sustained way is how we become gardeners of collective wisdom.

Cultivating the conditions that support the emergence of collective wisdom requires two aspects of leadership: *self* leadership and *collective* leadership. The Leadership for Collective Wisdom framework maps these different aspects of leadership to the four dimensions of change.

Self leadership involves commitments and practices in the individual interior and exterior dimensions of change, while *collective leadership* requires commitments and practices in the group dimensions of change:

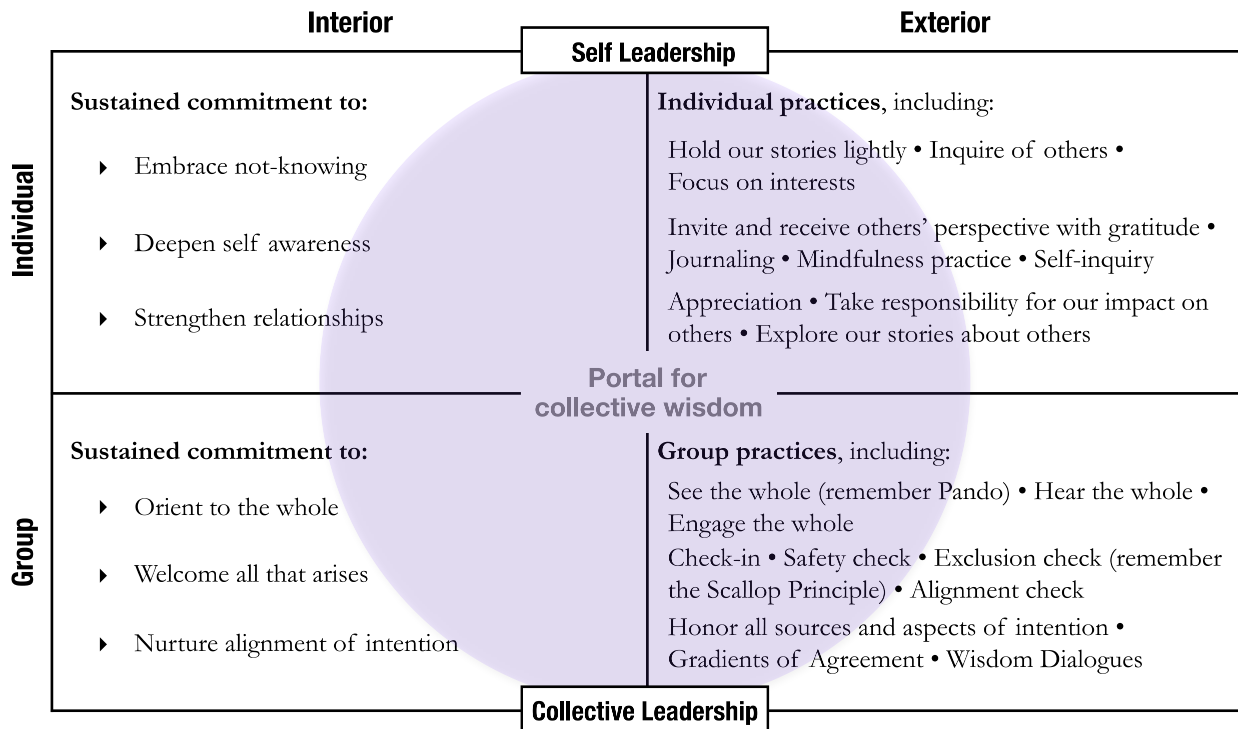


The framework includes both interior *commitments* we make to ourselves and to each other, and exterior *practices* to help us embody these commitments in the day-to-day work of our organizations and communities. In the diagram on the following page, we have mapped some of the practices that we have found most impactful in helping people embody the commitments of self- and collective leadership.

Much of our early work with WTI organizations was focused on teaching these commitments and beginning practices to senior leaders and others within the organization. That is, we helped staff and others learn how better to systematically engage the four dimensions of change through the commitments and practices of the Leadership for Collective Wisdom framework.

Although no organization or community can will itself to be wise, we can become better at cultivating the conditions that support collective wisdom, and more alert to signs that it is arising to support us. A first sign is an emergent *quality of knowing* that is beyond the mind, and beyond any one individual. Sometimes this quality of knowing manifests in a sudden and shared sense of what to do next, or a knowing that extends beyond words and amplifies a shared sense of connection and purpose.

A second sign is the emergence of spontaneous moments of *joy and generosity*, and a *sense of deeper connection*—to ourselves, to each other, and to a greater whole. A third sign is *positive, often surprising results*. Collective wisdom emerges by opening to it, not by trying to control or will it into being. The effects are often surprising because they are not predetermined; they arise through the openness of heart, deep curiosity, and intentional conversations that unfold within the group.[10]



Why the Commitment to Leadership

We define *leadership*, then, as the capacity to cultivate the conditions for collective wisdom in support of effective action. Any person, in any context, has the capacity to exercise leadership, to act in ways that support a group becoming more capable of effective action guided by collective wisdom. And any action that helps a group access collective wisdom in support of effective action is an act of leadership.

This understanding of leadership was a crucial starting place for WTI. Within hierarchical organizations, staff members can sometimes confuse leadership with authority. Authority is the right to make decisions and exercise control within a specified jurisdiction. For example, the BHRS director has authority to submit a proposed budget to the chief executive office (CEO) of the county, but not to formally enact it. That authority rests, by legislation, with the Board of Supervisors.

[10] Alan Briskin, Sheryl Erickson, John Ott, and Tom Callanan, *The Power of Collective Wisdom and the Trap of Collective Folly,* San Francisco: Berrett-Koehler Publishers, 2009, pp. 15-34.

Authority alone cannot ensure effective action. How often have we heard of a beautifully crafted strategic plan that ends up collecting dust, with nothing of consequence changing? A group of people can have the authority to develop a plan, but lack the capacity to transform that plan into meaningful action.

No one person, even someone with formal authority, can mandate that a group engages all four dimensions of change. Such work requires the sustained effort of all group members. A commitment to leadership in this context, therefore, is a commitment to create a *leader-ful* organization, an organization in which each person is invited, encouraged, and supported to exercise leadership in service of increasing the organization's effectiveness.

This is why the commitment to leadership is arguably the most important of the four transformation commitments, and why it made sense to us to use this commitment as the entry place for our work with all WTI organizations. When each person in a group or organization begins to accept both her opportunity and responsibility for leadership, the group as a whole becomes more able to adapt and innovate, and more able to realize its potential for collective wisdom in response to any challenge it confronts.

Our Approach with the Organizations

Given our focus on the commitment to leadership through the Leadership for Collective Wisdom framework, our work with each WTI organization was designed to engage both the interior and exterior dimensions of change. At the same time, while the Leadership for Collective Wisdom framework (and by extension the Wisdom Transformation framework) was a given, each organization's senior leadership team decided how their organization would integrate the framework into the organization's work, and what issue(s) the organization would address using the framework. That is, rather than dictating what an organization had to work on, we instead supported each organization to work on any issue or issues that mattered to its senior leaders and staff.

We initially framed this invitation using the concept of *adaptive dilemmas*. We define adaptive dilemmas as challenges that cannot be resolved, or longings that cannot be realized, through habitual or known responses. As part of the early planning process with each organization, we invited senior leadership teams to identify adaptive dilemmas that mattered enough for staff, volunteers, and others to invest significant time and energy to learn a new way of engaging each other—through the Leadership for Collective Wisdom framework—in service of discovering breakthrough responses that were vital for the organization's success. Each senior leadership team then developed a beginning plan for how to address their adaptive dilemma(s), including actions they would take and how they would assess progress over time.

These plans, and the processes to create them, were important starting places for each organization in WTI. This way of beginning the initiative made it clear that each organization would chart its own path, and was ultimately responsible for the progress it made through the initiative.

At the same time, the initial plans and adaptive dilemmas identified by the organizations were not the point. Our focus throughout WTI was to help participants across an organization embody a *new way of being,* and *new ways of engaging* each other, the larger whole of the organization, their partners, and BHRS, so that they could more reliably access collective wisdom in support of their ongoing work together. Some organizations remained focused for the entire initiative on the adaptive dilemmas first identified by their senior leaders. Others evolved their focus over the course of the

initiative, for a variety of reasons—e.g., as more people engaged with WTI and perceptions about what would have the highest leverage evolved, or as trust increased among participants and deeper conversations revealed different issues needing to be addressed, or as events unfolded that created a different urgency for the organization.

This way of working—helping each organization chart a process aligned with the capacity and commitments of people within the organization, and with the organization's larger culture—is an essential orientation for C4CW: essential because in every process we design, we invite people to engage at ever greater depths of the interior dimensions of change, even as they work to improve skills, practices, structures, and processes in the exterior dimensions. Such depth of work can never be mandated—participants and the organization as a whole must continue to say *yes* to this level of engagement, and must always be able to say *no* throughout the process.[11]

[11] As noted previously, two organizations that originally said *yes* to WTI decided to withdraw during the first year. We explore these developments more fully in Section 5. We helped each organization exit gracefully from the initiative, and leaders from both expressed interest in engaging again should there be a next iteration of WTI. For us, this marked a success for the initiative because the organizations discerned what was in their best interests and were supported to act accordingly.

Section 2: How Much Did We Do?

In this section, we summarize data about the organizations and people who participated in WTI, including some of the demographic characteristics of these participants. We also detail the kinds and amount of support provided to participating organizations.

Participating Organizations

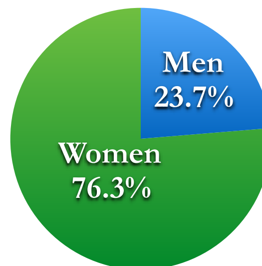
Four organizations participated in the WTI.

- **Center for Human Services** (CHS) was established as a local non-profit in 1970 to serve youth and families. Currently, CHS serves tens of thousands of children, individuals and families annually in Stanislaus County through six core program areas: Mental Health Services, Shelter Services, Youth Services, School-based Services, Substance Abuse Treatment, and Family Resource Centers.
- **Sierra Vista Child and Family Services** (SVCFS) has grown over the past four decades into one of the largest nonprofit agencies in the region, serving more than 22,000 children and families each year with nearly 300 dedicated employees, 21 programs, and providing services in every school district throughout Stanislaus and Merced Counties.
- **Turning Point Community Programs** (TPCP) is a state-wide organization with a unique vision about offering caring, hope, respect, and support on the path to recovery and mental health. Each year Turning Point serves close to 5,000 people who need mental health services in seven counties. Programs in Stanislaus County include The Empowerment Center; Garden of Eat'n; Integrated Services Agency; Garden Gate Respite Center; Warm Line; and Peer Navigators.
- **West Modesto King Kennedy Neighborhood Collaborative** (WMKKNC) is one of the leading community-based organizations addressing the health care concerns and needs of West Modesto residents in Stanislaus County. The WMKKNC has been in existence since 1993 with approximately 500 members and oversees the coordination and implementation of various state and locally funded programs and initiatives.[12]

Number and Demographics of Participants

In total, **704 unique individuals** participated in WTI across the four organizations. Participants included 167 men and 537 women.[13]

Figure 1: Gender distribution of WTI participants (N: 704)

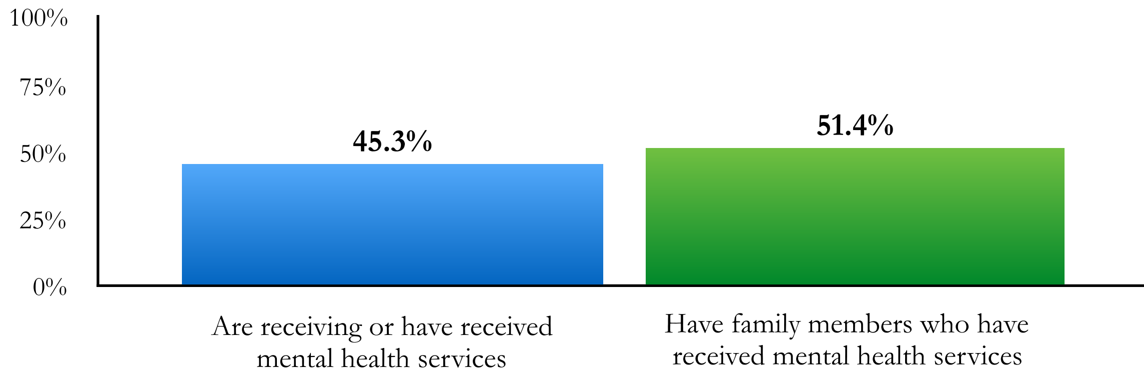


[12] Descriptions of participating organizations came from the organizations' websites.

[13] Data as reported by organizations in their progress reports.

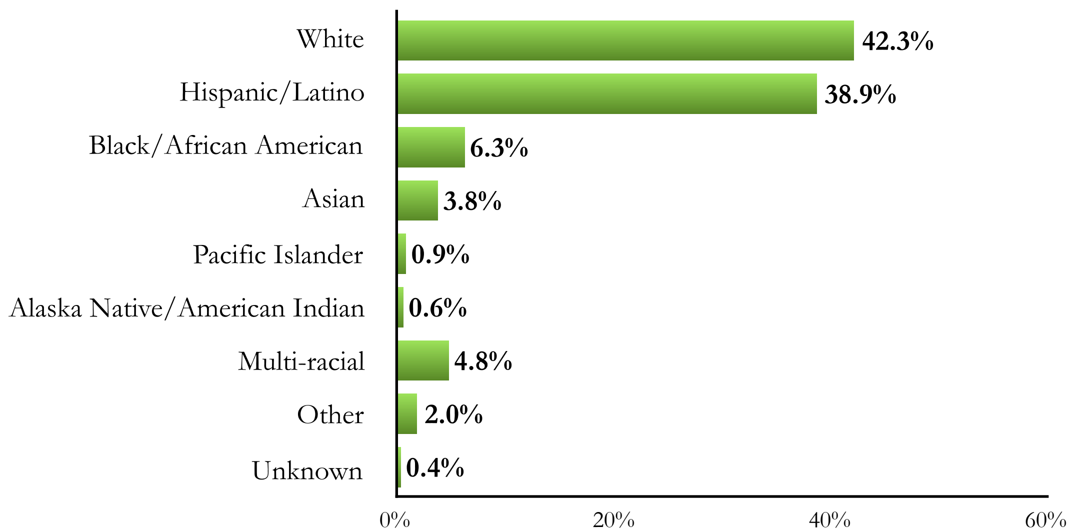
Of these 704 participants, 319 people (45.3%) were currently receiving or had received mental health services, and 362 (51.4%) were family members of people who were currently receiving or had received mental health services.[14]

Figure 2: Distribution of WTI participants by experience with mental health services (N: 704)



Participants reflected an array of races and ethnicities, including: 297 people (42.3%) who are white; 274 people (38.9%) who are Hispanic or Latino; and 44 people (6.3%) who are African American.[15]

Figure 3: Race/ethnic distribution of WTI participants (N: 704)



14 Ibid.

15 Ibid.

SUPPORT PROVIDED TO ORGANIZATIONS

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

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

We periodically reviewed this plan with organization leaders and helped them adjust their plans as necessary to track how the initiative was evolving in each organization. In response to these plans and ongoing feedback from the organizations, C4CW created custom-designed support processes for each organization. These tailored support processes included:

- **Consultation support:** Each organization received significant hours of support from C4CW, with the total number for all organizations exceeding 3,300 hours.[16] Examples of how organizations used this time included immersions in the framework for specific audiences and/or the entire organization; group and 1:1 coaching; design and facilitation of Wisdom Dialogues[17] to address specific adaptive dilemmas; design and facilitation of strategic planning sessions to integrate the framework more deeply into the day-to-day operations of the organization.
- **Small grants:** Each organization received two $5,000 grants[18] to support its efforts, one in each of the first two years of the initiative. Organizations used these grants mostly to pay for expenses associated with trainings, strategic planning retreats, and extended Wisdom Dialogue sessions, including meeting costs, mileage, overtime, stipends, and other expenses. At least two organizations purchased technology to support online learning sessions.
- **Ally training:** Leadership teams from two of the participating organizations received intensive training, coaching, and support to become "in-house experts" on the Wisdom Transformation framework generally, and the Leadership for Collective Wisdom framework in particular.
- **Webinars:** Staff members and volunteers from one of the participating organizations, including people who have received services and family members, participated in a series of

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[16] Analysis of C4CW monthly work summaries and related reports.

[17] See a detailed description of this process innovation in Section 5.

[18] One of the organizations received only one $5,000 grant because they started the project later than the others.

webinars in the second year of the project to reinforce the fundamentals of the framework and engage with emerging implementation questions.

- **Online resources:** C4CW created a website of training videos—c4cwwti.org—so that volunteers, staff, people receiving services, and partners of participating organizations can review and continue to reflect upon and teach the essential elements of the Leadership for Collective Wisdom framework.

Additionally, C4CW designed and facilitated periodic meetings of leaders from participating organizations to share emerging lessons and challenges, explore how to improve the project over time, and develop plans for sustaining the effort beyond the Innovation Project.

SECTION 3: HOW WELL DID WE DO IT?

Participants' feedback offered over the course of the initiative highlighted aspects of WTI that worked well, and other aspects that could be improved. This section summarizes this feedback.

Throughout this section, frequency counts (as indicated by "n") are specified for each key finding and are based on analyses of the multiple data sources used for this report. While the primary unit of analysis is individual organizations, progress was documented at one or more levels, depending upon the chosen scope of engagement for each organization. These levels included: leadership teams, individual programs and program staff, and individual staff members and volunteers.

A final preliminary note: Throughout this section, we use reflections and quotes from participating organizations to illustrate key findings and themes. To protect participants' confidentiality, however, we excluded any information that would explicitly reveal their identity.

WHAT WORKED WELL

Progress reports, key informant interviews, and survey data indicated that a number of dimensions of the initiative worked well, including the following.

1. The overall support provided by the Center for Collective Wisdom (C4CW). (n: all 4 participating organizations)
2. Wisdom dialogues and other collective engagement and discernment processes designed and facilitated by C4CW. (n: 4)
3. Engagement of staff and volunteers in trainings to learn the Leadership for Collective Wisdom framework. (n: 3)
4. The Leadership for Collective Wisdom framework and C4CW's orientation to leadership. (n: 2)
5. Flexibility to adapt the plan for implementing Wisdom Transformation processes. (n: 2)

The following sample quotes (noted in *italics*) illustrate these themes.

> *The support we continue to receive from C4CW is vital to helping us slow our pace and helping us to keep a healthy, effective focus, staying out of the firefighting mode which we desperately need when changes in programming can surface so abruptly.*[19] (Theme 1)
>
> *The 1:1 coaching was very specific, allowing me to be able [to] receive targeted knowledge about how a dynamic or process could be interpreted, consider all data, and work on application on a personal level which was very helpful about several key issues I was needing help with.*[20] (Theme 1)
>
> *The support … has been undeniably effective, timely, and very well designed to respond to specific needs, understand key processes and where management and staff may be experiencing areas that*

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[19] Organization progress report, January 2014.

[20] Organization final report, December 2015.

could become more effective. Many consultations have resulted in re-examining more effective ways to communicate concerns, provide and receive feedback, and continue to explore the priority of staff and organizational wellbeing.[21] (Theme 1)

The consultation and meetings with C4CW, [which] continues to enlighten [and] provide hope and relief to our leadership team is paramount to our resiliency. Our meetings are a safe place for reflection, support, and well-being that is vital to our mission.[22] (Themes 1, 2)

Annual Senior Leadership retreats … helped us understand and embrace the practices, identify our personal and collective "yes" to implementation, and develop our strategic plan to continue to embed the practices in our leadership/organizational culture. Facilitated learning dialogues, both planned and unplanned have been invaluable as we have identified "dilemmas" at the organizational, program and team levels.[23] (Theme 2)

The manner in which the training was framed … facilitated senior admin to "buy in" first, supporting and encouraging leadership to become excited about the Leadership Training, which in turn helped leadership to embrace and "sell" it to staff prior to staff orientation. Furthermore, the breakout sessions during the three day Leadership training really helped each broad set of programs drill down into the framework and "make it their own." It was great to see wisdom arising and an alignment of intention emerge across leadership leading to focused and well received Wisdom Dialog sessions.[24] (Themes 2, 3)

The beginning pictures [depicting aspects of the framework] were powerful. They grasped our attention and recognition of how growth and change can occur, and the importance of "collective" vs. "individual" efforts (whether agency or people) in creating sustainable change.[25] (Theme 4)

Though much of leadership's efforts focused how to adopt the WTI framework internally within the agency, many staff also connected the utility of the framework to our work directly with families.[26] (Theme 4)

What has worked well has been: … The freedom to change our minds/direction, question without feeling uncomfortable, knowing that all dialogue was accepted, appreciated and understood. The evolution of a clear direction after many "new revelations." Knowing the outcome substantiates the need for the journey. It was well worth it.[27] (Theme 5)

Participants from at least one organization mentioned the small grants, and participants from another organization mentioned the online resources, as aspects of WTI that also worked well.

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[21] Organization progress report, January 2015.

[22] Organization progress report, January 2014.

[23] Organization final report, December 2015.

[24] Organization final report, December 2015.

[25] Organization final report, December 2015.

[26] Organization final report, December 2015.

[27] Organization progress report, August 2015.

WHAT COULD BE IMPROVED

Progress reports, key informant interviews, and survey data also offered suggestions on how the initiative could have been improved, although participants generated less data and reflections in response to this question, and no theme resonated with all four or even three organizations. Themes that arose included the following.

1. Increasing resources and processes to reinforce the Leadership for Collective Wisdom framework to deepen participants' engagement, learning, and embodiment. (n: 2)
2. Focusing early initiative engagements at the intra-organizational and program level as opposed to the inter-organizational level. (n: 2)
3. Continuing WTI and C4CW's support beyond the Innovation Project. (n: 2)

A number of sample quotes (noted in *italics*) illustrate these findings.

> *There is a need to continue returning to core Leadership for Collective Wisdom framework [concepts]. In some instances it requires new ways of thinking about the [organization] and participants need support in making these conceptual shifts.*[28] (Theme 1)

> *Perhaps in the initial introduction, to emphasize this as a gradual, individually-program-paced process. Once [we] focused more on understanding the foundation of the framework rather than thinking ahead about the "hows" and the "whens," the door was opened for a more deepened understanding.*[29] (Theme 2)

> *The only challenge was initially when [the] focus was on working with [all of the organizations together] vs. developing [each individual organization's capacity] and then aligning their efforts based on identified needs in developing partnerships.*[30] (Theme 2)

> *If going forward means moving from where the process is now toward something else, [we] could not identify improvements to the process now. The only thing would be some continued engagement as the organizations move from planning to action. C4CW is now in a greater position to assist the organization as challenges will emerge in implementing strategies. It would not entail the monthly meetings, but quarterly or as needed support.*[31] (Theme 3)

Participants from one organization thought that the early orientations of the initiative could be designed to better help people understand the overall arc of the process. Program staff from another organization struggled with adapting and translating the language of the Leadership for Collective Wisdom framework to make sense within their day-to-day responsibilities.

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[28] Organization progress report, January 2015.

[29] Organization progress report, January 2015.

[30] Organization final report, December 2015.

[31] Organization progress report, August 2015.

SECTION 4: THE IMPACT OF WTI

The first set of learning questions that defined the focus of WTI focused on the impact of adopting and learning to embody the Wisdom Transformation framework by participating organizations.

Specifically, we assessed whether and how the adoption of the Wisdom Transformation framework helped participating organizations increase their capacity to:

- Learn to adapt better to the policy and fiscal volatility within the behavioral health system;
- Create a stronger and more positive internal environment for staff and others connected to the organization so they can better support the people they serve; and
- Cultivate more effective collaboration among each other and with BHRS.

This section analyzes the data to respond to these learning questions. We also explore what the data suggest about the potential for the Wisdom Transformation framework to help organizations improve outcomes for people suffering from or at risk of mental illness. While the timeframe for this project prohibited us from being able to document sustained impact on outcomes for people receiving services, the data we have collected allows us to offer beginning reflections about the potential for this lasting impact.

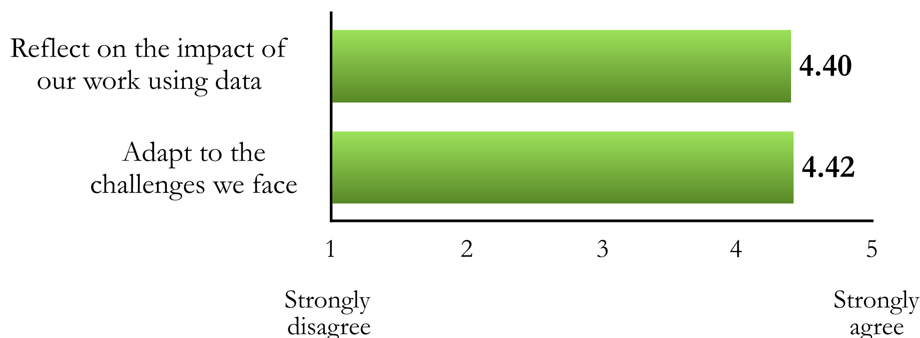
ORGANIZATIONS LEARNING TO BETTER ADAPT

BHRS adopted the Wisdom Transformation framework to help the department better navigate the fiscal and policy instability that accelerated as a result of the recession and its cascading effects. And although the recession's effects have diminished somewhat, the policy and fiscal instability within the system remains.

A major focus of this Innovation Project was to explore whether the Wisdom Transformation framework could similarly benefit participating organizations, increasing their ability to adapt and respond effectively to the system instability they encounter. The data suggests the answer to this question is clearly *yes*.

First, a significant majority of the Impact Assessment survey respondents agreed or strongly agreed that their organizations had an increased capacity to reflect on and adapt to changes as a result of participating in WTI. *None* of the 56 respondents disagreed with this statement.

Figure 4: As a result of participating in WTI, my organization/program has an increased capacity to: (N: 56)



More compelling than this simple quantitative data, organizations demonstrated a capacity for learning and adaptation through the application of various aspects of the framework across the whole organization, within senior leadership teams, and within particular programs.

Senior Leadership and Organization-wide effects

One organization developed a long-range strategic plan grounded in the commitments to leadership and results. Senior leaders have taken steps to integrate the Leadership for Collective Wisdom framework into all aspects of the organization, including staff surveys, performance evaluations, orientations for new staff, and others. One senior leader reflected:

> *I believe job satisfaction is higher. We are more transparent, more inclusive and more intentional in our words and actions. There has been a promising shift in our culture that has made us even stronger and more appealing for employees.*[32]

A second senior leader observed:

> *I was thinking about the move [to our new office location]. … [and] the potential for our culture to change, or for us to lose some of who we were in our previous location. … I feel like the wisdom transformation has allowed us to maintain [our culture] to a great degree but also respond to the potential for all of that to change, in a way that has been really productive and inclusive. … It's given us tools to respond in a really effective way whereas we may have just gotten caught up in getting this move done.*[33]

A second organization developed a first-ever, organization-wide budget as part of a strategic planning process that included major revisions to the organization chart and key job descriptions. This long-term budget, developed in response to changing community needs and the need for succession planning, was unanimously endorsed by the board and key community stakeholders as an essential adaptation for the organization's long-term sustainability. A senior leader from this organization observed:

> *The dilemma, adaptive or otherwise, was huge. I think [the result] was way past what we had anticipated, and I don't think we had anticipated being where we are today … So, I learned that really, anything is possible if you continue to work at it and go through all the ups and downs.*[34]

A third organization developed a series of responses to strengthen its recruitment, training, and retention of new staff. The advent of the Affordable Care Act and other changes in the labor market are putting pressure on the organization as long-term staff leave for private sector positions paying more than the organization can match. A senior leader described her team's evolving response as follows:

> *We are improving job descriptions across the agency so that there is greater clarity about roles and responsibilities. We are also [benchmarking] salaries, so that people feel appreciated, and we are continuing to renegotiate contracts to be able to grant more increases. We have been more open as a*

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[32] Impact assessment, November-December 2015.

[33] Key informant interview, September 2015.

[34] Key informant interview and focus group, September 2015.

> *leadership team and increased our understanding of what we want, and now we have come up with something that will get us to where we want to be. This couldn't have been achieved with a top down process. Our organism is working through change toward a goal that we have put in place. It is like climbing a mountain as a team; we must help each other out.*[35]

A fourth organization's senior leaders demonstrated increased capacity to strengthen their teams' capacity for leader-ful behavior. One leader observed:

> *[WTI] has broadened my perspective of being not [just] more open to feedback, but more purposeful in soliciting feedback from staff. There are times, when in my exuberance about a particular thing, I will just go forward. Then I have to play catch-up, and that's not the best way to do that. This is sort of enlightening me to that process, or the fact that I do that. Second, as a leader, [it helped me] to be more purposeful about cultivating this way of being with our leadership staff in general. Certainly, when I work with parents, I knew it wasn't enough to be a role model. There has to be teaching as well. And, as a leader, I have been more a role model and not as purposeful in teaching or leading in this sort of capacity. So I think to be purposeful about cultivating the way of being in collective wisdom [has affected my understanding of leadership through WTI].*[36]

Another leader observed:

> *Apart from the work on results, the [Wisdom Transformation] WT has had a profound impact on the quality of [our leadership team's] relationships, and created a deeper trust and bond between us. I've seen individual growth and maturity develop as we embody the WT commitments and practices of self-leadership. Connecting the WT to individual challenges and goals has made a big difference in our understanding of what it means and takes to be a leader.*[37]

Program-level effects

Three of the four participating organizations also applied the framework to program-level efforts, typically involving the implementation of Wisdom Dialogues.

In one program, staff developed new processes for supporting participants to play a more active role in their own recovery. These new processes not only helped the participants, but also helped staff to better adapt to changes that could impact participants' progress. A staff leader described this process as follows:

> *[Our program] has spent the past six months developing an assessment process that identifies the particular needs of each resident, the kinds of support they need and the capacities the program needs to support their success. The process is evolving and has focused on the development of staff and youth surveys and how to have conversations among staff based on the results of the surveys. The structure the surveys gave to weekly staff meetings and the differing perspectives that were revealed led to productive discussions about additional support we could offer a young person and the clarity that in some cases we had offered all the support we could but there was a misalignment of intentions between what the program could offer and what the young person wanted or needed … This subtle shift in*

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[35] Key informant interview and focus group, November 2015.

[36] Key informant interview and focus group, November 2015

[37] Organization final report, December 2015.

> *thinking about misalignment vs. failing as a program/staff is and will continue to have profound effects on staff and therefore on programming. It allows us to move from fear of failure to inquiry about what's working and not working and why.*[38]

Family Resources Centers (FRC) began a process of transforming their focus from delivering discrete units of available services to helping communities strengthen their capacity to promote the recovery and wellbeing of their members. One of the FRC leaders observed:

> *We have been focused on developing common results related to the movement toward and engagement of community. All … teams have engaged in work to help develop a survey with common outcomes and indicators. … Teams were able to review and reflect on the results, which were overwhelmingly positive and will help guide next steps as we move forward. … Leadership [team members] are learning how to hold Wisdom Dialogues with their staff/teams, to help understand what we're learning together and to address adaptive dilemmas as they arise.*[39]

Several programs implemented new approaches to decision-making for process improvements led by staff. Managers for these programs described these processes as follows:

> *[One of our programs] experienced tremendous growth. … Staffing is pretty much nine-months onsite at schools, but we've kept staff employed over the summer because it helps with retention. … Well, going from 25 to 50 staff, we don't have enough space for all of them over the summer, so it was a little dicey. It was people sitting around like 'What am I going to do?' and 'How do I work?' I suggested that the team start having conversations now about this adaptive dilemma. Is it really about how do we provide productive work experiences for people 12 months out of the year, and is there a different service delivery model that we might be able to implement that will be better? They're in the process of gathering that data. … When we had an experience like this before it might have just been 'Let's hold a meeting and figure out what we're going to do.' Now it's like 'let's start having some learning conversations, figure out what we need, and be more intentional about how we approach dilemmas.' We're practicing getting more eyes on it and creating a collective understanding before we jump to action.*[40]

> *For us, [scheduling holiday vacation] is a huge, huge issue. The nature of our program is 24/7 and there are people [who] literally don't see one another more than once every month or two. Our first learning dialogues were around creating a holiday schedule. That was a big point of contention. It was almost like there was campaigning going on—early in the year—about who would get what holiday off. It was about identifying what the problem is and looking at what the givens are, what is negotiable, what's not negotiable and then, bringing out the self-interests and putting everything on the table so it no longer becomes, "I don't have to think about what his family might have going on. I'm just thinking about what I want to do on my holiday." But when all those things are out on the table, it's hard to look away. … And to see the generosity and the graciousness that came out of that process. … It really helped everyone to think beyond themselves.*[41]

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[38] Organization progress report, August 2015.

[39] Organization final report, December 2015.

[40] Key informant interview and focus group, October 2015.

[41] Key informant interview and focus group, November 2015.

> *One of the key lessons learned related to billing obligations. Some staff members were welcoming only what they wanted. … It was only later when we discussed at a much deeper level about what was getting in our way and how we could help each other to offset some of the hurdles we were having, while at the same time holding people accountable for hitting their floors … that [we made significant choices about personnel]. This had a huge impact on staff, and it also motivated staff to step up and join the intent of the group, understanding that we need everyone's effort to make this work. It became quite rewarding as we continued to pick up momentum, hitting our goal two months in a row, three, and then four. … The team was demonstrating that they were at capacity as a cohesive team to effect positive results and become excited about "being on a roll."* [42]

And almost all participating programs have implemented practices and processes to strengthen the engagement and leadership capacity of staff. Staff members from two different programs described this work as follows:

> *We had such monumental shifts [in our programs] that I think if we didn't have Collective Wisdom, we wouldn't have, at least for me, been able to really fulfill my own needs and the needs of the whole. … Collective Wisdom has been able to [provide a] structure for learning how to get alignment versus 'I don't know why my supervisor is doing this' or 'Why can't the county get that our population doesn't fit into their cookie-cutter mold.' I've been able to sort through those feelings and not take it personally, or feel defeated. It's just kind of like, 'Okay, so there is that ginormous log in the road and we're all going to kind of laugh about it, and eventually without realizing it, we'll all be able to move that log and work along side each other.' Collective Wisdom built that confidence.*[43]

> *We had received feedback that caused concern about the culture of this team. [A senior leader] decided to meet with the team, instituting the WT practices as she began to work with them. In the three meetings they held, much progress has been made in their relationships and their commitment to work together to improve the culture in their office. One of the keys was creating an environment where they could hold their stories lightly and welcome the experience of others. Another big turning point occurred with the leader of this team as she acknowledged her need to lead differently, modeling self leadership.*[44]

MORE POSITIVE INTERNAL ENVIRONMENTS

A second intended impact of organizations embodying the Leadership for Collective Wisdom framework is to strengthen their internal working environments so that staff are better able to support the recovery and wellbeing of the people they serve.

A significant majority of respondents to the Impact Assessment agreed or strongly agreed that their organizations were able to create a more positive working environment as a result of participating in WTI. *None* of the 55 respondents to this question disagreed with this statement.

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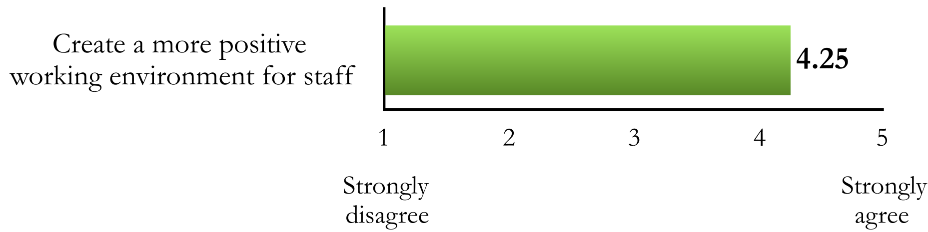
[42] Organization progress report, August 2015.

[43] Key informant interview and focus group, November 2015.

[44] Organization progress report, July 2014.

Figure 5: As a result of participating in WTI, my organization/program has an increased capacity to: (N: 55)



One senior leader described the impact she observed this way:

> *Employees are holding their stories lightly, welcoming all that arises, and there is overall a sense of calm that comes from embodying these practices. Wisdom Transformation is leading us to more thoughtful decision making, including "more eyes on the scallop" and being leader-ful. I have literally watched the change from senior management level to our receptionist and everywhere in between.*[45]

Another senior leader agreed:

> *The concepts associated with self-leadership have created better relationships, more thoughtful decision making, and employees are finding their voice. This has an overall positive impact on our culture which translates to job satisfaction which translates to working smarter.*[46]

And a staff member from a different organization described the impact of WTI this way:

> *To see the willingness, the desire, the wanting, of the organization that you work for to [commit to WTI]—it creates a better work environment, but it bleeds over. It creates better employees. You have tools that you didn't have before because of work to go home to your life. That's meaningful. That says a lot. That's huge. ..I don't want it to end. Just keep it going …*[47]

The data document that staff members' increased capacity for leader-ful behavior, a foundational concept of the Leadership for Collective Wisdom framework, was a key factor in creating a more positive working environment. The concept of being leader-ful distinguishes between formal authority and leadership. The LfCW framework recognizes that every person can exercise leadership —defined as acting to help create the conditions for collective wisdom to arise in support of profound action.

The data identify two types of leader-ful behavior that significantly contributed to improved working relationships and more positive internal environments: (1) initiating conversations with others to improve shared understanding and resolve issues, and (2) initiating actions that intentionally provide tangible support to others.

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[45] Impact assessment, November-December 2015.

[46] Impact assessment, November-December 2015.

[47] Key informant interview and focus group, September 2015.

The data include numerous examples of staff members initiating conversations to resolve differences and/or to create shared understanding, including the following.

> *A shift is occurring and there are more employees seeking guidance in dealing with internal relationships. I see this as a positive behavior that people are finding their voice through the wisdom transformation practices and dialogues. Employees who would typically work around behaviors that aren't in line with our culture, values and the [Wisdom Transformation] are now coming forward and addressing the issues directly with the person. … This is a huge benefit and issues are getting resolved quicker. Starting a conversation with "this is my story …" tends to lessen defensiveness and negative responses. Once employees experience the positive outcome of these conversations they are more willing to address issues in a timely manner.*[48]

> *Staff are able to approach each other about situations that come up and use terms that we have learned to have a learning conversation. It has provided a way to talk and communicate with each other where it does not seem like a personal attack.*[49]

> *Although still present, there seems to be considerably less influence of attitudes and behavior based on third-party communication, rumors, and gossip. There is also greater willingness to communicate openly and directly, with less fear of judgment and reprisal, although the degree to which this has developed varies widely among staff members.*[50]

The following stories, shared by line staff from three different programs, are typical of the data about staff members' increased leader-ful behavior to more intentionally provide support to others.

> *The WTI trainings have been a rather unusual experience for me. I have never attended a training set up quite like it and it has been a rather interesting and hopeful journey. I found myself drawn most strongly to the portion of the training responding to orienting to the whole, in regards to seeing the whole and hearing the whole. I work predominantly night shifts and the interactions I am able to have with my team members is restricted to a once-a-month scheduled meeting. Staying informed and up-to-date with team communications is rather hard. After our first WTI training we had a staff meeting and one of our team members mentioned how someone had a rather incredible job—or did a rather incredible job handling a situation that had arisen on their shift. No one in the team had heard about it and we spent a good portion of time discussing how sometimes everyone gets a bit down due to lack of support. The feelings of isolation and stress, of wondering if we are actually doing our job and giving our job our all. After someone thought on how best to remedy this, the notion of the box was born [to document our appreciation of someone on a slip of paper]. It was a simple fix and an easy way for everyone in the office to give the support to each other and offset the feeling of being on our own. It gives us something to look forward to at the meetings and a fun event to recognize our coworkers and to be recognized ourselves. It allows all of us to feel appreciated and ensure that we always end meetings on a positive note.*[51]

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[48] Organization final report, December 2015.

[49] Impact assessment, November-December 2015.

[50] Impact assessment, November-December 2015.

[51] Key informant interview, September 2015.

> *[WTI] has affected how we work together. Before [WTI], it hadn't been easy, it was stressful. Since we've been doing the Collective Wisdom, we've been able to support each other more. It can make me a lot better and it makes a better environment for us to feel comfortable being at work … It's not about showing up and just doing our job. It's about looking at each other and saying, 'Are you okay? What's going on?' It's not something we're doing just for our members, but we're doing it for each other as well.*[52]

> *So that's made me step back and take a breath and get my team members' story and not just automatically—and embrace it and be okay with silence. Be okay with not knowing all the answers or not knowing everything right now. Be patient, it'll eventually come out. And then what happened with us as a team was we started to talk to each other collectively about, okay, ''I'm doing this. I have this client. This is what I tried. Oh, I know this and this might work.' And then we started talking as a team together. Instead of having our weekly team meeting with our supervisor, we started having our own team meetings on a daily basis and going over what we were going to do. And we noticed that [one of our team members] would not face us. So I brought it to the team's attention and we had a conversation with her. And we were like, 'We feel you're not part of the team. What's going on? This is a collective wisdom thing. We're trying to get all different thoughts.' And in that conversation it was really great because she admitted, "I felt like I was being left out." We had the courage, I guess you could say to have this conversation amongst ourselves. Since then we've worked on it and now when we do our roundtable discussion, she turns around and tells us about her ladies. … She engages and shares whereas before she literally had her back to us. So I just took it upon myself. I was like we've got to figure this out because I don't like this uncomfortable feeling.*[53]

INCREASED CAPACITY FOR COLLABORATION

The senior leaders from all four organizations reported that, as a result of WTI, their organizations experienced an increased capacity to more effectively collaborate with each other and with BHRS. The following stories are typical of the data about how organizations were better able to collaborate with each other.

> *The benefit of everyone having participated in wisdom transformation through the Center for Collective Wisdom has been a positive effect on communication, appreciation for the overall intent of the partners and greater understanding and willingness to move selves aside for the greater good of all communities. [Our organization] has been able to understand and appreciate those areas where other organizations are different, engage in meaningful dialogue and acknowledge that in order to achieve desired results strong partnerships will determine the outcomes.*[54]

> *With other partner organizations who may experience frustration due to stories based on misperceptions about who we are or what we do, keeping in mind the WTI framework, and approaching individuals with genuine concern for and curiosity about the sources of their frustration, helps set the stage for a conversation focused on providing education to partner organizations, and*

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[52] Key informant interview and focus group, November 2015.

[53] Key informant interview, September 2015.

[54] Organization progress report, August 2015.

> *problem solving about how both entities can meet legal and ethical obligations, while still being in service of the guest considered for and/or being served.*[55]
> *Leadership continues to work alongside our partners at CSA, exploring ways to improve the system experience for participants. Our approach is informing the way we work together, promoting inquiry [and] welcoming all perspectives.*[56]

> *We had an experience with our partner [organization] as it relates to changes within a program. … Our initial response was frustration as we saw this as a major problem for us. We held a learning conversation … and really explored the stories we were holding about this and ultimately … we agreed that we would share our story … to both understand their perspective and help them understand ours. … As a result, we did something we have never done; tell a partner that we understood and would accept their decision and that we were okay with backing out of the partnership as this was staying true to what [our organization] needed to be an effective partner. They asked for time to consider this and I'm happy to report [the issue was resolved and we are still partners].*[57]

The following stories are typical of the data illustrating how organizations strengthened their collaboration with BHRS.

> *The Leadership for Collective Wisdom framework helped to improve [our] program's capacity and effectiveness with BHRS in several areas. Our ability to come to the contract monitoring meetings as a partner versus coming in as a one-down relationship … has been greatly improved. These conversations are tending to be more of learning dialogues and discussions about related information to have more informed opinions about service delivery. BHRS representatives … [also] contribute to these discussions in what feels like greater collaboration than in the past.*[58]

> *In interactions with BHRS, engaging others through the framework has helped remove antagonistic or adversarial dynamics that interfere with problem solving, and recognition that we share the same mission in our desire to be of service to others. It has also helped to encourage all involved in complex situations to step back, consider the complexity, and how that might lead to the perception/experience of feeling undermined or thwarted, when there is no such intention. It has helped make room for the intention behind perceptions to emerge, which almost always helps open communication and facilitate constructive problem solving.*[59]

> *The thing that shifted was me being able to go to BHRS and say this is a shared story. We're part of your system and we need to tell you this is our story, that we have 300 or 400 referrals we can't manage right now. We're at capacity, but we're holding a story that we're going to be out of compliance if we don't, so how do we as a System of Care start looking at this and prompting more conversations about how to look at that? Not just [our organization], but all of us orienting … to the whole, … The nice thing about it was the chief was like, "Well, it looks like I need to give you more support to*

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[55] Organization final report, December 2015.

[56] Organization final report, December 2015.

[57] Organization progress report, January 2015.

[58] Organization final report, December 2015.

[59] Organization progress report, August 2015.

do your work and then, yes, you're right. This is not just your responsibility. This belongs to the whole system, so let's start looking at that as a system." In the past, when we'd sit and brew and stew about the stories that we're holding that [our patterns were] saying and that wasn't their story at all.[60]

Some of the ways we have been able to realize a more effective collaboration with BHRS is to explore much of the perceived problems(s) that really lean more toward systemic concerns or adaptive dilemmas [that have] come out of staff discussions where the stories we hold are not about an "us" or "them" mentality but really how an adaptive dilemma is impacting the system. [61]

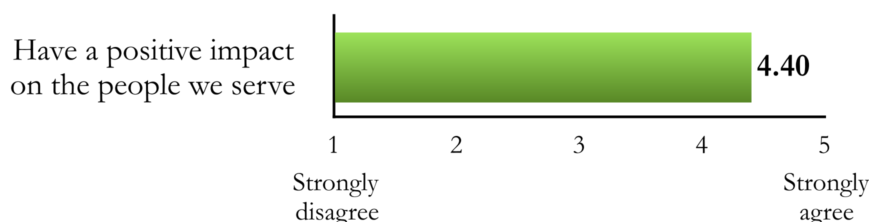
Improved Results for People Receiving Services

The principal focus of this project was to promote interagency and community collaboration, and the data suggest substantial progress toward this objective. The ultimate purpose of any transformation effort, however, and any project funded through the Mental Health Services Act, is to improve results for people who struggle with mental health issues.

Although the scope and timeframe of the project did not permit us to independently assess sustained improvement in performance measures for participating programs, the data we do have indicate the potential for sustained improvements in results.

First, a significant majority of the Impact Assessment survey respondents agreed or strongly agreed that participating in WTI increased their organization's capacity to have a positive impact on the people they served. None of the 57 respondents disagreed with this statement.

Figure 6: As a result of participating in WTI, my organization/program has an increased capacity to: (N: 57)



Moreover, participants offered multiple reflections connecting the positive impact of WTI on their programs and organizations to their capacity to effect more positive results for the people they serve. Some examples of these reflections follow.

We are seeing a pattern developing where the standard role of case management has shifted to more partnerships to obtain treatment outcomes and fostering learning conversations with clients. … We are

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[60] Key informant interview, October 2015.

[61] Grantee report, August 2015.

also beginning to see the benefits of a collaborative work site that includes the folding together of [two programs].[62]

Our four Family Resource Centers have benefited … significantly thus far. Employing principles of WTI, the FRCs have more effectively engaged the populations they serve in open dialog regarding needs of the population. Through advisory boards, focus groups and outreach efforts, the FRCs have come together with their local communities to identify and bring specific services, trainings, and resources to the families in each of their regions.[63]

I've found that being able to come to work with a positive attitude has made me more effective at helping people. When I'm frustrated, it's kind of hard to pay attention to what they're saying. And the people we serve don't always say things directly because they don't always know what they want. But it's been helpful for me to learn how to present myself in such a way that they feel comfortable and they're more open to share with me what their concerns are. That can help me help them figure out what their needs are.[64]

The goal now is more on developing relationships than getting tasks done. The information will come from that relationship instead of just, 'Did you do this today?' … Wisdom transformation makes us stop and think about every person we meet and what our impact on them is, and how they perceive us.[65]

One of my biggest problems that I have is I assume. I will have a train of thought and then I will keep following that train of thought toward my logical outcome of what will happen. WTI has sort of helped break that rhythm … to actually talk to people and figure out what's going on instead of thinking I know best. … [T]he outcomes for the clients are a lot more positive.[66]

The dialogue we have with [people who receive services] has been positive. Feedback from [them] has been encouraging, as they have shared that they feel supported. Our data in the county surveys reflects this increase as well.[67]

[Our organization] has benefitted primarily as an organization, yet ultimately the community will achieve an even greater benefit. The ability to have realistic expectations about the structure and finances needed to ensure services are provided is a monumental achievement for the organization. This has led to focusing only on those services and activities that are important to creating change and engaging community. … Ultimately, the community and the organization can find great satisfaction in achievements within the community as a result of services and other efforts.[68]

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62 Organization progress report, January 2015.

63 Organization final report, December 2015.

64 Key informant interview and focus group, September 2015.

65 Key informant interview and focus group, September 2015.

66 Key informant interview and focus group, September 2015.

67 Impact assessment, November-December 2015.

68 Organization progress report, August 2015.

A benefit I see is it can be very challenging to work with adults with intensive, psychiatric disabilities with high acuity, and maintain hope and promote wellness and recovery. So there is [a] relationship between staff well-being and the belief that people (clients) can have better lives, and make better choices that support more peace of mind and less suffering.[69]

One of the stories that our staff members hold and continue to evolve is, 'We're here as a service provider. People are coming to us to get a service and that's what we do.' We've been in the process of really changing that story with wisdom transformation, with a family strengthening philosophy. It's about building community, and we can't do that, on our own. … This movement to community has been wanting to happen for a long time. And we've just been in our own way. … What the data .. is showing is [that there are] all these folks out there who are wanting to engage as part of the community with us. We now have this opportunity, which is really cool.[70]

Sustaining the Transformation

Essential to realizing the potential for improved results is the commitment and capacity of organizations to sustain their transformation processes beyond the project. In their final reports, every organization expressed a commitment to continue their particular WTI work beyond the initiative.[71] Two stories in particular illustrate this commitment.

Our organization is adopting a 5-year strategic plan in which WTI is prominently incorporated. Over the past 2+ years we have seen the benefits of working within the WTI framework and we see the framework as a logical strategy for developing our next generation of organizational leaders. As part of our 5-year strategic plan we are looking at ways to make the framework as much a part of our culture as our values (which have been accepted, embraced and incorporated into our work agency-wide). In a recent development we are looking to "brand" the framework to match our other organizational documents so it can be clearly recognized as something in which we are invested. While giving credit to C4CW for all they have done to create and share WTI with us, our organization needs to make it our own so our employees can fully embody it.[72]

The consensus among leadership is, '[we want to sustain] all of it.' Practically, our plan is to keep WTI alive in our Leadership Meetings. We feel strongly that if Senior Administration and Leadership continue to embrace the framework, utilize the principles, and employ the language, WTI will naturally penetrate the entire agency and be adopted by staff across programs. In particular, we would like to continue the Wisdom Dialogue work regarding the animating question … Moreover, we would be pleased to see the general framework alive throughout the agency as it aligns meaningfully with our Strategic Plan.[73]

Leaders from participating organizations have also developed a proposal—endorsed in March 2016 by MHSA stakeholders—to sustain and deepen the changes begun through WTI through the use of

[69] Organization progress report, August 2015.

[70] Key informant interview and focus group, September 2015.

[71] Final Organization progress reports, December 2015.

[72] Organization final report, December 2015.

[73] Organization final report, December 2015.

Workforce Education and Training funds. We explore some of the reasons and implications of this proposal as part of the Section 6 discussion of recommendations for continuing WTI beyond this initiative. For now, the point is that all four organizations experienced substantial benefit from WTI for their capacity to achieve and improve positive results for the people they serve, so much so that they initiated conversations with BHRS and stakeholders about continuing and extending the initiative beyond this project.

This section explored and documented the benefits of organizations learning to adopt the Wisdom Transformation framework. These benefits include:

- Increased capacity to adapt and respond effectively to complexity;
- More positive internal working environments for staff, volunteers, and others associated with the organization; and
- Increased capacity for collaboration among programs within the same organization, among partner organizations, and with BHRS.

And again, the data suggests that these benefits have already begun to translate into sustained and improved positive outcomes for people receiving services, though we cannot assert this last benefit conclusively, given the timeframe and data limitations of the initiative.

We might describe this analysis as the *why* of this exploration: why might other mental and behavioral health systems and organizations want to undertake a process to adopt the Wisdom Transformation framework for their own purposes?

In Section 5, we turn to the *how* of this exploration: what challenges did we encounter, and what did we learn about what helps organizations effectively adopt and embody the framework?

SECTION 5: CHALLENGES AND LESSONS LEARNED

A central focus of this project was the exploration of what would help organizations successfully adapt the Wisdom Transformation framework into their day-to-day operations and larger cultures. Our beginning learning questions for this part of the exploration included:

- What processes would help community-based organizations—each with different missions, cultures, and histories—successfully adapt the Wisdom Transformation framework within their particular programs and services?

- What processes would help build effective intra-organizational learning communities among staff members, community leaders, family members, and people who receive services?

- Whether cross-organizational learning communities and peer allies are promising strategies for sustaining long-term transformation efforts?

This section explores what we learned in response to these questions, and details a number of the challenges that brought forth these lessons.

WHAT HELPS ORGANIZATIONS SUCCESSFULLY ADOPT THE FRAMEWORK

We have learned a number of lessons about what helps organizations successfully adopt the framework, including the need for:

- Assessing readiness for undertaking an ongoing transformation process, given the current challenges confronting an organization;
- Regularly assessing the commitment within the organization to continue the process;
- Re-framing and translating the framework to fit each organization's unique culture;
- Engaging senior leaders first, and coaching them as allies, to help sustain the process; and
- Using technology and online resources to support the ongoing transformation.

Assessing readiness for undertaking an ongoing transformation process

WTI emerged as a proposal to support six organizations who, in the year prior to the start of the Innovation Project, had participated in an intensive discernment process about how to adapt and integrate the BHRS transformation framework to support their work. Delegations from all six organizations had exposure to the original version of the framework, and had participated in extensive conversations about how the framework aligned with their distinct organizational cultures and could help them improve the positive impact of their behavioral health services in the county.

Despite this in-depth discernment process, two organizations withdrew from the initiative during the first year, and one decided to postpone its engagement until the second year. The two organizations that withdrew from the initiative were statewide organizations that provide services in multiple counties. The senior-most leaders of these organizations do not reside in Stanislaus County, and had not participated in the prior trainings and conversations.

For one of these organizations, another internal transformation process had begun at the same time as WTI. The Stanislaus County leaders of this organization initially perceived the Wisdom Transformation process as highly compatible with their larger organization's change effort. Over time, however the organization's statewide and county leaders concluded that introducing the Wisdom Transformation framework in Stanislaus County alone, while the entire organization was undergoing a related but distinct internal transformation process, would create too much confusion among staff.

For the other organization that withdrew, while at least one senior leader in Stanislaus County wanted to continue WTI, most of the senior leadership team felt overwhelmed by new initiatives recently begun by the organization (both in Stanislaus County and across the rest of the organization). The leaders from this organization could not marshal the focus or time to fully engage in the initiative.

For the organization that postponed its participation, senior leaders discovered they had underestimated significantly the time and effort a major accreditation process would require of staff across the organization. They began to engage with WTI in January 2015, after they had successfully completed the accreditation process.

These first year developments presented the first major challenge for the project. As we reflected on these developments, we reached several conclusions and made several adaptations in the project.

First, when inviting multi-county organizations to participate in a county-based transformation process, we should engage state-level leaders in the assessment process along with the county-level leadership team. This would have meant, at minimum, holding one or more conversations with state-level leaders to explain the purpose and arc of the transformation process. Ideally, state-level leaders would have been part of the delegations that participated in the initial orientation sessions to the framework, and would have helped develop the initial plans for their county-level teams. These changes would either have identified the misalignment within the two organizations earlier, or would have helped create the statewide support they needed to continue their engagement.

Second, in subsequent interviews with county leaders from one of the organizations that withdrew, we discovered that many of them were hesitant about the initiative from the beginning, but were worried about the implications of choosing not to participate. They wanted to be good partners with BHRS, one of their major funders, and did not want to be seen as resisting a process that was clearly important to BHRS senior leaders.

This discovery reinforced a central orientation of our approach in WTI—namely, working with each organization to create a process aligned with the capacity and commitments of people within the organization, and with the organization's larger culture. and priorities. This process of transformation, of intentionally engaging all four dimensions of change in support of effective action and improved results over time, cannot be mandated by an external funder. A system to create an Electronic Health Record can be mandated; an ongoing process of transformation to cultivate cultures of collective wisdom can be *invited,* but not mandated.

Regularly assessing the commitment within the organization to continue

And this invitation must be continually extended, and the commitment to the process regularly renewed. A significant learning through WTI was the validation of our initial hypothesis that nurturing the capacity to embody the Leadership for Collective Wisdom framework requires

consistent opportunities for practice and social reinforcement over time. While one-time training events provide an essential forum for developing intellectual understanding of key concepts, ongoing practice in real settings over time is needed to produce sustainable changes in mindsets, behaviors, cultural norms, and institutional policies and procedures.

Many naturally occurring dynamics can inhibit and challenge our innate capacity for learning and growing together: individual and group emotional reactions and attachments to particular mental models; conflicts among staff and others that fester over time; changes in leadership; new regulations requiring significant program changes; shifts in budgets; and on and on. All of these dynamics and potential developments are constantly present, and any one or more of them can quickly deteriorate into the conditions for collective folly. To cultivate the conditions for collective wisdom to emerge in the midst of these constant challenges requires ongoing attention, practice, and discipline, as an integral part of the work. As one program staff member observed:

> *With trainings that we go to such as a day, or half-day training, I think actually sometimes it's a Band-Aid. I think you really have to be dedicated to be able to continue your learning. And sometimes that's difficult because things get in the way, so you can't really practice it. But since [C4CW has] been here on a regular basis with us, I think it helps us really embrace it more, kind of soak it up more. Just because we don't understand the term or the idea [at first], we'll get it again, and then once we do get it, we are able to transfer it to our staff. And they've gone to a few trainings, too, and it's the same thing: once they get it, they will transfer it to new staff or to their personal lives or to the participants. … So, I think just having the consistency that it's not just a one-day kind of thing has really helped the process in making sure that we continue the learning even when [C4CW is] not coming back anymore.*[74]

A senior leader from another organization made this point in a different way:

> *The only challenge that I can think of is the constant challenge to balance workloads and pace our work. What we are learning is that the time we invest in WTI activities is enhancing and enriching our work. While it is an investment of time and energy, our staff is beginning to recognize that by applying these practices to their work (meetings, decision-making, leadership approaches), it is improving outcomes and informing systems.*[75]

And a line staff member made the distinction between training events and the invitation extended through WTI this way:

> *People were able to reflect and see how they were responding to certain things … —self-leadership and how that's all something that comes from within, not from just saying we're all going to be leaders now. Those staff have really just embraced all that we have learned and have been able to be intentional about what they do during their day and with their programs. And then the staff that have a difficult time reflecting, I've noticed I had to be more intentional about journaling and getting them to try too—it's hard because my staff at first thought that this was a program, and so it was really talking to them and helping them understand that it's not really a program, it's … a way of being.*[76]

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[74] Key informant interview and focus group, September 2015.

[75] Organization progress report, January 2015.

[76] Key informant interview and focus group, September 2015.

Re-framing and translating the framework

As we outlined in Section 1, one of the early adaptations we made was to translate the framework so that it was more relevant and appropriate to community-based and non-profit organizations. The internal realities for these organizations, and the perspective and frames of reference for their staff, are often quite different from those of a county-wide department.

We first simplified the language of the four commitments, and developed illustrations and applications more appropriate for community-based and non-profit organizations. We quickly discovered that we needed to do more. Within BHRS, the four commitments of the transformation framework have been developed and taught as co-equal. Within the WTI organizations, however, the four commitments were not co-equal.

At the beginning of WTI, every organization chose to begin their process with the commitment to leadership, followed closely by the commitment to results. These commitments were foundational for every organization. The remaining two commitments—community and sustainability—became more contextual. We did not drop these commitments, but rather incorporated particular aspects of their content and orientation as appropriate to support Wisdom Dialogues emerging through the application of the first two commitments. For example, the commitment to community was central to a Wisdom Dialogue that emerged among Family Resource Centers, and the commitment to sustainability was at the heart of the transformation process for one of the participating organizations. What changed was that we did not insist that every participant from every organization, or even every senior leader from every organization, had to master the content and orientations of every commitment.

This adaptation significantly reduced some of the complexity of the framework, and made it easier for managers, line staff and volunteers to engage more immediately in the process. We believe this adaptation could serve BHRS as well, particularly as senior leaders and mid-level managers consider how to introduce the framework to new staff who have not had any exposure to the framework or the larger transformation process.

Engaging senior leaders first, and coaching them as allies

Central to the success of WTI was our decision to work more deeply with senior leaders from each organization first before we began to directly engage others in the organization.

The original orientation and training sessions for WTI engaged learning delegations from each organization comprised of a cross-section of senior leaders, mid-level managers, line staff and others. Our intention for creating this structure for the initial learning delegation was to seed the transformation process at all levels of each organization from the beginning of the initiative.

As we moved from these first orientation sessions into the planning process, however, we shifted course, concluding that we had to engage senior leaders at a far deeper level before beginning trainings or other engagements with mid-level managers, program staff, and others. Why?

First, senior leaders' ability to discern how best to roll out the transformation process within the multiple contexts of their organization was crucial for WTI's success. A commitment to engage the whole organization does not necessarily mean engaging the whole organization at the same time. For example, within one organization, a group of staff members was beginning a new program. To

require that they immediately begin participating in the Wisdom Transformation process would have likely overwhelmed them.

Second, as senior leaders began using the language of the framework and modeling the commitments and practices, staff and others in the organization began to take the process more seriously, and understand that this was not a one-time experience but reflected a commitment to a deep level of engagement and change. This early adoption by senior leaders helped prepare the ground for C4CW team members to begin working directly with program and line staff. As a manager from one organization reflected:

> *This structure facilitated senior admin to "buy in" first, supporting and encouraging leadership to become excited about the leadership training, which in turn helped leadership to embrace and "sell" it to staff prior to staff orientations. Furthermore, the breakout sessions during the three day leadership training really helped each broad set of programs drill down into the framework and "make it their own." It was great to see wisdom arising and an alignment of intention emerge across leadership leading to focused and well received Wisdom Dialogue sessions.*[77]

A part-time employee in another program reflected on how essential senior leaders' active modeling was for staff and volunteers to trust that it was safe to try out new skills and behaviors, such as offering a divergent perspective during meetings and discussions:

> *Without that safety I'm not sure any of us could venture out and do what we've done through this [process]. But we feel … my senior leader has created that. Totally created that. … If people aren't willing to verbalize what their true interests are, you're not ever going to have a good relationship with the staff. And if there's not a good relationship with the staff, the results that you have with the people you serve are not going to be good. … So I think Wisdom Transformation has given us tools and a certain level of safety where we can talk about those things.*[78]

Building on this early success with senior leaders, we made another course correction mid-way through the initiative. Originally we expected to train 2-3 people from each organization as peer allies, "in-house experts" on the Wisdom Transformation framework who would be available to continue supporting the transformation process once the Innovation Project was complete.

As we thought more about this structure, however, we began to see that we had reflexively gravitated to a Train the Trainer model for this role, despite our clear understanding that this process was not about a discrete *training,* but about modeling and inviting a different way of being and learning in the midst of day-to-day responsibilities. Once we recognized this misalignment of structure and intention, we shifted to developing a senior leader mentoring model instead, providing additional training and 1:1 coaching for participating senior leaders.

While we cannot say with certainty that this hypothesis will prove true, we have received numerous stories, and have observed first-hand myriad examples of senior leaders progressing to a next level of embodiment of the framework. And data from a pre- and post-assessment are also promising.

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77 Organization final report, December 2015.

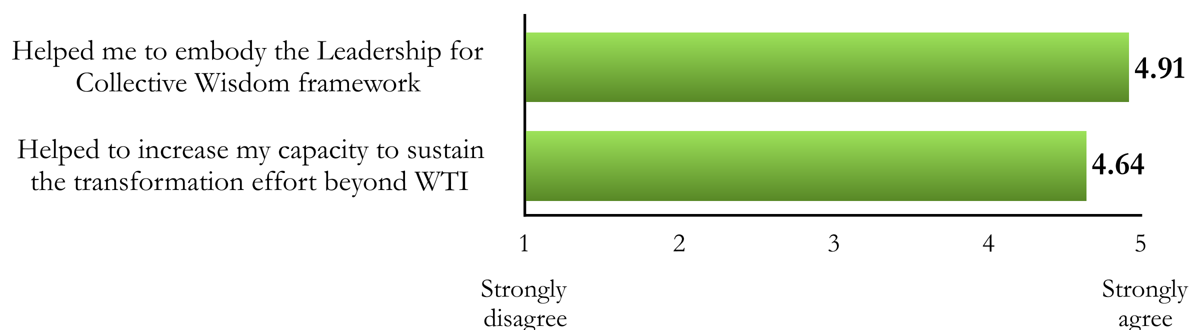
78 Key informant interview and focus group, September 2015.

Eleven senior leaders from two of the four organizations[79] received periodic 1:1 coaching support, primarily by video conference and phone, between February and December 2015. Each participant completed a self-assessment instrument before beginning the coaching sessions (Time 1), and again after completing the process in December 2015 (Time 2).

At the end of this process, participants reported both a statistically significant increase in their perceived capacity to embody the Leadership for Collective Wisdom framework, and in their experience of joy, enthusiasm, and gratitude.[80]

Focusing particularly on the question of sustainability beyond WTI, in the Time 2 assessment, the mean score of responses for the question of whether the coaching sessions helped participants to embody the framework was **4.91**, and **4.64** for the question of whether they were better able to sustain the transformation beyond WTI.

Figure 7: The coaching sessions with John and/or Rose: (N: 11)



Using technology and online resources to support the ongoing transformation

We experimented with using technology and online resources to support the organizations during the initiative, and to be available as resources even after the Innovation Project concluded.

First, we used video conferencing technology for planning meetings and coaching sessions to great effect. We used the same video conferencing platform for a series of webinars with new staff and community volunteers in one of the participating organizations. Through this experience, we have developed a beginning list of best practices to maximize the benefit of webinars as a modality for teaching aspects of the Leadership for Collective Wisdom framework. Specifically, we now believe that webinars are most effective when they:

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[79] Of the 4 participating organizations, only 2 organizations were able to participate in the additional training and 1:1 coaching sessions for senior leaders. One organization began the initiative too late to allow senior leaders to effectively participate in this process. The other organization's adaptive dilemma was too consuming to allow time for senior leaders to participate.

[80] The total combined score for 28 questions related to the embodiment of the LfCW framework increased from a mean of 106.1 (SD=9.44) at Time 1 to 118.9 (SD=9.64) at Time 2, a statistically significant finding at t=5.25; p=.000. The score for the question assessing the experience of joy, enthusiasm, and gratitude increased from a mean of 4.0 (SD=0.77) at Time 1 to 4.6 (SD=0.93) at Time 2, a statistically significant finding at t=3.46; p=.006.

- Involve staff and volunteers who are at similar levels of understanding about the framework —e.g, when the webinars are used to conduct a beginning orientation for new staff and volunteers, or to deepen an understanding of a particular commitment among people who have some experience working with the commitments and practices.

- Are followed by facilitated conversations led by organizational leaders (which has the added benefit of being a leadership development opportunity for the managers).

- Are combined with in-person engagements, especially when there is a greater level of complexity in the content and a deeper level of holding is necessary.

We have also developed on online website—c4cwwti.org—that is available to all of the WTI organizations. We developed this website in response to requests for resources to help orient new staff, Board members, volunteers, and others. The website contains text and brief videos teaching the essential aspects of the Leadership for Collective Wisdom framework. The responses to the website has been very positive, and people from three of the organizations are regularly accessing the website.

BUILDING EFFECTIVE INTRA-ORGANIZATIONAL LEARNING COMMUNITIES

A particular focus of WTI, beyond discovering what can help organizations successfully adapt the Leadership for Collective Wisdom framework, was how to help organizations build effective intra-organizational learning communities.

There is of course a connection between these two questions. The data shared in previous sections document how the commitments and practices of the framework can support the emergence of such learning conversations and communities among staff, community partners, family members, and people who receive services. The more that staff, volunteers, and others learn to embody the commitments of self- and collective leadership, the more they will be able to create safe spaces to engage with each other in service of achieving and sustaining profound results.

Two additional lessons emerged through WTI in response to the question about learning communities, and the learning conversations that help them thrive: the first is about data, and the second is about process.

Data and data capacity

Senior leaders and managers from every WTI organization were eager to work with data in service of improving the results of their programs, as were most line staff and volunteers. So what was the problem? Actually, there were many.

Some programs simply did not have protocols in place to collect data, much less report and reflect on it. A number of programs, however, were collecting prodigious amounts of data, typically to comply with requirements of various funders. Unfortunately, more often than not, the data requested did not address questions that were vital to staff, reflecting more of a bias toward compliance than results and learning.

And even if the data collected did matter to staff, it typically traveled in a single direction: from line staff and managers who collected and turned in raw data to data staff within the organization, who

then assembled the data into reports that were then sent to the funders. Rarely did the data travel back to line staff to support learning conversations about what the data meant, and what implications it had for program impact and improvement. And if the data was returned to the organization, it often came back too late to matter, or in a format that made it difficult for staff to comprehend.

Given this experience, many line staff, and program managers too, learned to see data and data collection as at best a nuisance, and at worst a barrier to getting meaningful work done.

Through our work with the WTI organizations, and two programs in particular, we have developed some beginning reflections about how to help staff work with data in service of learning conversations among themselves and with partners.

First, the data has to matter to staff. "Because the funder says so" may be true, but if this is the only reason staff are collecting and reporting data, they will not likely engage in meaningful learning conversations among themselves or with others. When we began working with these two programs, one of the first questions we explored with staff and volunteers was: "If there was one thing you could improve about this program and the results you are getting, what would it be? And why this?" Once we could identify the question(s) that most mattered to staff and volunteers, then a conversation about data was in service to what the group was committed to learning and improving.

Related to this first reflection, staff and partners also have to trust that the data they are collecting will be used to help them learn and improve, and not as a weapon against them. The experience of "blame and shame" conversations can be profoundly traumatic, even years later. In one program, even with the senior leader in the room assuring staff that the data we were exploring and the dialogues we were proposing were for *them,* staff and managers could still return to a place of fear and hesitation. In these instances, we returned again and again to the commitments and practices of the Leadership for Collective Wisdom framework, and in time the team moved into a remarkable dialogue about how to transform their program for greater impact, and how to improve the data they needed to support this ongoing transformation.

In addition to staff and partners wanting the data, and trusting that the process of working with the data will be focused on learning and mutual accountability, for data to be useful it has to be timely and accessible. One way to ensure timely and accessible data is by helping programs develop their own data sources, collection protocols, and simple report formats to help frame the learning conversations. This is time-consuming work, but not trivial. Helping staff and partners learn how to access and report on data in a timely way is essential for making learning conversations possible.

A process to engage complexity: Wisdom Dialogues

As we engaged with teams and programs within each of the four organizations, we began to see patterns about what can help groups embody the commitments and practices of the framework when they were tackling complex issues. Ultimately we created a process that we call Wisdom Dialogues to capture our learning about these patterns.

The purpose of this process is to give groups who are committed to embodying the Leadership for Collective Wisdom framework a road map for how to address complex issues and adaptive dilemmas. Indeed, all four organizations have engaged in Wisdom Dialogues to successfully address one or more adaptive dilemmas, including:

- Redesigning programs for better impact;
- Making significant progress on team productivity goals;
- Developing plans for long-term sustainability; and
- Improving staff recruitment, training, and retention practices.

There are five stages to a Wisdom Dialogue. These include:

Stage 1: Define the question
What's the animating question? Is this a vital question to us?

Stage 2: Document givens
What are the givens and non-negotiables?

Stage 3: Discern the movement
What would progress look like? What aspects of reality across all four dimensions of change are aligned and mis-aligned with progress?

Stage 4: Develop a plan
What do we commit to do? By when? How will we assess and document progress and impact?

Stage 5: Act • Assess • Reflect • Adapt
Begin implementation • Schedule periodic wisdom dialogues to reflect on data, assess progress, and adapt

The process is scalable. For some issues, a Wisdom Dialogue can be completed in a single session. For more complex adaptive dilemmas, it may take several sessions just to clarify the animating question and the givens and non-negotiables.

Wisdom Dialogues share a number of similarities to other planning process structures, including participatory action research, the Plan Do Study Act process, RBA's seven questions for program performance, and others. Indeed, we incorporate aspects of RBA and other frameworks into this process. Some of the reasons we created the Wisdom Dialogue process, and some of its defining characteristics, include the following:

- The process is precisely tailored to help groups address a broad range of issues while embodying the Leadership for Collective Wisdom framework.

- Often groups need to work to define the issue they are trying to resolve—what we call the animating question. Stage 1 of a Wisdom Dialogue not only invites group members to discover and precisely define this question, but also to reflect on whether the question is vital to the group. Wisdom Dialogues are not for pretend conversations or exercises. Why spend time going through a process to address a question that no one has passion for or a deep commitment to resolve?

- Right away this first exploration focuses the group on an essential concept of the Leadership for Collective Wisdom framework: the concept of *intention.*

- None of the Wisdom Dialogues we facilitated through WTI started with a blank slate. It was essential for people to understand and document the givens and non-negotiables for each

adaptive dilemma or animating question they addressed. Often conflict can arise among stakeholders not because of divergent interests or perspectives, but because of a lack of shared understanding about the constraints (or lack thereof) that may be framing a potential exploration. This exploration of givens and non-negotiables introduces group members to another basic concept in the Leadership for Collective Wisdom framework: the distinction between *facts* and *stories*.

- In Stage 3, we invite people to focus on what success would look like if they made progress in addressing the animating question. We invite this exploration without forcing them at this stage to define specific performance measures.

- Once group members have articulated success well enough, then they use the four dimensions of change to assess what aspects of the current reality are aligned or misaligned with our success. This helps groups explicitly differentiate and assess the interior and exterior dimensions of reality, a foundational concept for the Leadership for Collective Wisdom framework.

- We invite people to decide what they want to do after they have assessed the current reality, so that they do not move to action before considering interior and exterior dimensions of reality.

- And after people have decided what they want to do, then we invite them to discern how they will assess progress (how much and how well) and impact (anyone better off). We have found that participants have greater willingness to wrestle with the question of how they will assess progress after they have experienced their collective excitement about what they want to do together and why.

BUILDING EFFECTIVE CROSS-ORGANIZATIONAL LEARNING COMMUNITIES

In addition to the question of intra-organizational learning communities, WTI also intended to explore whether *cross-organizational* learning communities and peer allies are promising strategies for sustaining long-term transformation efforts. We have already addressed the question of peer allies earlier in this section.

The question of cross-organizational communities*,* however, yielded an unexpected result. At the outset of WTI, we projected that staff across the participating organizations would form learning communities over time, grounded in a shared commitment to results and the Leadership for Collective Wisdom framework. This part of the Innovation Project was fully endorsed by the organization leaders, who had been meeting together for a year prior to the launch of this Innovation Project.

Once implementation began, however, and each organization began to move more deeply into its own transformation process, all of our perspectives changed. While all four organizations are funded by BHRS and provide mental health services, their cultures and histories are quite different. As organizations began to develop their individual plans, these differences became more pronounced. Each organization was charting its own course, and each path was significantly different from that being pursued by the other organizations.

So when it came time to begin planning for the first cross-organizational experience, all of the organizational leaders expressed a strong preference for delving more deeply into their own intra-organizational transformation processes rather than investing time and resources in the cross-organizational work.

After many conversations with senior leaders and reflecting on the data, the story we now hold is that the proposed cross-organizational work was simply premature. Having made substantial progress on their individual transformation plans, leaders of the WTI organizations are now proposing the creation of one or more cross-organizational learning communities to address systemic adaptive dilemmas. We address this and other proposals in the next section.

SECTION 6: BUILDING ON THE PROGRESS OF WTI

All WTI organizations made progress in addressing adaptive dilemmas through the adoption and application of the Leadership for Collective Wisdom framework, demonstrating in the process an increased capacity to:

- Better adapt to the policy and fiscal volatility within the behavioral health system;
- Create stronger and more positive internal environments for staff and others connected to the organization; and
- Support more effective collaboration among each other and with BHRS.

The organizations showed clear signs of healthier and more resilient cultures, cultures defined by the capacity to cultivate the conditions for collective wisdom. This progress is already paying dividends in improved services and supports for people struggling with mental health issues, and preliminary data point to improved results over time.

WTI also demonstrated a number of promising practices and documented compelling lessons about how to help community-based organizations successfully adapt the Leadership for Collective Wisdom framework within their particular programs and services.

So now what?

WTI organizational leaders had clear responses to this question. Building on the progress of WTI, leaders from participating organizations recommended:

- Organizing inter-agency Wisdom Dialogues to address systemic adaptive dilemmas;
- Strengthening the capacity for mental and behavioral health organizations and providers to work together as a more coherent system; and
- Leveraging the lessons of WTI to amplify the larger change agendas unfolding across the County.

WISDOM DIALOGUES TO ADDRESS SYSTEMIC ADAPTIVE DILEMMAS

WTI organization leaders have proposed, and stakeholders have endorsed, a potential MHSA project to:

- Address one or more systemic adaptive dilemmas through multi-stakeholder Wisdom Dialogues, focusing particularly on solutions that do not require additional revenue;

- Help selected BHRS and community leaders learn how to design and facilitate multi-stakeholder Wisdom Dialogues to address future adaptive dilemmas; and

- Help selected BHRS and community organization staff members learn how to develop and report data to support multi-stakeholder Wisdom Dialogues.

This proposed project would support multi-stakeholder engagements to address some of the behavioral health system's most intractable challenges. Examples of adaptive dilemmas that could be addressed include:

- The shortage of psychiatric and locked facility beds for people who are in conservatorship or otherwise experiencing severe symptoms from serious and persistent mental illnesses;

- Developing treatment and support approaches that promote strengths-based care and long-term behavioral health and wellbeing within the current reimbursement system that focuses on symptoms-based responses; and

- Developing more effective responses for children who are suffering severe emotional distress, but who cannot access or qualify for Full Service Partnerships, and for whom Crisis Stabilization responses are not enough.

Again, these are only examples of adaptive dilemmas that the four participating organizations recognize within the current system. If the project is approved, BHRS Senior Leaders and stakeholders would develop agreement about which adaptive dilemmas to address through this process.

The proposed project calls for using the Wisdom Dialogue process to address systemic adaptive dilemmas, while simultaneously building the capacity of identified staff and community members to design and lead future Wisdom Dialogues.

Some of the reflections from organization leaders and participants that led to the creation of this proposed project include the following.

> *I don't think it's currently on BHRS' radar as a regular practice when they face an adaptive dilemma to [engage the broader community]. Is it sitting in the office with two or three BHRS people or is it let's invite the community–whatever that looks like–into the conversation in a broader way? That's something that will be helpful. I have high hopes. … I trust BHRS. I think they want to do the right thing. I'm so grateful for the resource they gave to us to be able to do this process. It truly benefited us in ways I never even imagined. … I think they want to do this too.*[81]

> *BHRS has a new leadership team and they have the opportunity to really learn from each other and others. It doesn't take that much time. One of my biggest concerns about this was that it was going to take a lot of time. We're all very busy and we've got to get things done. But it's really not taking any more time to work this way. It's just working differently.*[82]

> *I know I don't hold the decision-making power. I don't even presume to do that. But it's the data collecting, the voices being heard part, which is the going slow to go fast. You can frame a whole conversation like they did for the substance abuse [stakeholder] process. They set the parameters and process ahead of time. We want to engage everybody in the learning, and we want the richness of this experience. Bottom line was that BHRS had the authority to create the budget. We all knew that. … But get more eyes on it, maybe there's a creative solution that they're not even thinking about.*[83]

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[81] Key informant interview and focus group, September 2015.

[82] Key informant interview and focus group, September 2015.

[83] Key informant interview and focus group, September 2015.

STRENGTHENING THE CAPACITY OF THE LARGER BEHAVIORAL HEALTH SYSTEM

The first recommendation—funding Wisdom Dialogues to address systemic adaptive dilemmas—is a specific illustration of the second, more general recommendation. Participants at all levels of WTI organizations encouraged BHRS to explore strategies that leverage the success of WTI to build the capacity of organizations and providers to act in concert with BHRS as a larger, more integrated system. Two quotes illustrate this larger theme:

> *It will be fantastic [to engage the larger system]. We have not only experienced changes in staffing, BHRS has experienced changes as well. I think it would be phenomenal if we could all come together as one team. It would strengthen the concept of partnership. Sometimes the power of collective wisdom and the power of coming together as a collaborative can be totally missed. … BHRS did their thing [wisdom transformation]. We did our thing. But we've never come together. … There are many wholes, but we want to do it as a greater whole.*[84]

> *BHRS offers a lot of training based on educational units to ensure licensure but the number of trainings for internal health are few. But we need an intentional training like within the Wisdom Transformation Initiative. We have to have something that talks about holding our stories lightly and examples of collective folly. We should take away the scariness and the awkwardness of collective folly. … Maybe we can have panels of contractors who have gone through Collective Wisdom and share what that looks like because it's really neat to have other contractors also have this language, this new insight. This lightbulb keeps going on for us and our BHRS counterparts aren't really quite there. And we're like, gee, you could be there. 'Can we share that with you?' There is a lot of typical routine work but here we are seeing Collective Wisdom as an adaptation to where we want to be. … They will have no notion of this if they haven't been exposed to it.*[85]

Another way BHRS could strengthen its capacity and the capacity of its partners to function as a larger system would be to pursue strategies to systematically enhance the data capacity of its programs and funded partners, consistent with the lessons of WTI. The Department has already begun this work; the lessons from WTI suggest some ways it could be expanded and enhanced, perhaps in partnership with the Community Services Agency (CSA), Health Services Agency (HSA), and/or other large agencies and funders that have a similar stake in increasing the capacity of community-based partners to work effectively with data.

WTI AS A BRIDGE TO LARGER CHANGE INITIATIVES IN THE COUNTY

WTI did not unfold in isolation; it developed at a time when other institutions and community partners were beginning large-scale change initiatives of their own, including most notably the Focus on Prevention Initiative. Not surprisingly, many WTI participants are connected to these other change initiatives, and anticipated the potential leadership role that the behavioral health system could play in these efforts.

> *The exciting thing is if we're truly going to have these conversations, then we're looking around the room going 'We need to invite the senior leaders or chiefs from Community Services Agency or Probation because then they also start to see the whole, because their systems touch it too.' We would*

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[84] Key informant interview and focus group, September 2015.

[85] Organization final report, December 2015.

> *also need to invite the Chief of Police from Modesto to this conversation. It could be really cool to start looking at [adaptive dilemmas] from a perspective where we start growing other organizations' capacities to look at things more collectively.*[86]
>
> *[We should]encourage more BHRS staff and its contracted partners to embrace and utilize the LfCW framework to bring everyone together for dialogues. Perhaps we could find a way to bring this training to a larger Stanislaus County audience, including faith-based organizations.*[87]

Six years ago when BHRS was just beginning its journey of transformation, department leaders were virtually alone in their conviction that a new way was needed.

No longer.

In particular, the Focus on Prevention Initiative provides a unique opportunity for BHRS and its partners to leverage the learning of WTI. Launched by the Board of Supervisors in 2014, the Focus on Prevention Initiative (FPI) reflects a growing awareness among leaders across the county that what has worked before is no longer enough.

Inspired in part by the BHRS transformation process and WTI, this long-term effort has embraced much of the Wisdom Transformation framework, including the commitment to results, and essential aspects of the commitments to community capacity-building and leadership development. Stan Risen, CEO for Stanislaus County, has summarized the aspiration of FPI this way:

> Our hope is that *Focus on Prevention* doesn't just become an initiative or the latest fad. Instead, we want this effort to form the foundation for an ongoing transformation and culture change that inspires a deeper experience of connection and tangible improvements in the quality of life for Stanislaus County's residents.[88]

Two of the five priority results for this initiative—'Our families are healthy physically, mentally, emotionally, and spiritually' and 'Our families and neighbors who are homeless, or at risk of homelessness, permanently escape homelessness'—are central to the mission of BHRS. And the defining value of FPI—*there is no other*—speaks directly to the calling of the behavioral health system to help people who struggle with mental and behavioral health issues to become valued members of our communities.

By sharing the story and lessons of WTI with the Focus on Prevention Initiative, and with other change efforts emerging across the county, BHRS can further amplify the original impulse that gave rise to WTI and its own transformation process. Indeed, from this perspective WTI has already succeeded, inspiring substantial innovation and learning not only within the behavioral health system, but in sectors and efforts across the county. No small achievement.

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[86] Key informant interview and focus group, September 2015.

[87] Organization final report, December 2015.

[88] Boggs, Keith. "More Than an Ounce of Prevention: An Interview with County CEO Stan Risen," Stanislaus Magazine, March/April 2015, p. 22.

Garden Gate Innovative Respite Project

Elisa Duke Heslin

Turning Point Community Programs

Garden Gate Innovative Respite Project ("GGIRP") was developed on the foundation of the prior existing program, Garden Gate Respite ("GGR"), a 6-bed facility started in 2000 through AB34 and AB2034 to address the needs of the local population identified by law enforcement as homeless and mentally ill through the provision of hospitality and welcoming by consumer or peer staff for a very short stay to culminate in the screening by another agency to determine which individuals may meet criteria for outpatient mental health services and direct them to a Medi-Cal assessment process. The duration of a stay was 24 hours or less, except in the case of weekends and holidays when stays concluded at the first available opportunity for such a screening. Discharges were issued by the other agency. Referrals were limited to those provided by law enforcement, and resources were ultimately determined to be underutilized.

The doorway to respite broadened to accept referrals provided by public mental health outpatient providers, funding moved to MHSA CSS funds, and documentation expanded with the needs of the COC HMIS system. On the heels of early MHSA implementation, the economy entered a recession, and local services were impacted as MHSA funds are revenue-based. In a single fiscal year, the need for acute psychiatric hospital beds increased dramatically while county mental health staffing was also significantly reduced. On the periphery were other factors contributing to the traditional system of mental health in which intervention was only available during an acute crisis: the assumptions that formal treatment is required for wellness; that individuals are interested in treatment, know what treatment may consist of, or actively participate in treatment; that the only resource for crisis is the hospital or to struggle alone.

The local MHSA Stakeholders, Mental Health Board, and County Board of Supervisors concluded there was "a better way," and moved forward with a learning project proposal, out of which was birthed the Garden Gate Innovation Respite Project, a new 5-bed facility next door to

the original Garden Gate Respite, funded through MHSA Innovation. However, innovation in delivery of services was not the purpose, though of course services are important. The purpose of the project was to learn through service provision whether a culture shift was possible, and if so, its ultimate impact on a paradigm shifts in thinking both within he system and to those the system of mental health services supports: consumers and family members.

Method

This project examined the ways in which respite services supported consumers of mental health services ("guests"), their adult family members or other support persons, and systemic "ripples" through service provision such as impact on hospitalizations.

Participants

GGIRP served 610 unduplicated (910 duplicated) individuals during the course of the project. Detailed demographic information is provided in the appendix. Guests were referred to GGIRP through a pre-approved list of local service providers who were oriented to the program and also had some degree of expertise and experience identifying individuals thought to experience mental illness. These agencies included: any law enforcement agency in the county (e.g., police or sheriff's department patrol units, jail, state and federal parole), any mental health provider in the county (i.e., public and private providers, as well as the Veterans' Administration), and select community agencies (e.g., local shelters including domestic violence shelter, community drop-in centers linked with mental health services, and professional payee services). Innovation practices for services were considered best practice and implemented identically at GGR. Therefore, admissions simply alternated between the houses to keep the census even,

except in cases where one house was found to better meet guest needs, such as needing an ADA-accessible bathroom or ramp, which were only available at GGR. Program eligibility also was identical to GGR.

To qualify for services, referred guest standard eligibility criteria was that they be residents of the county, 18 years old or older, identified by the referring party as having a known or suspected mental illness as the primary risk factor considered, and having met all these, meet one or more of the following secondary risk factors: homeless or at risk of homelessness, at risk for criminal activity or arrest, at risk for psychiatric hospitalization, or at risk for victimization in the community.

Consideration for secondary risks included not simply whether an individual was homeless in the traditional sense, such as staying in a shelter or at an illegal park camp site, but also whether they lived with family members who were in a dispute or otherwise a tense situation, and the consumer maintaining stable housing might be positively impacted by the family members having a time of respite and then the guest returning home. Another example is someone who lives independently and experiences an increase in symptoms, and needs some support during a medication change, and is then able to go home. Risk for criminal activity or arrest could be easily determined by the referral of a law enforcement officer, but also if a guest had been engaging in behaviors which could have resulted in arrest or citation if they had been observed by an officer. Common examples of behaviors in this risk category include loitering, trespassing, illegal camping, theft or burglary, prostitution, trafficking, and assault/battery, intoxicated and disorderly in public, violation of no-contact orders, violation of parole or probation, and selling or using illegal substances. Similarly, risk of victimization may be obvious, such as an individual who appears very elderly or frail, but also includes those who victimize others and as a result are also

at increased risk for victimization. An example could be an individual who steals substances from a dealer and is then assaulted. Last, risk for psychiatric hospitalization does not include those who meet criteria for an involuntary hold; such individuals must be placed in an acute setting. However, individuals often struggle with a crisis prior to meeting criteria. An example is a person who staff noted had a crisis evaluation every year on the same date; upon inquiry, this person shared it was the anniversary of a parent's death. With respite support, the person was able to avoid a hospitalization for the first time in several years. All respite services were voluntary and provided at no cost through MHSA funding.

Project Design and Measures

The project, its measures, and objectives were created through the MHSA stakeholder process. As such, the measures were not subjected to evaluation of reliability or validity. Measures were all self-reported by using a 5-point Lichert-like scale. Measures consisted of statements with which responses could be issued in the following range: Strongly agree, agree, neither agree nor disagree, disagree, or strong disagree (not applicable was also an available response). This scale was used to report law enforcement satisfaction (at intake), guest satisfaction (as close to discharge as reasonably possible), and family member satisfaction (during or after stay, with written consent of guest). Stakeholders developing measures included consumers of mental health services, family members of consumers, local mental health agency representatives including private and contracted providers, and other interested parties. GGIRP staff also assessed guests at intake and discharge for a Milestones of Recovery Scale ("MORS") score, which was inaccessible for reporting purposes. MORS is a validated measurement tool.

The project was implemented by GGIRP directors and staff with structured monthly feedback from guests through an on-site Roundtable, and quarterly feedback from service partners and community members through an Implementation Workgroup Meeting. Staff also sought insight feedback from the guests and their self-reported family members during the course of each guest's stay, as well as collaborative daily input from outside service providers.

Procedure and Materials

Guests were referred to respite by the referring party calling to inquire whether a bed was available by biological sex (male or female bed; or whether the person identified as transgender, in which case a protocol was implemented to reduce any potential for their victimization), as the bedrooms were single-sex though the houses themselves were co-ed. The referring party then would provide the individuals name and date of birth so staff could screen for specific eligibility in addition to the standard eligibility criteria. A list of previous guests specifically identified as ineligible or eligible under specific conditions is maintained and updated by the program directors using a password-protected file. A printed version also was available to staff and secured in compliance with HIPPA and other health privacy laws. All entries to the list were made in consultation with the individual guest's service provider, and was regularly reviewed by the contract monitor as well as housing and outreach representatives in a confidential meeting to ensure appropriate entries and use. Three lists were maintained: those ineligible due to significant and persistent unsafe behaviors such as assaulting staff or peers, those individuals temporarily ineligible (30, 60, or 90-day suspension of services due to inappropriate or unsafe behaviors on site which could not be directed, in addition to individuals whose services providers had asked not be admitted due needing a greater level of support than respite could safely provide during pursuit

of conservatorship), and those individuals with specific conditions which determined their eligibility (e.g., someone who had shingles must be determined by a medical professional not to be contagious prior to referral).

If the referred individual was found to be eligible, someone from the referring agency was required to transport or otherwise meet them at the site, as the intake process required both the individual being referred, and a representative of the agency providing the referral to be present at the same time. Staff would inquire as to an estimated time of arrival and call to check-in if this period lapsed without arrival. Upon both the referred person and an agency representative appearing, staff would commence the intake process, which included consent for services in the form of agreeing to abide by "House Rules" and general program policies, provided in detail verbally and in writing, and followed by guest signature. The rules enumerate the program purpose and structure, behavioral expectations, limits to confidentiality, safety and property policy, and so on. Intake generally required 15-20 minutes to complete. The representative would complete a referral form and guest contact record, unless they were law enforcement officers, in which case they would complete the referral form and police survey. An intake packet is attached for reference. During intake, staff also inquired with the person and the agency as to the goal for their stay at GGIRP and a projected timeline for achieving that goal, as GGIRP used a self-help model and services are client-directed.

After intake, the individual program participant is then referred to by staff as a guest of respite, accurately reflecting their temporary relationship while also avoiding any stigmatizing labels. The guest was oriented to the site by the staff person and also tended to any immediate needs the guest had, such as providing items for a shower and clean donated clothing, or preparing food. The guest was given an open bed, either a room with two single twin beds or a

room with a bunk bed and single twin. In order to mitigate fall risk, the top bunk was always issued last. The house is located in a residential neighborhood, and kept in good repair without any signage indicating its purpose. The inside of the house was furnished for comfortable and home-like, with the exception of a small office corner with two computers at a desk. Staff use their and guest first names, wear casual clothing, and provide peer support in a warm, approachable manner. Guests are encouraged to exercise independence within the structure of the house rules, but reasonable precautions for safety are taken, such as staff securing cleaning supplies, sharp knives, when not in use, and staff using the stove and oven to mitigate risk.

Each morning following intake, Monday through Friday, the guest is required as a condition of their stay to meet collaboratively with the GGIRP case manager and their primary mental health provider/case manager. If they do not have such a connection to services, then they are required to meet with a contacting agency outreach team to complete a screening for formal services in addition to meeting with the GGIRP case manager. In other words, every guest actively participates in a daily intensive, interagency, collaborative, case management process to determine a service/discharge plan using motivational interviewing as services are client-directed and implemented using a self-help model. GGIRP case managers, in consultation with directors, support progress toward this goal, and evaluate progress every 24 hours.

GGIRP case managers are on site seven days per week, from 8:00am through 4:00pm. These staff members create summary progress notes in the county behavioral health electronic health record system, peer-review records, and create discharge plans in addition to other duties. Other shifts are maintained by a paraprofessional peer-support staff. Staff working 4:00pm to 12:00am provide support groups on site, ranging from recovery-directed (Seeking Safety, Dual Recovery Anonymous) to interest-driven (Poetry Night, Game Night, Movie Night), to skill-

building (Stress Reduction, Baking). Staff working from 12:00am to 8:00am often performs program-specific data-entry and crisis intervention. Each shift has a specific list of tasks to attend to (provided in appendix). In effect, this daily evaluation dictated that an guest whose goals could be met in 4 days, should have a stay of neither 3 days nor 5 days, reflecting efficacy in use of resources. On the seventh day, GGIRP's contract required that an extension of up to 7 additional days must be submitted to the county contract monitor, and each 7 days thereafter another request would need to be submitted, with a maximum stay of 27 days.

Results

Detailed quantitative data and analytical narrative is provided in the Appendix. In this section, learning outcomes will be reported in brief as the overarching questions shaping the program will be explored.

Regarding Learning Question 1, "Can a "culture" shift occur in the community? Creating better alignment between need and support available? Creating a more effective way of supporting individuals and families that experience the negative consequences of mental illness?" Stakeholders defined this as the respite population reaching out for links to support, and also specific peer support links. To that end, 550 (90.2%) of unduplicated individuals had at least 1 successful linkage and 81.8% (3,439 of 4,203 total referrals) were successful. A majority of individuals linked to Mental Health Services (BHRS/Contractor) (21.1%, n=885), Peer Support (19.1%, n=802), and Shelter/Housing (17.1%, n=717). Additionally, peer support groups were begun and hosted on site at least once per day by staff.

Learning Question 2 is, "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?" Stakeholders did not identify an outcome or measurement for this. Use of the Guest Satisfaction Survey seems appropriate here as it records the guest's self-reported satisfaction on 12 different perspectives, including opportunities to engage in peer support, knowledge of resources in the community other than a psychiatric hospital, and whether they feel more hopeful or empowered as a result of services. A total of 419 surveys were completed, and 91.2% of guests agreed or strongly agreed that they were satisfied with all services.

Learning Question 3 is, "Can we assist people to avoid the trauma of psychiatric hospitalization by offering community-based peer support paired with short-term respite care?" Stakeholders indicated desired outcomes included pre-post respite stay measures of aggregate hospital days at 1 year. However, annualized (not aggregate) data, extrapolating from known data, was provided and apparent contradictions with other data have led to this not being a valid measure. Additionally, due to the short-term structure of the program, long-term measure, and possible confounding variables and artifacts, respite impact at one year would be difficult to measure. In April 2014, staff began recording referrals to avoid psychiatric hospitalization. Between that date and April 30, 2016, a total of 732 referrals were made to respite, of which 367 (50.1%) were to avoid a hospitalization.

Regarding Learning Question 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?" Stakeholders indicated a desired outcome of project hospital days cost as correlated to pre-post stay measures. These figures are not available due to previous cited complications with validity.

Stakeholders indicated that through addressing the overarching questions, respite then would learn how to connect individuals to community supports and related outcomes would be significantly impacted. In the instance of Learning Question 5 through 7, "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? 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? Can we move outside the paradigm of thinking that there are only two choices for people in mental health crisis: "treatment vs. no treatment"? Stakeholders indicated that this should be measured through links to community resources previously reported, as well as family or social support links and whether these individuals are aware of support in the community other than a psychiatric hospital. Every individual served at intake was offered staff support for the guest's family or support persons. Of those guests offered this support, 82 family surveys were successfully completed. Participating family members or support persons indicated at a rate of 88.5% that because of this project "I know that there are resources, other than the psychiatric hospital, available to help support me and my family member/loved one cope with their mental illness," while guests of respite reported the same at a rate of 91.0%. Furthermore, 284 referrals (6.8% of total) were successful in linking guest with family/social support, and 85.7% of guests completing a survey reported Garden Gate had helped them reconnect with a family member or loved one.

Stakeholders did not indicate a desired measure for Learning Question 8, "Can we move outside the paradigm of "treatment vs. no treatment" to assist people in avoiding the trauma and isolation of no support?" However, this is reflected in the mission, eligibility criteria, and outcome

reporting previously indicated about 50% of all referrals are made in order to avoid a hospitalization.

Outcomes for learning Question 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 collaborative workgroup will coordinate efforts to ensure adherence to the proposed learning approaches to integrating: culturally specific, community-based peer support and family support,” are reported in workgroup surveys conducted at least quarterly per stakeholder requirements. They survey examines workgroup satisfaction in 14 items, ranging from whether the individual felt comfortable sharing to whether the project is integrating culturally-specific criteria into its approach on a Lichert-like scale (except question 12, which is reported yes/no regarding verbal participation): 94.4% of all 44 attendees reported they strongly agreed, agreed, or somewhat agreed that they were satisfied.

Discussion

The issues to be addressed by the innovation are significant. First, stakeholders noted respite should address “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.” At the time the project was conceived, this was a fair representation as MHSA was in its infancy and previous to this, system focus was on treatment rather than outreach or prevention. At the present, MHSA programs, including PEI, O&E, and others, have acted as a prism. A spectrum of services in between hospitalization and struggling alone exist, of which respite is one way of support. An average of just over 50% of all referrals are made in order to avoid a hospitalization, reflecting a remarkable achievement.

These referrals exist within a subset of the population that meets standard eligibility criteria including homeless individuals with high law enforcement contact and hospitalizations who are at risk for victimization in the community. By definition, these guests are already struggling and lack access to services promoting wellness such as therapy, case management, and/or medications, and treatment for co-morbidities (chronic unmanaged health conditions, substance dependence) as well as lacking shelter, housing, and clothing (basic human needs), and opportunities to increase quality of life where they may identify with meaning and joy in a non-disabled role (volunteer, employee, parent, parishioner). Respite's focus on outreach and engagement may sometimes be less effective for some individuals than if respite mission focused on PEI or a rapid housing and stabilization mission. This is not to say that the current mission is unhelpful, rather, the mission has served to identify more opportunities to support the community we serve, and future projects could consider these approaches as well as the current approach. Outcomes reflect most guests discharge to their previous living situation, or a shelter. A gap in our system of services is the availability of anything in between those two extremes (stable housing or no housing), the next front after learning about serving the spectrum in between "treatment or no treatment," that needs to be addressed. Meeting this basic human need – or not – would tackle an entire category of risk that deeply impacts mental health services, co-occurring services, medical services, and law enforcement services.

Another interesting point is the stakeholder focus on co-occurring substance or alcohol use. The instance of this could be anecdotally placed at about 85%. Often, respite was confused with the things that guests need but which we don't provide, including substance use dependence treatment, mental health treatment, and emergency shelter services. The most appropriate place of treatment locally which has a co-occurring track requires a $200 co-pay over Medi-Cal for

inpatient treatment and is usually impacted and thus admission dates can often be measured in weeks, which often exceeds the time frame that respite can support. If individuals are not able to admit to treatment from the supportive structure of respite, they will often relapse and have to start the assessment process over again. Medi-Cal mental health assessments are often scheduled 4 weeks away, exceeding the respite contract limit. This means that guest may end up working a short-term plan at respite that does not help their long-term needs, or the guest may end up working a plan that creates additional risks, such as entering a free work-based recovery program in large metropolitan areas about 2 hours' drive from Modesto. These programs usually do not allow its participants to take psychiatric medications, which can result in relapse or hospitalization and law enforcement contact followed by being homeless in an unfamiliar area with no support. Guests have identified this as an opportunity at an alternative to living on the streets if it goes according to plan, but have little or no contingency if they are unsuccessful.

At times, respite is also confused with a mental health treatment program such as a psychiatric hospital for acute holds, or as a crisis residential program with 24-hour case management-level support. However, on occasion agencies call prior to conducting a crisis evaluation as a respite bed would prevent an individual from meeting grave disability criteria, and are gently asked to evaluate the individual prior to calling to see if a bed is available. On occasion, law enforcement agencies who have heard of respite through another officer friend may think respite is a place someone being held on a 5150 can be placed, or on the converse, think respite is a conventional shelter and are unaware of any mental health services. These occurrences are infrequent and usually are genuine misunderstandings from new staff who are then oriented to the program and able to utilize resources appropriately.

Adding to this complication are longstanding relationships with other agencies that existed prior to the innovation project when respite provided only peer support and hospitality. Transition from one model to a very different innovation model, though accepted as best practice, proved difficult on many fronts. There was a significant culture shift in interagency relationships as previously another agency had made discharge plans, while under Innovation, respite case management staff make these in collaboration with the guest and outside provider. This has eased through making the distinction that respite relationships with guest are always acting in alignment with the treatment plan developed in the long-standing relationship between the outpatient provider and the guest and should never be at cross-purposes. The daily collaborative approach to case management has done well at ensuring the service plan is being carried out and by existence leaves little space for the "Uncoordinated outreach and peer support efforts between agencies and community-based programs" Stakeholders asked to be addressed. Indeed, the effectiveness of connecting individuals with resources relies heavily on this coordination and respite outcomes would look very different indeed if this unified approach was lax.

Another area of difficulty is in internal staff relationships, as some peer support staff expressed feeling "less than" with the addition of case management staff who met minimum qualifications equal to that of county staff occupying equivalent positions, while other staff felt entitled to positions simply because of their longevity. Merit increase freezes, a tight budget, and high turnover also contributed to a cool internal climate. The addition of the respite directors near the start of the innovation project was challenging for these reasons, and required a strong focus on recruiting strong candidates for open positions, a focus on build staff communication skills and self-leadership, and developing staff unity through ensuring equal expectation of staff (such as

mandatory meetings all must attend), staff appreciation of each other acknowledged at each staff meeting, annual staff appreciation event by directors, and so on.

Respite directors participate in interagency partnerships across systems including the Modesto Recovery, a public-private partnership of recovery providers hosting by faith-based sectors and public recovery services, the Continuum of Care addressing chronic homelessness, the Modesto Police Department Restorative Policing Meeting in which agencies collaborate to address the needs of individuals with high law enforcement contact, and the Prevention Focus Initiative, a local multisector commitment to address homelessness and prevention across systems. Deep learning has occurred in community capacity building, with diverse service partners coming together to recognize no one agency or field or study has all the knowledge, services, or funds to hold all the struggles of the marginalized. Focus on Prevention's core value is that "we are one – there is no other," and places significant value on the expertise and stories of those with lived experience.

Indeed, respite addressed "Individuals in a mental health crisis often feel isolated, alone, and vulnerable which makes it hard to reach out for support," through intensive collaborative case management which focused on helping individuals build support in the community, such as by encouraging the attendance of AA meetings or peer support groups or drop-in centers, assisting in connecting any identified support (including religious communities the guest self-reports as helpful, of which mental health services have traditionally been, at best, indifferent) and attempting to build rapport through in-house support groups to build peer relationships. The short-term structure of the program means that it must act as a place to start building support, a jumping-off point rather than a place to build stability. The success of this approach is likely reflected in the guest's internal motivation as staff observes through external action, of course, but

also their functional deficits, access to other resources, acuity of symptoms, and triage of beds when the census is high. The most common experience is a 1-day stay at respite through the statistical average is 4.0 days, indicating 50% experience a stay of shorter duration and 50% experience a stay of longer duration. There is a limit as to what can be accomplished in such a short time, and this may be reflected also in the duplicated individuals served being about 3 times higher than unduplicated. On the other hand, evaluating stays every 24 hours, and the ability to discharge or extend as warranted is a tool of great use to leverage the resources of the program to fully serve the mission and needs of the guests that a more rigid structure could not support.

A place where respite services may shine is the stakeholder mandate to address "Repeat hospital admissions for individuals who are not connected to community supports or service programs." The majority of referrals to respite came from Telecare Transition TRAC, another partnering contract agency. Transition TRAC is the program which meets with individuals while they are hospitalized and provides intensive case management services for 60 days for the ourpose of avoiding readmission. This was followed by Modesto Police Department, often conducting welfare checks or deciding whether to place an individual on an involuntary hold, followed by CERT referrals. Community Emergency Response Team, or CERT, are the public mental health clinicians who conduct crisis assessments to determine whether a hold will be maintained or lifted. If an individual does not meet criteria for 5150, CERT can refer to respite. A previously stated, about 50% of all respite referrals are made in order to avoid a hospitalization; records indicate guests discharge from respite to a psychiatric hospital just 1.7% of the time through the duration of the project. This also addresses the Stakeholder concern that respite address "Soaring cost of psychiatric hospitalization that is diminishing resources in the behavioral health system."

Stakeholders indicated "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." Respite is proud to be a place individuals can go to receive support other than the hospital; as previously reported, most guests and their family member, at rates of more than 80%, specify that as a result of this project, they are aware of other resources in the community to support them. When respite has the opportunity to connect with a family member, a NAMI referral is made in order to connect peer families. Guests are often referred to their families in addition to mental health drop-in centers, non-crisis peer support lines, and secular and faith-based recovery groups for support.

Of significant interest is the Stakeholder report that "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 ailing their mentally ill family member. Families don't have enough opportunities to learn self-care and receive support from other families members who have 'been there and done that.'" Results indicate that guests connect with their families much more often than respite staff was able to do so (284 successful referrals to family/social support versus staff successfully collecting 82 surveys). This could reflect the rapport that it takes time to build being difficult to do in a program that typifies a 24-hours stay, or a lack of family rapport with the guest or staff, or lack of any connection between guest and family, or a combination thereof. Overall, a total of 71.3% reported being able to connect with peer families as a result of the program, but this includes individuals misunderstanding the survey due to taking it over the phone, not knowing what a peer family is, and respite being unable to connect families directly and simply relying on providing a referral to NAMI and the family member either already having a connection, or reporting their degree of interest in making one. The statements of the

family survey do not allow the person being surveyed to indicate whether connecting with a peer family is of interest. Thus having the opportunity to connect with a peer family and satisfaction with that connection may not be applicable, but the person may mark disagree. Or they may reflect on relationships of support they currently have that are unrelated to respite services and mark agree though this is no reflection on the program. It also does not allow the flexibility strained familial relationships may need to respond to questions. For instance, family members sometime– are unwilling to speak with the guest and only willing to talk to staff (or vice versa), so reporting on whether they have been able to reconnect is sometimes reported as "disagree" though "not applicable" may be more appropriate. Anecdotally, the final question was an open-response to self-care, and many respondents were able to provide relevant responses. It may be the case that the assumption that families need a formal connection to peer families is either not able to be reasonably executed within respite structure, or perhaps recognizing "peer family connection vs no support" may be just as tied to system perception as "treatment vs no treatment"; perhaps both are true. It seems likely that families may need individualized strengths-based plans for support just as guests do, reflecting their access to resources, deficits, and interests.

Limitations

There were significant limitations in data reporting due to numerous factors. First, the data reported is stored by another entity, and is not always accessible to use. If so, correlations demonstrating impact may have been possible, such as an increase in MORS score relating to length of stay. Another issue is the data provided is not always helpful, and sometimes confounded by artifacts, such as pre-post measures at one year. Aggregate data is not available, so annualized was examined, but not applicable due to regression artifacts. Stakeholder process is a

priceless asset that reflects the rich diversity of the community and subset of providers, however, this also means that project are not held to a peer-review process and measures are not evaluated for validity and reliability. Are we measuring the thing we intended to measure? Is that measure accurate? We cannot say for sure.

Learning

We can say that we need to ask, are the interests of the mental health system aligned with the interests of those outside, looking in? Perhaps this is most clear in the family survey, where stakeholder interest and family interests are likely the same (obtaining support) but may have very different trajectories or perceptions about what kind of support interests them; the measure measured assumptions, but we learned. We learned that respite may not be a realistic venue for this connection to be made, but more than that, we learned that the dichotomy doesn't serve anyone very well. We have considered treatment versus no treatment, now we realize we have to consider family needs (formal connection to peer families versus no formal connection) in the same way, as well as housing needs (stable housing versus shelters).

We began to understand that though we speak about moving away from "treatment versus no treatment" our structure requires guests to undergo a screening for formal treatment, and assessments and appointments roll on as they always have. Case managers ask for permission to provide bus tickets to a worship service a guest would like to attend because it is where they feel hopeful, or a family picnic where estranged individuals can decide if they feel comfortable moving forward together. It feels strange, but freeing, to do so after years of only providing them for doctor, therapist, and medication appointments. We learned that having someone available to walk with a guest to AA means they will probably attend, and that sitting with a guest in a doctor

appointment means an assessment may increase in accuracy for those with significant cognitive deficits, we learned that some guests need a peer to navigate to the next link, and that respite has none of those things....but we know who does because of our collaborative interagency approach. Because of that approach, we can leverage resources and move service mountains that otherwise might be an impenetrable barrier.

We relearned a lot of things we thought we already knew about recovery: that guest are peers and we respect their autonomy, and that guests are not always ready for recovery the way we think they should be, maybe not the 2nd time or the 3rd time, but our job is to be there every time, ready to meet them where they are. We relearned that formal treatment is not always required, and people tend toward wellness. We relearned that guests have something to teach us, even with our own lived experience, about living with uncertainty, finding hope, and finding a way forward when we feel stuck with the help of others.

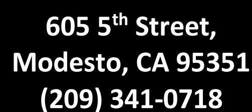
We learned, in a deep way, that our futures are tied together in our community and living together in a small home has helped us to see each other in a rare and unique way.

TURNING POINT
COMMUNITY PROGRAMS
A Path to Mental Health

Garden Gate Innovative Respite Project [GGIRP]

PROGRAM OUTCOMES REPORT

October 1, 2013 – April 30, 2016



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Garden Gate Innovative Respite Project [GGIRP]

October 1, 2013 – April 30, 2016

Our Vision

To expand the bridge between Garden Gate into the community, making connections to resources and programs that will facilitate the recovery process for the individuals we are privileged to serve.

WHAT WE DO

Turning Point Garden Gate Innovative Respite Project (GGIRP) in Modesto provides a safe home-like environment for individuals who are homeless or at risk of homelessness and known or expected to be experiencing symptoms of mental illness.

This program links these at risk individuals to community resources and encourages a focus on wellness through enhanced services such as: in-house case management services, psycho-educational groups, group activities, guest speaker presentations, and guest/alumni Roundtable meetings that inform services. These services are provided in addition to the provision of basic care such as home-cooked meals and clothing.

Open 24/7, the center works together with law enforcement, Stanislaus County Behavioral Health, Recovery services, and other Community Partner Agencies to reduce incarceration, risk of victimization, criminal activities, incidence of homelessness, and acute psychiatric hospitalizations. The center works with an outreach team to engage and connect individuals with needed services.

Stanislaus County Mental Health provides funding for this program through the MHSA.

STAFFING

Garden Gate Innovative Respite Project (GGIRP) is staffed 24-hours a day, seven days a week with two paraprofessionals who are awake and alert at all times. Turning Point continues to employ a culturally diverse staff. GGIR staff continues to provide client-driven advocacy and support within a “moving toward wellness” framework. They also facilitate community collaboration and capacity-building within an atmosphere of cultural awareness, sensitivity, and tolerance. In spite of the challenges inherent in their work, all of the staff strives to maintain a basic attitude that is pleasant, congenial, and supportive.

BEST PRACTICES

The following represent the current groups at the Garden Gate Innovative Respite Project which offer additional support to its individuals.

Consumer-Driven, Strength-Based Philosophy	Consumer-driven services ensure that clients make the choices that guide their recovery by helping them establish their own life goals to strive for. Our strength-based approach helps clients focus and build on the innate strengths they possess but may have overlooked. There is also an emphasis on establishing healthy peer relationships and engaging in leisure activities.

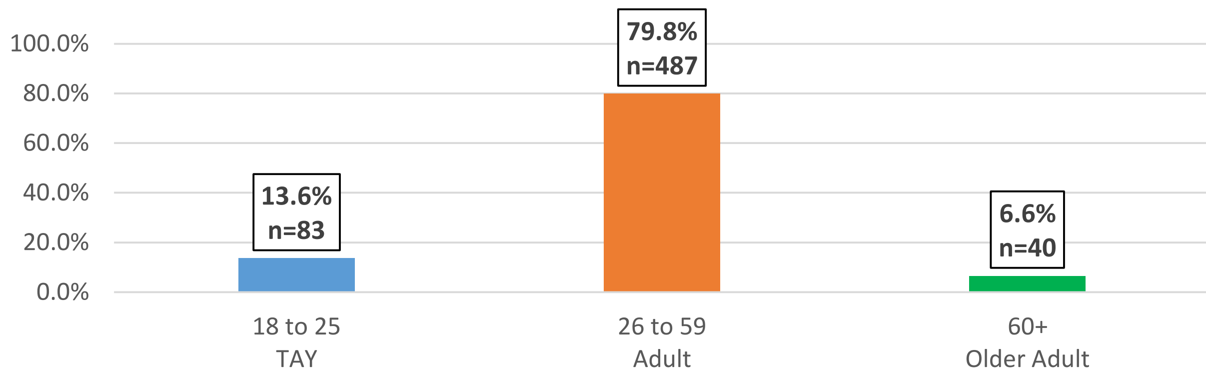
NUMBER OF INDIVIDUALS ENROLLED

Status	10/1/2013 – 4/30/2016
Individuals Served (Unduplicated)	610
Individuals Served (Duplicated)	927

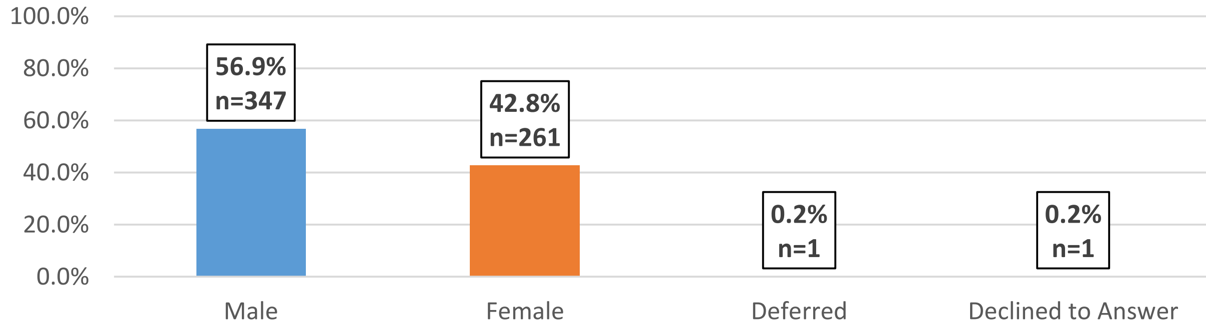
SECTION I: DEMOGRAPHICS

All demographic outcomes below are based on the unduplicated count of 610 individuals served.

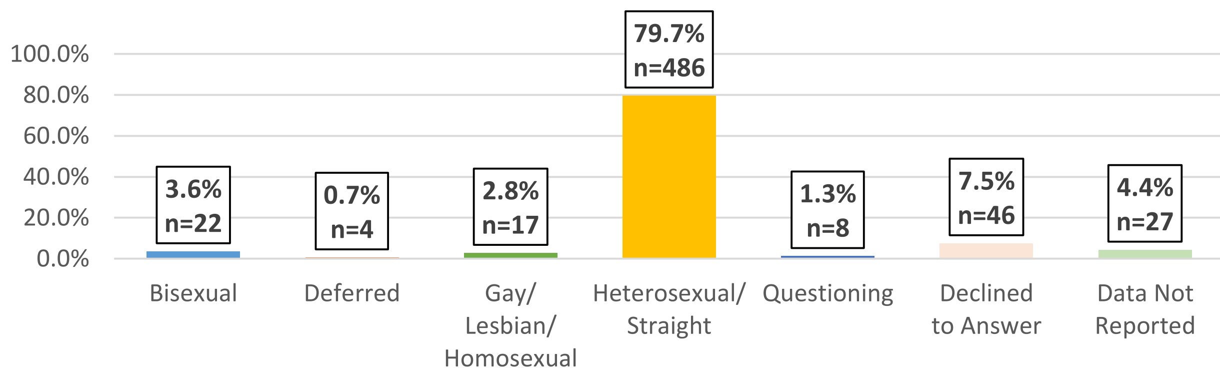
Age Groupings by Percentage



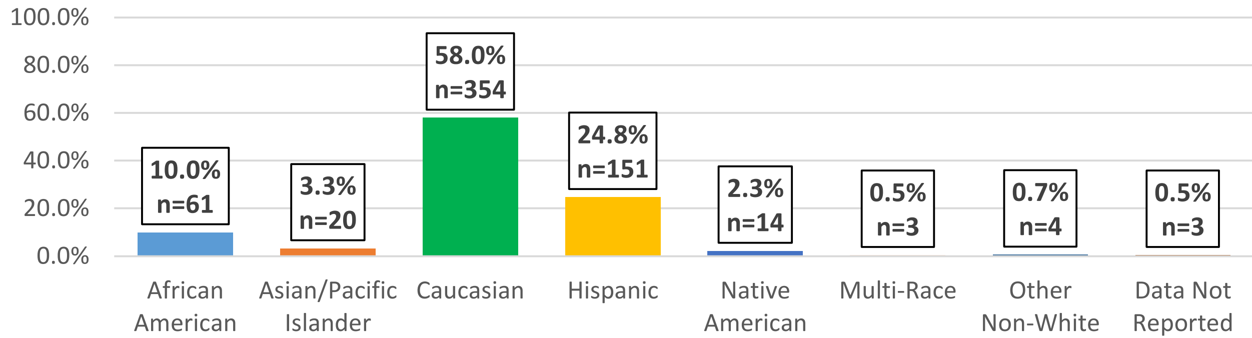
Sex (Gender Self-Identified)



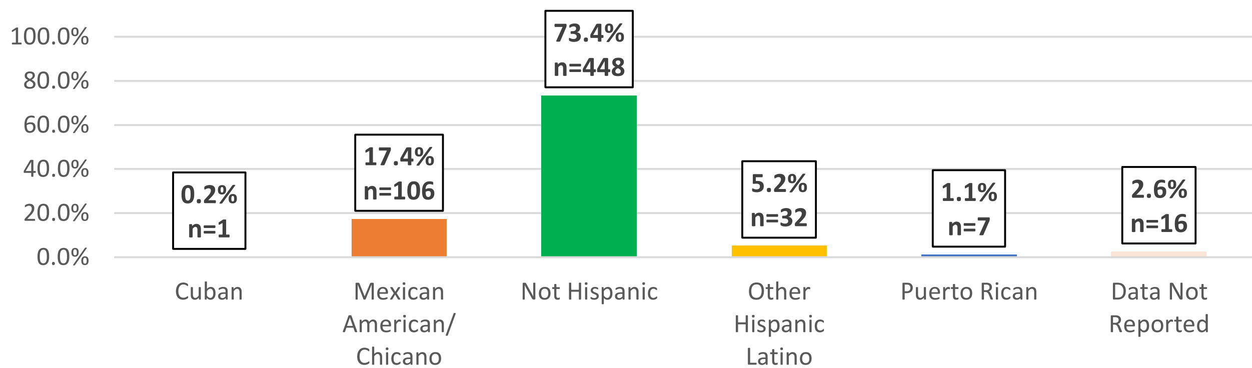
Sexual Orientation



Race



Ethnicity



Veteran Status

Status	October 2013 – April 2016 (N=610)	
	#	%
No	571	93.6%
Yes	26	4.3%
Declined to Answer	13	2.1%

SECTION II: REFERRALS AND COMMUNITY LINKAGES

Referral Sources

Outcomes below represent all referrals received between October 1, 2013 and April 30, 2016. Due to clients being discharged and returning to the program within the same reporting period, and perhaps being referred from a different source than their prior admission, duplicates have been included.

	October 2013 – April 2016	
	#	**%**
AB109	31	3.3%
Ceres PD	1	0.1%
Community Emergency Response Team (CERT)	100	10.8%
Empowerment Center	14	1.5%
High Risk Health & Senior Access	17	1.8%
Integrated Forensics Team (IFT)	57	6.1%
Josie's Place Service Team	14	1.5%
Modesto PD	169	18.2%
Modesto Recovery Services (MRS)	76	8.2%
PATH (BHRS Outreach)	31	3.3%
Stanislaus County Sherriff	52	5.6%
TRAC - FastTRAC	2	0.2%
TRAC - Josie's TRAC	22	2.4%
TRAC - MRS TRAC	6	0.6%
TRAC - Outreach	19	2.0%
TRAC - Partnership	21	2.3%
TRAC - Transition Team	193	20.8%
TRAC - TRMS	7	0.8%
TRAC - Wellness	1	0.1%
TRAC - Westside	13	1.4%
Turlock Recovery Services (TRS)	12	1.3%
Turlock PD	1	0.1%
Turning Point ISA	34	3.7%
Other	29	3.1%
Data Not Available	5	0.5%
Total Referrals	**927**	**100.0%**

As can be seen from the table above, the majority of referrals came from TRAC Transition Team between October 2013 and April 2016 (20.8%, n=193). A large portion also came from Modesto Police Department (18.2%, n=169) and Community Emergency Response Team (10.8%, n=100).

Additionally, of the 927 referrals made between October 2013 and April 2016, 197 (21.30%) were made for those at risk of arrest, 807 (87.1%) were made for those at risk of victimization, 877 (94.6%) were made for those at risk of homelessness, and 250 (27.0%) were made for those at risk of being involved in criminal activity. Additionally, beginning in April of 2014, GGIR began to track whether referrals were made to avoid an acute psychiatric hospitalization. Between April of 2014 and April 2016, a total of 732 referrals were made, and 367 (50.1%) of those were made to avoid an acute psychiatric hospitalization.

Community Linkages by Category

Due to clients having been discharged and returning within the reporting period, and possibly being linked to different resources, for the October 2013 to April 2016 reporting period, all 4,203 episodes of services are included instead of the 610 unduplicated. The following table represents all linkages for the reporting period, and is divided into 13 distinct categories as labeled below.

	October 2013 – April 2016	
	#	**%**
AOD Services	408	9.7%
Clothing	50	1.2%
Community Participation/ Involvement	81	1.9%
Family/Social Support	284	6.8%
Food/Food Pantries	54	1.3%
Health Education	46	1.1%
Medical	372	8.9%
Mental Health Services (BHRS/Contractor)	885	21.1%
Mental Health Services (Community)	24	0.6%
Mental Health Services (Private)	28	0.7%
Other	452	10.8%
Peer Support	802	19.1%
Shelter/Housing	717	17.1%
Total Linkages	**4203**	**100.0%**

The majority of individuals were linked to organizations or services that fell under the category of Mental Health Services (BHRS/Contractor) (21.1%, n=885). The next highest frequency fell under the category of Peer Support (19.1%, n=802), followed by Shelter/Housing (17.1%, n=717).

Linkages that fell under the "Other" category included the following: child and family advocacy; court-mandated services; disability advocacy; domestic violence support; education resources; employment services; faith-based or spiritual community support; fiduciary resources or support; law enforcement assistance or reporting; legal advocacy or resources; mail services; state identification card services; transportation services; veteran advocacy; and victim advocacy or support.

Of the 4,203 attempts at linking clients with services, 3,439 (81.8%) were successful. Additionally, a total of 550 (90.2%) unduplicated individuals had at least 1 successful linkage.

SECTION III: SERVICE UTILIZATION

Average Length of Stay

Between October 2013 and April 2016, the average length of stay per individual was approximately 4.0 days, ranging from anywhere between 1 and 36 days with a mode of 1 day.

Average Daily Population

There was an average of 3.3 individuals served daily between October 2013 and April 2016.

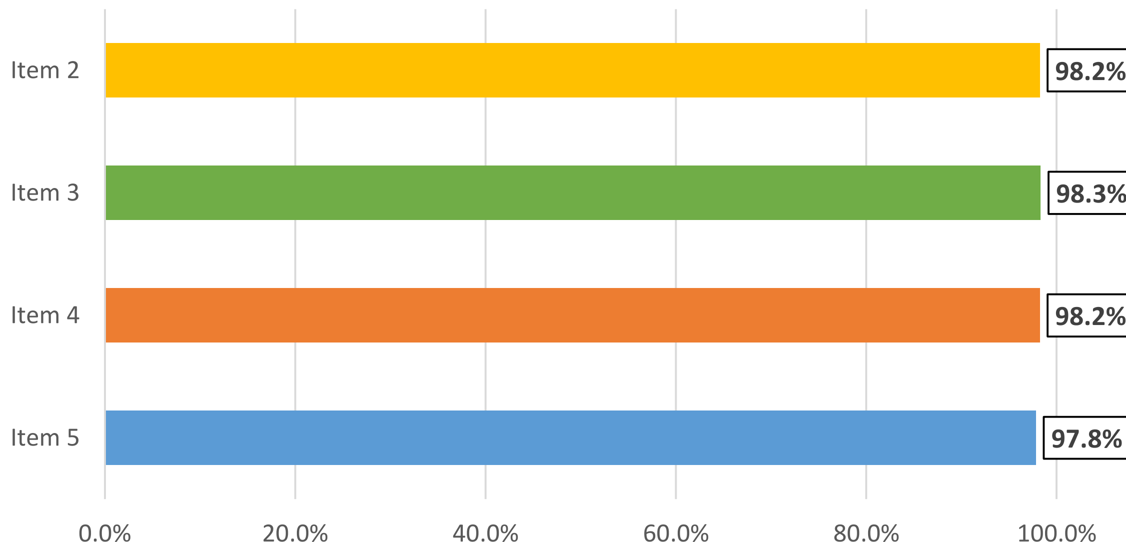
SECTION IV: SURVEY OUTCOMES

Police Department Survey

A Police Department Survey is distributed in order to collect the police department's opinions on the services provided at the Garden Gate Innovative Respite Project. A total of 203 surveys were completed during the October 2013 through April 2016 reporting period. Below is a legend of the item numbers and corresponding question texts, followed by a bar chart showing overall satisfaction percentages of the responses per item. Item one is the only exception, as its responses are on a different scale from the remaining four questions. The remaining questions fall on a 5-point scale ranging from "very satisfied" to "very unsatisfied".

Item #	Question Text
1	Have you previously utilized the Respite Center?
2	How would you rate the Respite Center as a beneficial tool for the Modesto PD?
3	How would you rate the efficiency of the staff at the Respite Center?
4	Are you satisfied at the accessibility of the staff at the Respite Center?
5	Are you satisfied that Respite Center's client criteria meets the needs of the population that MPD comes in contact with?

	October 2013 – April 2016			
	Yes		No	
	#	%	#	%
Item 1	165	81.7%	37	18.3%

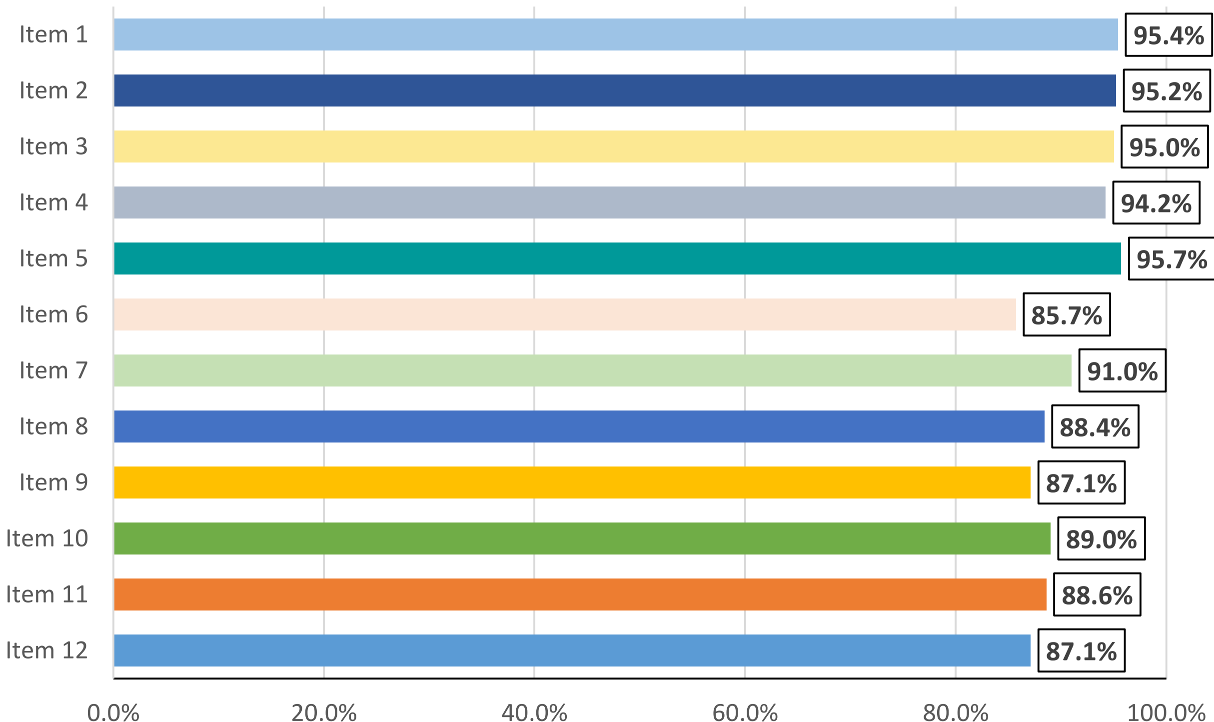


Overall, GGIRP received a satisfaction rate of 98.1%.

Client Survey

Client surveys are distributed in order to obtain information on individual's experiences at GGIRP. A total of 419 surveys were completed during the October 2013 through April 2016 reporting period. Below is a legend of the item numbers and corresponding question texts, followed by bar chart showing overall satisfaction percentages of the responses per item. The questions fall on a 5-point scale ranging from "strongly agree" to "strongly disagree", with an option for "not applicable".

Item #	Question Text
1	I am satisfied with the services I received at Garden Gate.
2	I am satisfied with the way staff interacted with me.
3	I am satisfied with the quality of food provided to me by Garden Gate staff.
4	I am satisfied with the level of safety at Garden Gate.
5	Garden Gate staff made me feel welcomed.
6	I have been able to reconnect with my family member/loved one.
7	I know that there are resources, other than the psychiatric hospital, available to help support me to cope in times of crisis.
8	I feel more hopeful and empowered in my ability to cope.
9	I have been able to connect with peers who were/are mental health consumers.
10	I am satisfied with the experience I had connecting with peers.
11	My contact with peers has helped me feel supported.
12	My contact with peers has helped me learn to practice self-care.



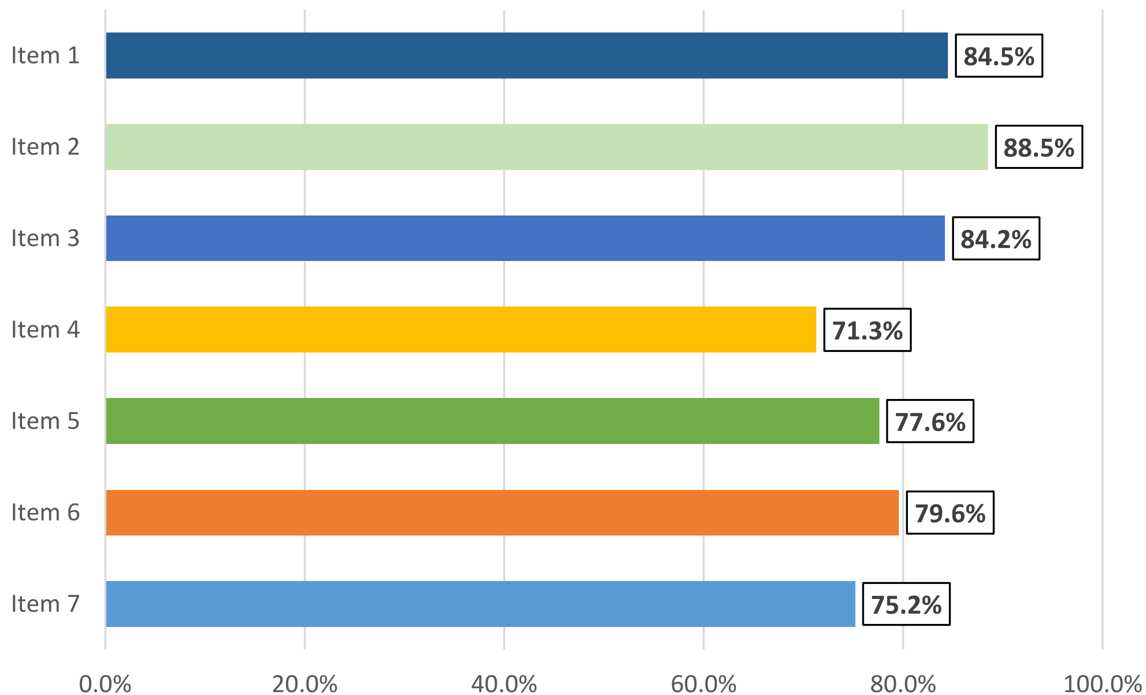
The majority of individuals served through the Garden Gate Innovative Respite Project had favorable satisfaction rates with the services they received. This is a very positive outcome.

Overall, GGIRP received a satisfaction rate of 91.2%.

Family Support Person Survey

For the Garden Gate Innovative Respite Project, a total of 82 surveys were completed between October 2013 and April 2016. Below is a legend of the item numbers and corresponding question texts, followed by a bar chart showing overall satisfaction percentages of the responses per item. The questions fall on a 5-point scale ranging from “strongly agree” to “strongly disagree”, with an option for “not applicable”.

Item #	Question Text
1	I have been able to reconnect with my family member/ loved one.
2	I know that there are resources, other than the psychiatric hospital, available to help support me and my family member/loved one cope with their mental illness.
3	I feel more hopeful and empowered in my ability to help my family member/loved one.
4	I have been able to connect with other families who also have family members experiencing mental illness (“peer families”).
5	I am satisfied with the experience I had connecting with peer families.
6	My contact with peer families has helped me feel supported while supporting my family member/loved one.
7	My contact with peer families has helped me learn to practice self-care while supporting my family member/loved one.



Overall, GGIRP received a satisfaction rate of 81.5%.

Garden Gate Innovative Respite Project Implementation Workgroup Survey

A Garden Gate Innovative Respite Project Implementation Workgroup meets at least quarterly. Members of the general community are welcomed to provide feedback regarding the Project's adherence to learning approaches to integrating culturally specific, community-based peer support, and family support, outlined in the Innovative Respite Work Plan and inform service provision. Often represented are BHRS and Turning Point employees, NAMI volunteers, law enforcement officers, disability and recovery advocates, and family members and consumers of mental health services. Each meeting includes an anonymous survey provided to participants in order to measure participant perceptions of progress toward identified outcomes, as well as the effectiveness and impact of the Workgroup's collaborative effort.

Below is a legend of the item numbers and corresponding question texts, followed by a comparison between all surveys thus far, of overall satisfaction percentages of the responses per item.

Item #	Question Text
1	The group worked towards addressing at least one or more of the Learning Questions outlined in the Innovation Work Plan Narrative.
2	I believe the Garden Gate Innovative Respite Project is integrating culturally specific criteria into its approach.
3	I believe the project is integrating community-based peer support into its approach.
4	I believe the project is integrating family support into its approach.
5	During the meeting, a summary of progress made to date was given verbally and/or in writing to the group.
6	The progress that was reported at the meeting was clear and easy to understand.
7	I am satisfied with the progress made up to this point.
8	I am confident that we will reach any new goals that were set today before the next meeting.
9	I have a clear idea of what is required to make this project successful.
10	Currently, I can say that I am confident in this project's ability to be successful.
11	Currently, I can say that I am confident in this work group's functionality.
12	I supplied some input to the group today (yes/no).
13	I felt comfortable giving my input to the group.
14	I felt my input was responded to in a respectful manner.

Garden Gate Innovative Respite Project Implementation Workgroup Survey (continued)

	Survey #1	Survey # 2	Survey #3	Survey #4	Survey #5	Survey #6	Survey #7	Survey #8	Survey #9	Survey #10	Overall
Total Surveys Completed	**7**	**12**	**3**	**14**	**5**	**12**	**17**	**14**	**13**	**15**	**112**
Participant's Position											
BHRS Employee	1	1	1	2	2	0	6	10	4	**6**	**33**
TPCP Employee	1	1	2	3	0	1	5	3	4	**0**	**20**
NAMI Representative	1	1	0	0	0	0	0	0	0	**2**	**4**
Mental Health Services Consumer	2	2	0	0	0	3	0	0	0	**0**	**7**
TPCP Empowerment Project Advocate	2	0	0	0	0	2	0	0	0	**0**	**4**
Other/Unknown	0	7	0	9	3	6	6	1	5	**7**	**44**
Survey Item Responses											
Item 1*	91.4%	88.1%	95.2%	95.2%	94.3%	89.3%	89.9%	91.8%	93.4%	92.9%	**92.0%**
Item 2*	94.3%	84.5%	90.5%	94.9%	91.4%	85.7%	88.2%	91.8%	94.5%	93.3%	**90.9%**
Item 3*	91.4%	86.9%	100.0%	92.9%	94.3%	90.5%	90.8%	93.9%	95.6%	90.5%	**92.1%**
Item 4*	91.4%	84.5%	90.5%	92.9%	94.3%	91.7%	86.6%	87.8%	92.3%	89.5%	**89.8%**
Item 5*	88.6%	88.1%	100.0%	91.8%	97.1%	92.9%	85.7%	90.8%	96.7%	95.2%	**91.8%**
Item 6*	91.4%	85.7%	95.2%	92.9%	91.4%	86.9%	89.9%	91.8%	93.4%	94.3%	**91.2%**
Item 7*	94.3%	83.3%	95.2%	92.9%	94.3%	91.7%	90.8%	90.1%	93.4%	91.4%	**91.2%**
Item 8*	85.7%	85.7%	90.5%	90.8%	94.3%	84.5%	91.6%	87.8%	90.1%	87.6%	**88.8%**
Item 9*	91.4%	88.1%	95.2%	89.8%	94.3%	89.3%	89.3%	86.7%	93.5%	87.6%	**89.8%**
Item 10*	88.6%	84.4%	100.0%	94.9%	94.3%	89.3%	95.5%	92.3%	92.2%	91.4%	**92.0%**
Item 11*	88.6%	83.1%	90.5%	93.9%	94.3%	89.3%	94.6%	91.2%	93.5%	90.5%	**91.3%**
Item 12*	100.0%	83.3%	100.0%	57.1%	100.0%	75.0%	43.8%	61.5%	63.6%	78.6%	**69.2%**
Item 13*	94.3%	87.0%	100.0%	92.9%	94.3%	92.1%	74.1%	88.3%	91.1%	96.9%	**87.2%**
Item 14*	91.4%	97.4%	100.0%	88.6%	94.3%	92.1%	55.4%	90.0%	92.9%	96.9%	**84.5%**

*Items are defined on the preceding page (page 13).

Overall, an average of 94.4% of the items in the survey were responded to as either “Strongly Agree”, “Agree”, or “Somewhat Agree”. A breakdown by item is presented below.

	Strongly Agree	Agree	Agree Somewhat	Total %
Item 1*	62	40	5	**96.4%**
Item 2*	59	40	8	**95.5%**
Item 3*	62	42	4	**96.4%**
Item 4*	51	47	9	**95.5%**
Item 5*	64	39	3	**94.6%**
Item 6*	58	43	6	**96.4%**
Item 7*	61	38	7	**95.5%**
Item 8*	49	46	9	**92.9%**
Item 9*	51	44	9	**95.4%**
Item 10*	59	41	4	**97.2%**
Item 11*	54	43	9	**99.1%**
Item 13*	56	25	4	**89.5%**
Item 14*	58	18	1	**82.8%**
Overall Average	**57.2**	**38.9**	**6.0**	**94.4%**

*Items are defined on page 13.

As can be seen from the table above, the majority of individuals responded to each item as either “Strongly Agree”, “Agree”, or “Somewhat Agree” ranging between 81.2% and 98.8%. This is a very positive outcome.

Item 12 has been excluded from the table due to the fact that is uses a different response scale of either “yes” or “no”.

SECTION V: DISCHARGE DISPOSITION

Between October 1, 2013 and April 30, 2016, a total of 609 unduplicated individuals were discharged (one individual was discharged after the end of the reporting period). Due to some individuals having multiple admissions and discharges within the reporting period, the chart below reflects the total number of discharges, which is equivalent to 296 (one discharge occurred after the end of the reporting period).

	October 2013 – April 2016	
	#	%
Board and Care	19	2.1%
DBHC	16	1.7%
Family	63	6.8%
Home (Previous Living Situation)	102	11.0%
Medical Hospital	25	2.7%
Modesto Gospel Mission	94	10.2%
Motel	25	2.7%
Non-Related Individuals	41	4.4%
Own Apartment	5	0.5%
Room and Board	50	5.4%
Salvation Army	68	7.3%
SRC/Residential SA Treatment	74	8.0%
Streets	29	3.1%
Transitional Housing	32	3.5%
Turning Point Supportive Housing	2	0.2%
Other	50	5.4%
Data Not Available	231	24.9%
Total	**926**	**100.0%**

As can be seen from the table above, the majority of clients did not have a discharge destination recorded between October 2013 and April 2016 (24.9%, n=231). Otherwise, the majority of individuals were either discharged to their previous living situation (11.0%, n=102) or to the Modesto Gospel Mission (10.2%, n=94).

APPENDIX B

TURNING POINT

Turning Point Respite At Garden Gate

Opening/Closing

Guest Name: ______________________________

Opening (this section to be completed upon admit):

Effective Date (date of admit): ☐☐ / ☐☐ / ☐☐☐☐

Form completed by (Staff Initials/County I.D. #): ____________________

SubUnit:
- ☐ Garden Gate Respite (7005) OR
- ☐ Garden Gate Innovative Respite Project (7006)

Closing (this section to be completed upon discharge):

Effective Date (date of discharge): ☐☐ / ☐☐ / ☐☐☐☐

Form completed by (Staff Initials/County I.D. #): ____________________

Reason:
- ☐ Client Incarcerated
- ☐ Death of Client
- ☐ MH – Client Moved Out of Area
- ☐ MH – Client Withdrew, Tx Partially Completed
- ☐ MH – Client Withdrew, No Improvement
- ☐ MH – Discharge/Administrative Reasons
- ☐ MH – Discharge/Unilateral Decision
- ☐ MH – Mutual/Tx Goals Partially Reached
- ☐ MH – Mutual/Tx Goals Not Reached
- ☐ MH – Mutual/Tx Goals Reached
- ☐ Other

PSC Use Only:	☒	Initial	Date
EHR Open	☐	________	___/___/___
Demographic	☐	________	___/___/___
EHR Close	☐	________	___/___/___
Summary Progress Note	☐	________	___/___/___
Database Entry	☐	________	___/___/___

OFFICE USE:

Client #: ☐☐☐☐☐☐☐

TURNING POINT
COMMUNITY PROGRAMS

Turning Point Respite At Garden Gate

Referral For Garden Gate Services

REFERRING AGENCY/REPRESENTATIVE INFORMATION

Last Name: ☐☐☐☐☐☐☐☐☐☐☐☐ **First Name:** ☐☐☐☐☐☐☐☐☐☐☐☐

Phone: (☐☐☐) ☐☐☐- ☐☐☐☐

Agency/Program (please check one):

☐ AB109	☐ Turning Point ISA
☐ Ceres PD	☐ Turlock PD
☐ CERT	☐ Telecare Recovery Access Center (TRAC):
☐ Community Navigation Team	☐ TMRS
☐ Empowerment Center	☐ Wellness
☐ HRH & SA (High Risk Health & Senior Access)*	☐ FastTRAC
☐ IFT*	☐ Partnership*
☐ Josie's Place Service Team	☐ Josie's TRAC*
☐ King Kennedy Collaborative	☐ Transition Team*
☐ Modesto PD	☐ Westside*
☐ MRS	☐ Outreach/Engagement
☐ PATH (BHRS Outreach)	☐ MRS TRAC*
☐ TRS	☐ Other_______________
☐ SATT	
☐ Stanislaus County Sheriff	*Programs with 24/7 services

What circumstances caused you to bring the individual in to Respite?

____

____

____

Is the individual ambulatory (can they get around the house by themselves independently, or by using a cane, walker, or wheelchair, etc.)?	☐ YES	☐ NO
Does the individual have a history of violence?	☐ YES	☐ NO
Is the purpose of this referral to avoid an inpatient psychiatric hospitalization?	☐ YES	☐ NO

OFFICE USE: Client #: ☐☐☐☐☐☐☐ DATE: ☐☐/☐☐/☐☐☐☐ TIME: ☐☐:☐☐AM/PM

Turning Point Respite At Garden Gate

Police Department Survey

Guest Name: ______________________________

Date: ________________

Have you previously utilized the Garden Gate Respite Center?	☐ YES ☐ NO

How satisfied are you with the following:

	Very Satisfied	Satisfied	Neutral	Unsatisfied	Very Unsatisfied
1. The Garden Gate Respite Center being a beneficial tool for the Modesto Police Department	5	4	3	2	1
2. The efficiency of Garden Gate Respite Center staff	5	4	3	2	1
3. The accessibility of the Garden Gate Respite Center	5	4	3	2	1
4. The Respite Center's client criteria meeting the needs of the population that MPD comes into contact with.	5	4	3	2	1

OFFICE USE:

Client #: ☐☐☐☐☐☐☐ SubUnit ____________ Staff Initials/County ID#:__________

Turning Point Respite At Garden Gate

MORS Scoring Sheet

Guest Name: ______________________________

Questions to Ask Yourself:

1. Is the consumer struggling (1-5) or succeeding (6-8)?

2. What is the consumer's level of risk? Is the individual exhibiting behaviors that reflect "Extreme Risk", "High Risk", or "Poorly Coping" (relatively low risk)?

3. Is the consumer engaged or not engaged?

Intake

Score: ________

Date: ___/___/_____ **Staff Initials/County ID#:**__________

Comments:

____

____

____

Discharge

Score: ________

Date: ___/___/_____ **Staff Initials/County ID#:**__________

Comments:

____

____

____

OFFICE USE:

Client#: [| | | | | |] SubUnit __________

TURNING POINT

Turning Point Respite At Garden Gate

Admission Form

Guest Information

Admission Date: ____/____/____

"Add Client" Information

Last Name: [ ] First Name: [ ] MI: [ ]

DOB: [ ]/[ ]/[ ] SSN: [ ]-[ ]-[ ] Sex: M [ ] F [ ]

Address (if applicable): ______________________________

Street Number Street Name City Zip Code

- If no address, "What zip code did you reside in before you came here?": [ ]

Phone: ([ ]) [ ] - [ ]

"Demographic" Information

If No SSN, Reason Not Provided:

- ☐ Decline
- ☐ Not Applicable
- ☐ Unable to Answer

DOB Is:

- ☐ Actual
- ☐ Estimated

Ethnicity and Race: (Please see "Race and Ethnicity" form)

Preferred Language:

- ☐ English
- ☐ Spanish
- ☐ Other (Refer to BHRS Hot Sheet values) ____________

If not English: "Are you comfortable communicating in English?"

- ☐ Yes
- ☐ No (Interpreter or Language Line services needed)

Veteran Status:

"Have you ever served in the United States military?"

- ☐ Yes (During which conflict? Refer to BHRS Hot Sheet values)________________
- ☐ No
- ☐ Decline to State
- ☐ Unable to Answer

Sexual Orientation:

- ☐ Bisexual
- ☐ Declined to Answer
- ☐ Gay/Lesbian/Homosexual
- ☐ Heterosexual/Straight
- ☐ Questioning

Emergency Contact Information

Last Name: [ ] First Name: [ ]

Relationship:______________________ Phone: ([ ]) [ ] - [ ]

OFFICE USE:

Client #: [ ] SubUnit ____________ Staff Initials/County ID#:____________

Guest Health Information

"Do you have any physical health problems that you might need assistance with?": ☐ YES ☐ NO

"So that we can be as helpful as possible, do you have any mental health issues that we should know about": ☐ YES ☐ NO

"Have you been admitted to a psychiatric hospital within the last 12 months?" ☐ YES ☐ NO

If ***YES***, "How many days total do you think you spent in the psychiatric hospital during that time? # Days:______

Was this Guest at Risk of:

☐ **Arrest** (brought in by police upon being observed while engaging in unlawful behavior, such as panhandling, loitering, trespassing, threatening behavior, etc.)

☐ **Victimization** (vulnerable to other due to mental status, poor boundaries, frailty, etc.)

☐ **Homelessness** (without long-term housing, potential loss of current housing, etc.)

☐ **Criminal Activity** (not brought in by police, but was observed to have been engaging in unlawful behavior, such as panhandling, loitering, trespassing, threatening behavior, etc.)

Personal Belongings

Review the "Personal Belongings Policy" with the guest, and obtain their signature accepting or declining locker access.

"Do you have any personal belongings, including valuables or medications, you'd like to store in a locker?"

I have read and/or reviewed the Personal Belongings Policy with staff, and have decided that:

☐ Yes, I would like to be loaned a locker and padlock during my stay. I agree that I am responsible for securing my belongings in it, holding the key, that I may not be able to access my belongings until the next business day should I lose the key, and that if a lock needs to be cut to access my belongings, I will not be issued another. (Locker Number Assigned: ________)

☐ No, I do not wish to be loaned a locker and padlock. I take responsibility for keeping my personal belongings with me and/or safe at all times.

Guest Signature ______________________ Date __________

Witnessed By (Staff Member) ______________________ Date __________

OFFICE USE:

Client #: ☐☐☐☐☐☐☐ SubUnit ____________ Staff Initials/County ID#:____________

TURNING POINT

Turning Point Respite At Garden Gate

Race/Ethnicity Form

Guest Name:_______________________________ Date: ________________

Which, if any, of the following do your consider to be your primary race?:

Choose up to 5

- ☐ Amerasian
- ☐ Asian (Other)
- ☐ Assyrian (Iran)
- ☐ Assyrian (Iraq)
- ☐ Black/African American
- ☐ Cambodian
- ☐ Chinese
- ☐ Eskimo/Alaskan Native
- ☐ Filipino
- ☐ Guamanian
- ☐ Hawaiian Native
- ☐ Hispanic (Black)
- ☐ Hispanic (Non-White)
- ☐ Hispanic (White)
- ☐ Hmong
- ☐ Indian (Asian)
- ☐ Japanese
- ☐ Korean
- ☐ Laotian
- ☐ Mien
- ☐ Multiple
- ☐ Native American
- ☐ Non-White Other
- ☐ Pacific Islander (Other)
- ☐ South Asian (Other)
- ☐ Samoan
- ☐ Vietnamese
- ☐ White
- ☐ Unknown

Which, if any, of the following do your consider to be your ethnicity?:

- ☐ Not Hispanic
- ☐ Mexican American/Chicano
- ☐ Cuban
- ☐ Puerto Rican
- ☐ Other Hispanic Latino
- ☐ Unknown/Not Reported

OFFICE USE:

Client #: ☐☐☐☐☐☐☐ SubUnit ____________ Staff Initials/County ID#:__________

Turning Point Garden Gate Respite House Rules

Our goal is to provide a safe, welcoming environment during your stay:

PROGRAM MISSION & STRUCTURE

1. Your time here is an opportunity to connect with resources to help you establish and maintain wellness in the community. To achieve this, we encourage you to collaborate with the Personal Service Coordinator (PSC) assigned to support you in identifying and working toward agreed-upon goals for the length of your stay.

2. We encourage you to participate in at least one group or other recovery-based activity (in-house or in the community) per day, in order to help build coping skills and peer support that will be essential to your continued success upon discharge.

3. Please remember that this is a temporary, short-term stay. There is no guaranteed length of stay. Your stay will be reevaluated by PSCs (in consultation with supervisors) every 24 hours.

4. If you are brought in by law enforcement (e.g. police/sheriff) or CERT, you must remain on site until you meet with a member of Telecare Outreach & Engagement team. If you do not to meet with them for any reason, you may be discharged.

SAFETY & CONDUCT

5. No weapons, drugs, or alcohol are allowed on the property at any time. For the safety of everyone, guests may be asked to empty their pockets or bags at any time to assure that no prohibited items are brought onto the property. Discovery of prohibited items at any time may result in immediate discharge.

6. Threats of violence to staff, guests, or self are taken seriously, and may result in your discharge, as well we temporary or permanent ineligibility for Respite services.

7. All guests and staff are expected to be courteous and respectful. Engaging in conduct that is disruptive to the house or neighborhood may result in your discharge.

8. Staff cannot hold personal belongings, or dispense medications at any time. You are responsible for securing personal belongings and medications at all times. If you choose, you may have use of a locker to store these items during your stay.

9. PERSONAL BELONGINGS, INCLUDING VALUABLES AND MEDICATIONS, LEFT FOR MORE THAN 24 HOURS AFTER DISCHARGE WILL BE DISCARDED WITHOUT NOTICE.

10. In consideration of all guests, please limit calls on the guest phone to 20 minutes.

11. No caffeinated beverages are allowed after 10:00 PM.

12. For your safety, socks, slippers, or shoes must be worn at all times.

13. Staff may restrict the content of television, music, or other media broadcast in the house if the content is inappropriate or upsetting to others.

14. To protect the privacy of all guests, lingering in the office areas is not allowed.

15. You must check in and out with staff when leaving the site or returning. When out, you must call or return at least every 4 hours to maintain your bed. Staff must give prior approval for any absence longer than 4 hours. If you leave the grounds for more than 4 hours without prior approval and/or without checking in, you may be discharged without further notice.

16. You must remain on site between the hours of 10:00pm and 6:00am. Staff approval is required to leave during that time. Leaving during these hours or staying out past 10:00 pm without prior approval may result in discharge without notice.

17. Any visitors to the site must be 18 years of age or older (no minor children permitted), and must adhere to the same rules of conduct for house guests.

SMOKING

18. Borrowing cigarettes from staff or clients is not permitted.

19. There is no rolling of tobacco allowed in the house or front porch. If you have loose tobacco, please let a staff member know, and they will provide you with a plastic bag to store it in.

20. There is no smoking of any kind (including "e-cigs" or vapor cigarettes). You may smoke only in the designated gravel area near the rear parking lot. Smoking inside the house may be grounds for immediate discharge as it presents a safety risk.

SANITARY CONERNS

21. To prevent potential for pest infestation, the volume of belongings allowed at Respite is limited to the capacity of a 24-gallon plastic storage bin (24" x 20" x 20"), approximately the size of a large carry-on bag. No belongings are allowed inside the house until they have been laundered, inspected, and deemed appropriate by staff. No exceptions can be made.

22. To prevent bug and other pest infestations, no food or drinks are allowed in bedroom or living room areas. They are allowed only in the kitchen and dining room.

23. For sanitary reasons, guests and staff must wear gloves when handling food items.

24. You are responsible for keeping your living area neat and clean. If you create a mess of any kind, accidentally or otherwise, you are expected to clean it and/or assist staff in doing so.

CONFIDENTIALITY

25. I understand that if I disclose any information to staff regarding abuse of a child, dependent adult (including individuals with physical or psychiatric disabilities), or elderly person, staff will be required by law to report this information to an investigating agency.

Guest Agreement:

By signing below, I agree to abide by all house rules, and cooperate with the general policies of the facility.

Guest Signature: ______________________ Date: ___________

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

I, _______________________________, acknowledge receipt of the Notice of Privacy Practices by signing this form. The Notice of Privacy Practices provides information about how Turning Point Community Programs (TPCP) may use or disclose protected health information about me. I was encouraged to read the document in full.

This Notice of Privacy Practices is subject to change. I understand that I can obtain a copy of the revised notice at one of the programs or sites of Turning Point Community Programs or from the Privacy Officer or other ways explained in the Notice I received.

I also understand that any self-publication (including the posting, broadcast or transfer) of my Protected Health Information (PHI), that reveals or otherwise contains individually identified provider information posted on a blog, internet website, or other printed/electronic form or forum, constitutes a waiver of any protections afforded such PHI under HIPAA, as well as any other applicable regulations, rules or laws. Further, any self-publication of my PHI permits provider to respond to the original publications to the extent necessary to defend, limit and challenge the factual assertions contained within such publications. Any and all comments and publications will be considered self-disclosed/waived protections of my PHI to the extent such publication is made.

I acknowledge receipt of the Notice of Privacy Practices of Turning Point Community Programs.

_______________________________ _______________________

Signature Date

I acknowledge receipt of the Notice of Privacy Practices of the County of Sacramento.

_______________________________ _______________________

Signature Date

OR

I acknowledge that I have been offered to receive the Notice of Privacy Practices of Turning Point Community Programs. I have read the Notice of Privacy Practices in the presence of TPCP staff and have chosen not to receive my personal copy. I understand that I can obtain a copy at any time from one of the sites of TPCP or from the Privacy Officer.

_______________________________ _______________________

Signature Date

INABILITY TO OBTAIN ACKNOWLEDGEMENT

To be completed only if no signed acknowledgement of receipt is obtained. If it is not possible to obtain the individual's acknowledgement, indicate the reason why the acknowledgement was not obtained.

____ Refused to sign ____ Unable to sign ____ Mailed to client Date: _____________

Staff Comments

____

Signature of provider representative: _____________________________ Date: ____________

Turning Point Community Programs

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

(File in HIPAA Section)

Turning Point Community Programs (TPCP) Garden Gate Respite/Garden Gate Innovative Respite
Consent to Release of Confidential Personal Information

I, (print name) ______________________________, (date)______________
authorize the staff members of TPCP Garden Gate Respite and/or Garden Gate Innovative Respite and the following individuals and/or Service Partners to communicate with and disclose to one another all information regarding my mental and physical health status, and service/resource/support needs observed, obtained by, or disclosed to Garden Gate staff members during the course of my stay:

	Name (Person or Agency):	Address:	Phone:
1.			
2.			
3.			
4.			

Initial each category that applies:

__________ my name and other personal identifying information;

__________ my status as a participant in support and referral services;

__________ mental and physical health status;

__________ identified needs and service recommendations made by Garden Gate staff members;

__________ other ______________________________

The purpose of the disclosures (authorized in this consent) is to assist Garden Gate staff in identifying any mental health, physical health, and practical needs I may have, so that they may provide me with appropriate referrals and linkage to outside services/resources/supports to get these needs met.

I understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows (circle only one selection):

(1)One year from the date that is listed on the top of this form: ______________

(2)Six months from the date that is listed on the top of this form: ______________

(3)Other: ______________________________

I understand that this authorization is voluntary; that my personal information may be protected under federal or state confidentiality laws. I understand that federal privacy laws protecting my personal confidential information may not apply to the recipient and may not prohibit the recipient from disclosure.

I understand that I may choose not to sign this authorization and this will not affect my ability to obtain services.

Date: ______________ ______________________________
Signature of Garden Gate Guest

Date: ______________ ______________________________
Signature of Witness (Garden Gate Staff Member)

Ver. 03.12.14

TURNING POINT

Turning Point Respite At Garden Gate

Needs Assessment

Guest Name:______________________________________ Date: ____/____/____

Identified Need List

1	=	AOD Services
2	=	Clothing
3	=	Community Participation/Involvement
4	=	Family/Social Support
5	=	Food/Food Pantries
6	=	Health Education
7	=	Medical
8	=	Mental Health Services (BHRS/Contractor)
9	=	Mental Health Services (Private Provider)
10	=	Peer Support
11	=	Shelter/Housing
12	=	Other

eferral	REFERRED TO: What specific support person, agency, or other resource did you refer the guest to? (Use the actual name of support person, agency, etc.)	IDENTIFIED NEED (Number corresponding with need listed above)	Did guest try to connect with this referral source?	Was linkage successful?
A			☐ YES ☐ NO	☐ YES ☐ NO
B			☐ YES ☐ NO	☐ YES ☐ NO
C			☐ YES ☐ NO	☐ YES ☐ NO
D			☐ YES ☐ NO	☐ YES ☐ NO
E			☐ YES ☐ NO	☐ YES ☐ NO
F			☐ YES ☐ NO	☐ YES ☐ NO
G			☐ YES ☐ NO	☐ YES ☐ NO
H			☐ YES ☐ NO	☐ YES ☐ NO
I			☐ YES ☐ NO	☐ YES ☐ NO
J			☐ YES ☐ NO	☐ YES ☐ NO
K			☐ YES ☐ NO	☐ YES ☐ NO

OFFICE USE:

Client #: ☐☐☐☐☐☐☐ SubUnit ______________ Staff Initials/County ID#:__________

Turning Point Respite At Garden Gate

Guest Contact Record

Guest Name:___________________________________	Date: ___/___/___
Staff Member Name____	

BEHAVIOR (What was the individual's behavior and/or attitude observed or reported to be? Did the guest disclose any symptoms, behaviors, or concerns? ____

____

____

____

____

____

____

____

IDENTIFIED NEEDS (What service, support, or practical needs do you see, or hope the guest will meet as a result of their stay here?)____

____

COPING STRATEGIES (Does the individual have constructive coping skills they know/can use to address emotional needs? What, if any, maladaptive coping skills do they tend to use? What type of coping skills would it be helpful for them to develop?)____

____

INTERVENTION/PLAN (**NON-TURNING POINT EMPLOYEES: What is the intended destination/specific discharge plan for this individual, and where are you at in facilitating this process?** TURNING POINT EMPLOYEES: What did you do today to help this individual address identified needs, or facilitate the outpatient service provider's discharge plan?):

____

____

____

____

____

____

SUGGESTED APPROACHES/OBSERVATIONS (What has been successful? What has either not been helpful or actually escalated problems/distress?) ________________________________

____

OFFICE USE:

Client #: ☐☐☐☐☐☐☐ SubUnit ________ Staff Initials/County ID#:______ Time: ☐☐:☐☐ AM/PM

Turning Point Respite At Garden Gate

Guest Contact Record

Guest Name:_______________	Date: ___/___/___
Staff Member Name:_______________	

BEHAVIOR (What was the individual's behavior and/or attitude observed or reported to be? Did the guest disclose any symptoms, behaviors, or concerns? ____________________

____

____

____

____

____

____

____

IDENTIFIED NEEDS (What service, support, or practical needs do you see, or hope the guest will meet as a result of their stay here?)____________________

____

COPING STRATEGIES (Does the individual have constructive coping skills they know/can use to address emotional needs? What, if any, maladaptive coping skills do they tend to use? What type of coping skills would it be helpful for them to develop?)____________________

____

INTERVENTION/PLAN (**NON-TURNING POINT EMPLOYEES: What is the intended destination/specific discharge plan for this individual, and where are you at in facilitating this process?** TURNING POINT EMPLOYEES: What did you do today to help this individual address identified needs, or facilitate the outpatient service provider's discharge plan?):

____

____

____

____

____

____

SUGGESTED APPROACHES/OBSERVATIONS (What has been successful? What has either not been helpful or actually escalated problems/distress?) ____________________

____

OFFICE USE:

Client #: ☐☐☐☐☐☐☐ SubUnit _______ Staff Initials/County ID#:_____ Time: ☐☐:☐☐ AM/PM

TURNING POINT

Turning Point Respite At Garden Gate

Guest Satisfaction Survey

If survey not completed, check reason:	☐ Guest declined to participate	☐ Guest not available

Guest Name: ______________________ **Date:** ______________

Please circle a response to the following statements:

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Non Applicable
1. I am satisfied with the services I received at Garden Gate Respite Center.	5	4	3	2	1	0
2. I am satisfied with the way staff interacted with me.	5	4	3	2	1	0
3. I am satisfied with the quality of food provided to me by Garden Gate Respite Center staff.	5	4	3	2	1	0
4. I am satisfied with the level of safety at the Garden Gate Respite Center	5	4	3	2	1	0
5. Garden Gate Respite Center staff made me feel welcomed.	5	4	3	2	1	0

Because of the services I received through the Garden Gate Respite Center:

	Strongly Agree	Agree	Neither Agree Nor Disagree	Disagree	Strongly Disagree	Non Applicable
6. I have been able to reconnect with my family member/loved one.	5	4	3	2	1	0
7. I know that there are resources, other than the psychiatric hospital, available to help support me to cope in times of crisis.	5	4	3	2	1	0
8. I feel more hopeful and empowered in my ability to cope.	5	4	3	2	1	0
9. I have been able to connect with peers who were/are mental health consumers.	5	4	3	2	1	0
10. I am satisfied with the experience I had connecting with peers.	5	4	3	2	1	0
11. My contact with peers has helped me feel supported .	5	4	3	2	1	0
12. My contact with peers has helped me learn to practice self-care.	5	4	3	2	1	0

OFFICE USE:

Client #: ☐☐☐☐☐☐☐ SubUnit ____________ Staff Initials/County ID#:__________

TURNING POINT
COMMUNITY PROGRAMS

Turning Point Respite At Garden Gate

Discharge Form

Discharge Date: ___/___/___

Guest Name: ______________________

Reason For Discharge

☐ Failed to Return (left and didn't return, failed to check in to hold bed)	☐ Safety Issues (verbal/physical aggression, threats, property destruction)
☐ Time Expired (authorized time period has ended)	☐ Moved out of County
☐ Housing Obtained	☐ Entered Other Residential Treatment
☐ Failed to Cooperate (did not follow program rules)	☐ Guest Decision/Request
☐ Did Not Meet Program Requirements (has/can utilize adequate housing, non-ambulatory, medically compromised, etc.)	☐ Other ______________
☐ Able to Return to Previous Living Situation	

Level of Needs Being Met

Needs related to the guest's stay were:

☐ Fully Met ☐ Partially Met ☐ Not Met

Discharged To Location

☐ Motel	☐ Home (previous living situation)
☐ DBHC	☐ Own Apartment (NOT Transitional or Supportive housing)
☐ Modesto Gospel Mission	☐ Medical Hospital
☐ Salvation Army Cold Weather Shelter	☐ Room and Board
☐ Salvation Army Hot Weather Shelter	☐ Board and Care
☐ Salvation Army Transitional Living	☐ Transitional Housing
☐ Streets	☐ Turning Point Supportive Housing
☐ SRC/Other Residential SA Treatment	☐ Unknown
☐ Family	☐ Other ______________
☐ Non-Related Individuals (friends, roommates, etc.)	

OFFICE USE: Client #: ☐☐☐☐☐☐☐ DATE: ☐☐/☐☐/☐☐☐☐ TIME: ☐☐:☐☐AM/PM

GARDEN GATE RESPITE MEDICATION/PERSONAL BELONGINGS POLICY

All Respite guests have the option of storing personal belongings, including valuables or medications, in a locker. If a locker is requested, staff will assign you a locker, padlock, and key for you to borrow for the duration of your stay.

Personal belongings rules:

- Should you choose to borrow a locker, you are responsible for securing your own personal belongings in it.
- You are responsible for holding the key to the locker. Should you lose the key, you may not be able to access your belongings until the next business day (Monday through Friday).
- **If you lose a key, and/or a padlock must be cut off of your locker to access your belongings, you will not be loaned another padlock and key set.**
- Should you decline to be loaned a locker with a padlock and key set, you are still responsible for keeping your personal belongings with you and/or safe at all times.
- Garden Gate staff members are not allowed to hold personal belongings for guests at any time, regardless of the reason.
- Garden Gate staff members are not allowed to hold or dispense any medications for you at any time. If you wish to secure your medications, you must do so in a locker.
- You must be able to manage your own medications. Although staff may agree to try to help you remember to take your medications, this cannot be guaranteed, and you are ultimately responsible for taking your medications in a timely manner.

Locker procedure:

- To be loaned a locker, you must check the "Yes" box in the "Personal Belongings" section on the Admission form and sign.
- If you are loaned a padlock and key, you will be required to return them at end of your stay. Keep the key on your person or in a safe place at all times.
- You are free to access your locker at any time during your stay.
- Should you lose your key, report it as missing to staff immediately.
- At discharge time, you should be sure to empty the locker to avoid loss of items, and as a courtesy for the next guest to use.
- At discharge time, you must return the padlock and key to staff.
- BELONGINGS LEFT IN LOCKERS FOR MORE THAN 24 HOURS AFTER DISCHARGE WILL BE DISCARDED WITHOUT NOTICE!!

Stanislaus County HMIS

Client Informed Consent and Release of Information

You are requesting or receiving services from ____________________________ (Agency Name) who is a member agency of the Stanislaus Housing and Support Services Collaborative (SHSSC), a group of area service providers that is required to maintain a database of client information to measure and report on the impact of services on ending and preventing homelessness. This database is called the Stanislaus County HMIS (Homeless Management Information System). As a potential or actual client of services, we collect the information listed below to more effectively deliver services in Stanislaus County and to maximize the level of federal funding obtained for our county.

In addition to collecting and sharing the specific data listed below the Stanislaus County HMIS is used to generate general reports on homelessness and reports required by the agencies funding the services you are receiving. These reports **DO NOT** have personal identifying information such as names, social security numbers, date of birth, addresses, or phone numbers.

NOTE: Strict controls are in place to protect your information which is only accessible to authorized personnel of member agencies of the collaborative.

I authorize the following information to be entered into the Stanislaus County HMIS and **shared** between SHSSC partner agencies:

Identifying Information: *Name, Social Security Number, Date of Birth, Gender, Ethnicity & Race, Marital & Family status, Household Relationships, Phone Numbers, and Address.*

I authorize the following information to be entered into the Stanislaus County HMIS but **not shared** between SHSSC partner agencies and only accessible by this agency, the HMIS System Administrator, and funding agency authorized users (If Applicable)*:

Basic Information: *Whether or not you have a disability, Veteran, General Health, Education, and Employment status*

Housing Information: *Homeless status, Residence Prior to Program Entry, Zip Code of Last Permanent Address*

Financial Information: *Income and Sources including Non-Cash Benefits*

Disabling Condition: *Physical Disability, Developmental Disability, HIV/AIDS, Mental Health, Substance Abuse, Chronic Health Condition*

Other: *Domestic Violence status, Program Entry Date and Program Exit Date, Services Rendered and Destination After Program Exit*

**Only Applicable if Agency is receiving funding for this program through local government.*

I understand that I may cancel this authorization at any time by written request, but the cancellation will not be retroactive (No records in the system will be removed).

I understand that I have the right to view my HMIS record and will have a report prepared within 72 hours of my written request.

I understand that if I refuse consent to share this information I cannot be denied services.

This release expires 18 months from the date signed below.

Signature of Client	**Printed Name of Client**	**Date**

Stanislaus County HMIS Shelter Data Intake

1. **Project Entry Date (e.g., 05/24/2010)** *[Please complete one for each adult]*

		/			/				

Month Day Year

2. **Name** (first, middle, last name, suffix (e.g., Jr, Sr, III)

First name																	
Middle name																	
Last name																	
Suffix																	

3.Name Data Quality

- ☐ Full name reported
- ☐ Partial, street name, or code name reported
- ☐ Client doesn't know
- ☐ Client refused

4. Social Security Number

			-			-				

5.Date of Birth (e.g., 10/23/1978)

		/			/				

Month Day Year

6. SSN Data Quality

- ☐ Full SSN reported
- ☐ Approximate or partial SSN reported
- ☐ Client doesn't know
- ☐ Client refused

7. DOB Data Quality

- ☐ Full DOB reported
- ☐ Approximate or partial DOB reported
- ☐ Client doesn't know
- ☐ Client refused

8. Gender

- ☐ Male
- ☐ Female
- ☐ Transgender male to female
- ☐ Transgender female to male
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Other [If other, Specify] ____________

9. Race *[More than one race is permitted]*

- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black / African American
- ☐ Native / Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Client doesn't know
- ☐ Client refused

10. Ethnicity

- ☐ Non-Hispanic / Latino
- ☐ Hispanic / Latino
- ☐ Client doesn't know
- ☐ Client refused

11. Veteran Status

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

12. Disabling Condition

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

Stanislaus County HMIS Shelter Data Intake

13. Residence Prior to Project Entry *(i.e., the night before project entry)*

☐	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	☐	Rental by client, with VASH subsidy
☐	Foster care home or foster care group home	☐	Rental by client, with GPD TIP subsidy
☐	Hospital or other residential non-psychiatric medical facility	☐	Rental by client, with other ongoing housing subsidy
☐	Hotel or motel paid for without emergency shelter voucher	☐	Residential project or halfway house with no homeless criteria
☐	Jail, prison or juvenile detention facility	☐	Safe Haven
☐	Long-term care facility or nursing home	☐	Staying or living in a family member's room, apartment or house
☐	Owned by client, no ongoing housing subsidy	☐	Staying or living in a friend's room, apartment or house
☐	Owned by client, with ongoing housing subsidy	☐	Substance abuse treatment facility or detox center
☐	Permanent housing for formerly homeless persons (such as: CoC project; HUD legacy programs; or HOPWA PH)	☐	Transitional housing for homeless persons (including homeless youth)
☐	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)	☐	Other (if other, specify) __________________
☐	Psychiatric hospital or other psychiatric facility	☐	Client doesn't know
☐	Rental by client, no ongoing housing subsidy	☐	Client refused

14. Length of Stay in Previous Place

☐	One day or less	☐	More than three months, but less than one year
☐	Two days to one week	☐	One year or longer
☐	More than one week, but less than one month	☐	Client doesn't know
☐	One to three months	☐	Client refused

15. ZIP CODE of last Permanent Address: Zip Code ___ ___ ___ ___ ___

☐ Client doesn't know ☐ Client refused

16. TIME ON STREET, EMERGENCY SHELTER OR SAFE HAVEN Client entering from the streets, ES or SH?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

17. If Yes, Approximate date started?

		/			/				

18. Regardless of where they stayed last night, number of times the client has been on the streets, in ES, or SH in the past three years including today?

☐	Never in the past 3 years (If checked, then skip to #20)	☐	Four or more times
☐	One time	☐	Client doesn't know
☐	Two times	☐	Client refused
☐	Three times		

Stanislaus County HMIS Shelter Data Intake

19. Total number of months homeless on the street, in ES, or SH in the past three years?

- ☐ One month (this time is the first month)
- ☐ **2-12 (enter # months ________)**
- ☐ More than 12 months
- ☐ Client doesn't know
- ☐ Client refused

20. COVERED BY HEALTH INSURANCE (IF YES, Please answer all questions below) *[All Clients]*

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

Medicaid	No	☐
	Yes	☐
Medicare	No	☐
	Yes	☐
State Children's Health Insurance Program	No	☐
	Yes	☐
Veteran's Administration (VA) Medical Services	No	☐
	Yes	☐
Employer-Provided Health	No	☐
	Yes	☐
Health Insurance obtained through COBRA	No	☐
	Yes	☐
Private Pay Health Insurance	No	☐
	Yes	☐
State Health Insurance for Adults (Medi-cal)	No	☐
	Yes	☐

21. DOMESTIC VIOLENCE Experience: Is client a domestic violence victim/survivor?

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

↓ **[IF YES]** When Experience Occurred?

- ☐ Within the past three months
- ☐ Three to six months (excluding six months exactly)
- ☐ Six months to one year ago (excluding one year exactly)
- ☐ One year ago or more
- ☐ Client doesn't know
- ☐ Client refused

↓ **[IF YES]** Are you currently fleeing?

- ☐ No
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

Case Information: Garden Gate Staff Comments:	HMIS Information: HMIS Staff Comments:
Form Completed by:	Staff Entering Data Into HMIS:
Date Completed:	Date Entered into HMIS:

Stanislaus County HMIS Shelter Data Intake

1. Project Exit Date (e.g., 05/24/2015)

		/			/				

2. DESTINATION:

☐	Deceased	☐	Rental by client, with VASH housing subsidy
☐	Emergency Shelter, Including hotel or motel paid for with emergency shelter voucher	☐	Rental by client, with GPD TIP housing subsidy
☐	Foster Care home or foster care group home	☐	Rental by client, with other ongoing housing subsidy
☐	Hospital or other residential non-psychiatric medical facility	☐	Residential project or halfway house with no homeless criteria
☐	Hotel or motel paid for without emergency shelter voucher	☐	Safe Haven
☐	Jail, prison or juvenile detention facility	☐	Staying or living with family, permanent tenure
☐	Long-term care facility or nursing home	☐	Staying or living with family, temporary tenure (e.g. room, apartment or house)
☐	Moved from one HOPWA funded project to HOPWA PH	☐	Staying or living with friends, permanent tenure
☐	Moved from one HOPWA funded project to HOPWA TH	☐	Staying or living with friends, temporary tenure (e.g. room apartment or house)
☐	Owned by client, no ongoing housing subsidy	☐	Substance abuse treatment facility or detox center
☐	Owned by client, with ongoing housing subsidy	☐	Transitional housing for homeless persons (including homeless youth)
☐	Permanent housing for formerly homeless persons (such as: CoC project, or HUD legacy programs, or HOPWA PH)	☐	Other ______________
☐	Place not meant for habitation (e.g. a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)	☐	No exit interview completed
☐	Psychiatric hospital or other psychiatric facility	☐	Client doesn't know
☐	Rental by client, no ongoing housing subsidy	☐	Client refused

3. EXIT REASON:

☐	Left for Housing before completed	☐	Completed Program
☐	Non-Pay of Rent/Occupancy charge	☐	Non-Compliance with Project
☐	Criminal Action/Property Destruction	☐	Max Time Allowed in Project
☐	Needs could not be met by Project	☐	Disagreement with Rules/Person
☐	Death	☐	Other ______________
☐	Unknown/Disappeared		

Case Information: Garden Gate Staff Comments:	**HMIS Information: HMIS Staff Comments:**
Form Completed by:	Staff Entering Data into HMIS:
Date Completed:	Date Entered into HMIS:

Quiet Time (INN-13)
Operated by Sierra Vista Child and Family Services

Summary: Quiet Time is a stress reduction and wellness program that enhances the holistic development of children with Severe Emotional Disturbance (SED) and children on the Autism spectrum. Implemented in school districts by the Center for Wellness and Achievement in Education (CWAE) in San Francisco, the program incorporates the practice of an extensively researched stress reduction technique known as Transcendental Meditation to reduce stress, balance lives, and increase a child's readiness to learn.

Learning proposed:
Evaluate whether or not Quiet Time can achieve similar outcomes that have been confirmed in non-SED settings. Test whether or not Quiet Time complements other school efforts, including the support of teachers, in creating changes and enabling SED students to improve their behavior, wellness, and academic performance.

Questions:

- Whether or not the data collected and results reported for this pilot project will be aligned with the data gathered and outcomes previously reported by the Center for Wellness and Achievement in Education.
- Will Quiet Time, implemented with SED students and their teachers, achieve these results?
    - Improved academic performance
    - Improved school attendance
    - Reduced student anxiety and psychological distress
    - Decreased attention problems in ADHD students
    - Decreased teacher burnout and psychological distress
    - Increased coping ability and emotional intelligence
    - Reduced blood pressure in students and adults at risk for hypertension

Strategy:
Introduce a new application to the mental health system of a promising community driving practice/approach or a practice/approach that has been successful in a non-mental health context or setting.

Adaptive Dilemma:
Improving the well-being of children/Honoring and Identifying More Holistic Approaches to Well-Being

Project ends in FY17-18

Program Name: Innovations—Quiet Time	Contract: **Stanislaus County Behavioral Health and Recovery Services**
Agency: **Sierra Vista Child & Family Services**	♦ **January 2017**
Contact: Jeff Anderson 523-4573	♦
Reporting Period: Semi Annual: **July – December 2016 & Final Report**	♦

Program Summary:

The Innovations "Quiet Time program is an innovative stress reduction and wellness program that enhances the holistic development of students and faculty. Quiet Time is implemented in school districts by the Center for Wellness and Achievement in Education (CWAE), based in San Francisco.

Initially designed for grades 5 through 12, Quiet Time provides the students two restful 15 to 18-minute periods each school day to reduce stress, balance their lives, and increase their readiness to learn. The primary effects of the program are produced from the practice of an extensively researched stress reduction technique known as Transcendental Meditation (TM). If the students choose not to practice TM, they do quiet sitting (QS), or sustained silent reading (SSR). The students' benefits include improved health, reduced violence, increased focus, better academic performance, and strengthened self-concept. Faculty and staff also have the opportunity to learn and practice meditation to reduce burn-out and improve teacher-student relationships.

Quiet Time has not been implemented at any non-public schools nor with severely emotionally disturbed children (SED) or children that are SED and on the Autism spectrum. Our intention is to introduce a new application to the mental health system of a promising community-driven practice/approach or a practice/approach that has been successful in a non-mental health context or setting.

The goal was to implement Quiet Time at Sierra Vista's K-8th grade Non-Public School campuses (Kirk Baucher School and Sierra Vista Learning Center). The project would test the Quiet Time strategy with children at the Kirk Baucher campus who are Severely Emotionally Disturbed (SED) and at the Learning Center campus with children who are SED and on the Autism spectrum.

Both of Sierra Vista's Non-Public Schools provide educational and mental health services to children who have emotional, behavioral, social, and academic difficulties. Most children have been identified as having special needs and qualify for special education services under the disability of Emotional Disturbance, Multiple Disabilities, Speech and Language, and/or Specific Learning Disability. Students at SV Learning Center are also on the Autism spectrum and may have Intellectual Disability. The educational therapeutic milieu offers special education services, behavior management, group therapy, social skills instruction, and functional skills.

Students at the two schools have demonstrated significant difficulties in a general education setting or a less restrictive educational placement related to the student's disability. Each student has an Individualized Education Plan (IEP) to meet academic and social needs. Services at the school include an emphasis on social and emotional growth, specialized skill-based group services, supportive socialization opportunities with structured peer interaction, vocational and independent living skills, community-based instruction, one-on-one aide, behavior intervention, special education instruction, counseling and guidance, parent network and support program, treatment planning, and collaborative work between programs, agencies, and the community.

During Quiet Time, students would have the option to meditate or do another quiet, relaxing activity like sustained silent reading. All students and teachers would have been offered the opportunity to receive training in an evidenced-based relaxation and self-development technique. Student benefits were conjectured to include improved health, reduced violence, increased focus, better academic performance, and strengthened self-concept.

INITIAL PROPOSED PROGRAM TIMELINE

Date	Activity
Aug 15	1. Contract with Center for Wellness and Achievement in Education a. Planning, forms development, outcomes development, measurement procedures
Sept 15	2. Introductory Presentation (1 hour as a group): Overview of the Quiet Time program, with emphasis on enhancing mental potential, health, social relationships, and promoting inner and outer peace.
Oct – Dec 15	3. Preparation Presentation (45 minutes as a group): Discuss the mechanics of the technique, how it works, why it's easy to learn and effortless to practice, how it's different from other forms of meditation, and its origins.
	4. Personal Interview (15 minutes per student/adult): Each student and teacher/administrator will meet privately with the instructor to discuss the process for personalized instruction and answer any questions/concerns they may have. Students will require written parent consent prior to instruction. In some cases, an aide or clinician may be present with the student.
	5. Personal Instruction (1 hour per student/adult): Instruction in the meditation technique. This will occur over several weeks at each school site. Students will be scheduled in one-hour increments. A male instructor will train the boys; a female instructor will train the girls. A similar process will occur for the teachers and administrators at their respective sites.
	6. Three Days of Checking (1 hour per group): After each student is instructed in the proper way to meditate, he/she will meet with the instructor in a small group with other students for three days in a row to verify correctness of the meditation and for further instruction. Boys will meet with the male instructor and girls will meet with the female instructor.
	7. Quiet Time facilitation training for teachers (2 hours): Instructors will provide a detailed training for the teachers to administer the program in the classroom. Behavior and classroom management techniques appropriate for the SED population will be emphasized during this session.
Feb 16	8. Begin Quiet Time in the classroom: Once new students are trained, they will begin the two, teacher-facilitated 18-minute Quiet Time periods (one during 1st period and one prior to the end of the school day). Quiet Time instructors from CWAE will be present during the first few weeks, if needed, to help each teacher with any classroom management issues.
Feb 16 – Jun 17	9. Weekly and Monthly "Check-ups" (1 hour): Quiet Time Instructors will meet weekly with their respective groups of students (male/female) for the first month of the program to verify that their meditation practice is optimal and to answer any questions. After the first month, the

instructors will meet one time per month with their group of students for the remainder of the school year.

PROGECT ELEMENTS

6.1 Contract with two certified instructors from the Center for Wellness and Achievement in Education in San Francisco to provide the training.

Key activities will include the following:

a. Training of 3 administrators, 13 teachers, and 3 mental health clinicians in the stress reduction and wellness method. A target of approximately 60 students will participate in the project (depending on student enrollment).
b. Implementing the eight program steps including weekly and monthly follow-up provided by Quiet Time instructors. The program will enable teachers and clinicians to spend more time on therapeutic interventions rather than classroom and behavior management.

6.2 Provide additional activities or strategies specified in MHSOAC-approved project plan

6.3 Evaluate the effectiveness of the Innovation project including the following:

a) Increased quality of mental health services
b) Additional outcomes as specified in MHSOAC project plan

6.4 Formal data tracking system to help evaluate the program. Project results will be measured through teacher evaluations, mental health clinician assessments and evaluations, SED student academic progress, and surveys/inventories.

6.5 Provide measurements to assess outcomes that will include the following:

a) Daily measurements of students behavior, including ability to stay on task and social interaction
b) Documentation by teachers and mental health clinicians in progress notes
c) IEP results and changes noted in IEP and academic progress.
d) How the Quiet Time project impacts the use and success of de-escalation techniques versus the use of “holds” when students behavior has escalated to the point where they are endangering themselves or others.

Project results and SED student impacts may also be measured using the following assessments where appropriate: Anxiety: Spielberger’s State-trait Anxiety Inventory, Depressive systems: MHI-5 (Mental Health Index), and Self-Esteem: Rosenberg Self-Esteem Scale.

6.6 Work collaboratively with BHRS to participate in an Innovation project learning collaborative and participate in annual report planning to the MHSOAC.

PROGRESS DURING IMPLEMENTATION PERIOD

<u>DEVELOPMENTS July – December 2015</u>

During the first reporting period Sierra Vista and CWAE began negotiation regarding design and implementation procedures. Since the time of the writing/submission of the initial RFP to the county

(Nov 2014), CWAE had further refined the Quiet Time Program implementation procedures. The newest iteration included communal "practice time" of the Quiet Time periods twice a day for teachers before and after school (without children present). This added procedure was designed to improve the wellbeing of teachers, as well as help teachers ready themselves for successful implementation of Quiet Time with students. That is, teachers were asked to come to school earlier to begin their day together in a session of Quiet Time prior to leading students in Quiet Time at the beginning of the school day. Likewise, teachers were asked to stay after school to engage in an end day Quiet Time together once children have completed their end day Quiet Time session and have departed campus. CWAE reported very positive results with this schedule.

This new request posed many challenges for Sierra Vista's non-public schools. Sierra Vista and CWAE had numerous conversations attempting to resolve these challenges in order to move forward with the implementation of Quiet Time.

1. As a non-public school with Mental Health and other required services we still have a strict requirement to adhere to a designated number of instructional minutes each day.
2. State requirements necessitated a change in the service delivery model at the schools.
3. Teachers have daily reports to complete and file on each child at the end of the school day.
4. Teachers have family responsibilities in the morning that prevent them from coming to campus earlier.
5. Teacher salaries are significantly less than those in the public school sector.
    a. Impacting willingness to commit to additional hours on campus.
    b. Turn-over. Seasoned teachers regularly move on to the public school sector. This impacts the training portion of the budget.
6. The new model CWAE proposed would place the project significantly over the approved budget.

DEVELOPMENTS January – June 2016

During the January through June reporting period SVCFS and CWAE engaged in several conversations working toward a mutually agreeable implementation plan for the 2016-2017 academic school year. These conversations culminated in two site visits by a CWAE representative to the SVCFS non-public school on Finny Rd. During the first visit (May 11) the CWAE representative observed the last two hours of the school day. The purpose was to facilitate CWAE's understanding of how the SVCFS non-public campus operates, observe the students behavior, and learn how staff work with the students. Mr. Rice, the CWAE representative, also presented the basics of Quiet Time, the training required for both staff and students, the time involved each day as well as answered questions.

The second visit occurred June 30 and was expressly scheduled for Mr. Rice to speak to a larger body of school staff and SVCFS administration. The primary purpose was for the SVCFS team to gain a stronger and more complete understanding of Quite Time. Mr. Rice presented research and outcomes, the neuroscience underlying the effects of Quite Time, and what students and teachers would actually doing a Quite Time session. Questions were entertained, concerns addressed, and effort was made toward reconciling a more agreeable implementation plan.

Developments July – December 2016

Two primary obstacles were unable to be overcome during this time period; practice of Quiet Time by staff on their own time and the concern that Quite Time in actuality introduced a religious practice in the school environment.

1. Practice of Quite Time by Staff
   When CWAE was first contacted by the person tasked with writing the Innovations proposal, it was understood that the school staff in the identified classrooms would be leading/participating in Quite Time along with the students. This was agreeable as it would be during regular school hours. However, after award of the proposal, and upon beginning negations of a formal agreement between CWEA and Sierra Vista, the idea of staff practicing communally before and after school was introduced. This proved significantly challenging. It essentially asked staff to lengthen their work day, impinging on their personal time before and after school. This was untenable for most staff as they had responsibilities with their own families before and after school, and was outside the proposed budget for the project and contracts signed by staff. Even when the communal practice requirement was lifted, and a personal requirement of before and after school was posited by CWAE, staff were unable to offer a commitment to this practice as it again impacted their personal time outside the normal work day. Though several staff were interested in participating in the project, they could not commit to following the model to fidelity due to the required use of personal time.

2. Introduction of Religious Practice
   Upon hearing directly from CWAE representative in May and June of 2016, several key leaders at the school developed concern that the exercise of Quiet Time actually introduced a religious practice into the school environment. Quite Time uses the core practice of Transcendental Meditation(TM) which was developed by Maharishi Mahesh Yogi. A primary tenet of TM is the use of a "nonsensical" mantra assigned by the trainer (consistent with CWEA training). Staff were concerned that most of these assigned mantras include the names of Hindu gods. Subsequent research by this writer confirmed that this is a common practice of TM. The school has long accepted, welcomed, and celebrated all beliefs of children and families, but has not supported a particular belief in its daily interactions, teaching and service delivery. Staff felt that the use of Quiet Time, as presented by the CWAE representative, would unknowingly and unnecessarily direct children and staff to invoke the names of Hindu gods, thus support the practice of a particular religious ritual. This resulted in the key leaders being unable to commit to supporting the practice in the school environment.

Sierra Vista administration carried out subsequent conversations with both staff and CWAE in attempts to mitigate concerns and find a mutually agreeable implementation plan that could advance the innovation project. CWEA reports tremendous success with its current implementation design, and did not want to stray far as a matter of maintaining fidelity for both research and outcomes purposes. Sierra Vista staff appreciated the idea and outcomes CWAE is experiencing, but could not overcome the impact on staff time and the position that, though the school can educate on different religious practice as part of a comprehensive curriculum, it cannot introduce a religious practice in the daily school environment. This culminated in CWAE and Sierra Vista concluding in November 2016 that a mutually satisfying agreement to implement Quiet Time in the non-public school was not forthcoming. As such, no billing/invoices have been submitted for this project. Though both entities are saddened by this conclusion, each recognizes the importance to have full commitment to a design that meets the needs of all involved. Moreover, CWEA and Sierra Vista maintain a mutual respect and neither has dismissed the idea of future collaborations.

Father Involvement Learning Network (FILN) – INN-14
Operated by Center for Human Services

Summary: The Father Involvement Project will create a collaborative learning network that brings organizations and community groups together to achieve positive results for fathers and build protective factors. The project will support and accelerate the local countywide transformation by advancing learning on the following issues: promote interagency collaboration.

Learning proposed:

1. How will participation in a learning network impact the growth and development of its members and father involvement in Stanislaus County?
2. What best practices for father involvement will emerge through network learning?

Strategy:
Through interagency collaboration, this project will introduce to the mental health system a community defined approach that has been successful in a non-mental health context or setting.

Adaptive Dilemma:
Improving parental competency and social support for fathers

Project ends in FY17-18

Semi-Annual/Annual Summary Report: January - December 2016

General Program Description and Goal:

The Father Involvement Project will create a collaborative learning network that brings organizations and community groups together to achieve positive mental health results and build protective factors against mental health problems for fathers in Stanislaus County. The Father Involvement Learning Network (FILN) will promote interagency collaboration to reach fathers with mental illness or those at risk of mental illness and their families. The learning goal is to increase broad father involvement at various Family Resource Centers (FRCs) and other Community or Strength Based organizations as a way to improve mental health and related outcomes, reduce risk factors and promote protective factors.

FILN Network Development and Learning Activities:

JANUARY – JUNE 2016

January:

- All (6) Network Partners were engaged and an initial Network meeting was held on 1/13/16 at CHS. Network partners reviewed the project learning questions and goals, and began to map known programs in the area engaged in father involvement work. Dr. Jaime McCreary shared an overview of the Evaluation process.
- Launched Facebook page to engage members and share information.

February – March:

- The Network worked with Valerie Thompson of CHS' Hutton House to explore a collective mission, vision and values, as well as potential network partners, structure and protocols. The following mission statement evolved:

  The Mission of the Father Involvement Learning Network is to act as a conduit for resources and best practices that support men as fathers.

April:

- Lamar Henderson, Program Coordinator for *All Dads Matter* Resource Center, gave a comprehensive presentation of the services and programs his agency provides for fathers in Merced County. *All Dads Matter* offers a monthly Bootcamp for New Dads, as well as other educational, support and engagement groups and activities for local fathers.

May:

- Stanislaus County CEO Stan Risen and Ruben Imperial of the county CEO's *Focus on Prevention* addressed the Network to discuss local data related to fatherless children and to support the FILN efforts on behalf of fathers throughout Stanislaus County.
- Justin Margolis, Butte County Parent Café Coordinator. Justin shared details regarding his Parent Cafes for fathers and their development through the Family Strengthening Framework and Five Protective Factors. Justin also shared his personal experience as a formerly incarcerated father and journey of learning and engagement. Justin addressed the following points with the network.

June:

- Network engaged a learning dialogue around local programs and best practices in father involvement work, including Dan Griffin's. "Men In Recovery" framework (Trauma Informed practices with men).

JULY – DECEMBER 2016

July:

- In July the Project Director and Liaison created a Father Involvement Matrix. The Matrix includes the Best Practices, Promising Practices, Evidenced Based, and Researched Based & Evidenced Informed programs. Matrix was also shared with the network and integrated into a comprehensive survey to begin to determine additional program learning. No network meeting was held this month as many partners were off for the summer.

August:

- In August FILN hosted a brief presentation from Jamie Beihn, Director at Tuolumne Me-Wuk Tribal TANF Program on their Motherhood and Fatherhood Sacred programs. Keith Amador and Peter Maldonado, CHS staff, presented information on their programs for fathers (*On My Shoulders*/co-parenting for non-custodial fathers, *Nurturing Fathers*, *Living the Protective Factors*, Creating Father-Friendly environments).

September:

- Jennifer Rangel, Coordinator at CHS' Ceres Partnership FRC, shared details about her Dad's only Parent Café, as well as local fatherhood activities and initiatives. Expanding Parent Cafes in the county is a current strategy the CAPC/Strengthening Families/Parent Engagement committee is utilizing to connect and engage parents and build protective factors. The FILN also began brainstorming about a possible father conference for 2017.

October:

- In October the Core FILN Partners met to discuss Funding Priorities and Infrastructure in an effort to assess our resources and make collective decisions to support network learning and best practices. The result was (1) the administration of a survey to determine which programs or practices would be of most interest to the broader network and (2) a focus on building county-wide capacity for continued Father Involvement in Stanislaus County.
- In October Damion Wright and Marcelino "Mars" Serna from the Inland Empire Father Involvement Coalition shared strategies to strengthen our own network/coalition around Father Involvement and about some of their Best Practices on the field in San Bernardino County and Inland Empire.

November:

- Based on feedback, the FILN met and established (6) new learning cohorts:
  - Curriculum & Materials
  - Father Conference
  - Learning and Education
  - Creating Father-Friendly Environments
  - Father-centered events
  - Site Visits/Touring

Cohorts give members an opportunity for focused learning and engagement with their peers for areas of specific interest related to father involvement, aside from monthly FILN meetings or other events. The Father Conference cohort began meeting in November to discuss the possibility of hosting a conference for local fathers in the spring of 2017.

December:

- The FILN did not meet in December due to the holidays; however, the Conference cohort did meet to begin discussing potential conference ideas. The Project Liaison also connected with the national Boot Camp for New Dads agency to plan for training and implementing the program in Stanislaus County.

FILN Evaluation:

January – December:

Dr. Jaime McCreary developed an evaluation plan for the project in March (*see attached*) to measure the following:

- Growth and development of network members participating in the FILN
- Impact of the FILN on the quantity and quality of father and men's programs at partner agencies
- Reaching fathers at risk for mental illness and determining any benefit from participating in FILN network programs or activities.

Evaluation Highlights: Network and Partners

After each FILN meeting, those attending are asked to respond to the following questions:

  - *I found this meeting to be a good use of my time.*
  - *The meeting was conducive to helping me accomplish my agency goal(s)*
  - *I learned something new that I can take back to my community and/or agency.*
  - *This meeting strengthened interagency collaboration.*

An additional member/partner survey was conducted in October to measure interest in specific programs, best practices, curricula and learning cohorts.

FILN Member/Partner Survey Highlights:

- Father Involvement Learning Network meeting attendees found the meetings to be a positive use of their time to achieve agency goals learn new information and strengthen interagency collaboration.
- Network participants have gained valuable new information from the monthly FILN presentations.
- There is a lot of energy and interest in the *Boot Camp for New Dads, Parent/Dad's Cafes,* understanding the Protective Factors framework, and the curricula for *Nurturing Fathers* and *Raising Children with Pride*.
- The Interagency Collaboration has really been evident at the Network Level in that members are working collectively to achieve Father Impact (i.e.) "Our Story Father Conference". Network members are connecting and building meaningful working relationships with one another.
- There is high interest in the Conference, Site Visit and Father-Friendly Environment cohorts

- Over 50% of the network partners that participated in the study felt a "Medium Interest" in terms of participating in the Father Involvement Cohorts. A 27.3% of the partners showed "High Interest".

Evaluation Highlights: Father Participants

- In order to measure participant well-being and growth, the WEMWBS (Warwick-Edinburgh Mental Well-being Scale) and Protective Factors survey have been implemented with baseline and ongoing survey data for the following groups:
  - *On My Shoulders*: being assessed on Weeks 1, 7, and 15.
  - Manos Unidas: being assessed every three months.
  - *The Bridge:* being assessed every three months.
  - *Project Uplift:* being assessed every six months.

According to the most recent findings (see attached report) many fathers who were evaluated for Protective Factors scored in the "Low to Moderate" range of Social Connections. This means that even though fathers are participating in certain community groups – some of which are specific to dads – dads continue to feel a gap in connection in the overall scheme of their lives. (Strongest Needs: Social Relations).

We also observed a "ceiling effect" as many of the results on the Protective Factors survey were relatively positive that it did not make it possible to measure for improvement. We are also led to believe that respondents may have answered bias to try to impress the testers with their skills.

When using the WEMWBS as a way to measure the impact of our work on mental well-being we found that 44% of fathers reported positive mental well-being often or all the time. A 73% reported already participating in a father group for a year or more; hence, we cannot expect these fathers to have much more room for improvement. We can expect that the remaining percentage who answered "Some of the Time" to shift over to "Often".

On the other hand, we see room for improvement in more than half the sample (56%).

A "*Fathers Needs Assessment"* survey was also conducted throughout 2016. It was administered with various and diverse groups of fathers throughout Stanislaus County. The non-random sample consisted of 101 males completed the survey in Spring-Summer of 2016. Ethnic groups in Stanislaus County were well represented. Countywide averages shows roughly the same proportion of Hispanic respondents as found in the population (40% vs. 45%) slightly more African American/Black participants (5% vs. 3%), and far more Asian/Asian American participants (29% vs. 6%).

- Results of the fathers surveyed showed that 88% of fathers were interested in access to more Father-child activities.
- When it came to the obstacles that prevent fathers from using community services like parent education and support groups 60% of the fathers surveyed indicated these barriers were significant for them.
- Fathers with financial challenges were seen as most in need of assistance (56%) as were fathers looking for jobs.
- The topics seen as most important to men in this survey were building a positive relationship with children (74%).

Project Liaison Highlights: January – June 2016

- Project Liaison met with each member of the Father Involvement Network.
  - Positive rapport was built between Project Liaison and network members.
  - Liaison received a tour of each site represented in the network.
  - Network partners shared programs with Project Liaison.
  - Initiated monthly meetings with network partners
- Began working with Dr. McCreary on the project Evaluation plan.
- Project Liaison conducted site visits in neighboring counties (Stockton and Merced) to collect information on *Father and Male Involvement best practices*:

- Visited with Fathers and Families of San Joaquin FFSJ Executive Director, Samuel "Sammy" Nunez and staff. www.ffsj.org
- Visited with All Dads Matter Resource Center Director Lamar Henderson. http://www.co.merced.ca.us/index.aspx?NID=981

- Worked with FIN partners to identify potential training and learning opportunities.
- Obtained training to provide Strengthening Families 5 Protective Factor trainings for Stanislaus County and FILN network and community partners
- Created Father Involvement Matrix
  - Project Liaison and director developed a Father Involvement Matrix.
  - The matrix includes 10 Father Involvement Programs, Approaches and Frameworks.
  - Each program has a description, information on cost, location(s), whether it is a Promising Practice, Evidenced Based or Research Based and Evidenced Informed and its impact on Mental Health.
  - This was shared with network partners and a surveyed was administered.
- Developing implementation of Boot Camp for New Dads – In Stanislaus County
  - Building Father Involvement capacity
  - Director and Project Liaison began planning the investment and implementation of Boot Camp for New Dads for (FILN) as a way to build county-wide capacity.
    - ✓ Planning entails centralizing the Boot Camp with committed trainers and that all network partners have access to Staff and Dad training.
- There is an intentional alignment to work with Lamar Henderson, Coordinator in Merced County for Boot Camp for New Dads
  - Objective is to form a Central Valley cross-county partnership, and collaborate in a supportive relationship with Lamar.
- Presented the Father Involvement project at various partner and community groups to engage more partners in the FILN:
  - *Catalyst Presentation (AUG. 4)*
    - ✓ Presented Father Involvement project in connection with the Protective Factors at Catalyst
    - ✓ There are approximately 100 people who attend Catalyst on a monthly basis from multi-sectors in Stanislaus County.
    - ✓ Catalyst is a faith-based approach to bring influencers together for community building.
  - *Pastors Luncheon (AUG. 4)*
    - ✓ Presented both on the Protective Factors and Father Café Model with Stanislaus County Pastors
    - ✓ There was good feedback and interest in staring Father Cafés with the Protective Factors framework in their communities
  - *El Concilio Coalition Meeting (SEPT. 29)*
    - ✓ Shared how the Protective Factors framework interweaves with Father Involvement efforts.
    - ✓ Father Groups that are happening are building on each Protective Factor in their own way.
    - ✓ The Coalition is comprised of several community stake holders.
  - *Apostolic Jubilee Center (AJC) (OCT. 7)*

- ✓ Presented the men's group with the Five Protective Factors
- ✓ Shared an informal training explaining how they each are fulfilling each Protective Factor by participating in such events and gatherings

- Working with the Faith-Based Father Involvement Movement :
  - *AJC*
    - ✓ Quarterly Fight Nights have been launched.
      - ❖ Father come together to listen to father testimonies, and hold table talk conversations.
      - ❖ *They have owned the Protective Factors and Protective Factors for Fathers in their own faith-infrastructure and faith-framework.*
  - *Sunshine Community Church*
    - ✓ We are still learning and looking for a way to engage with this faith-effort. What we learned is that it is occurring in South Modesto in a regular basis as a support mechanism for fathers.
- Community Based Father Involvement: Providing ongoing support and resources for FILN partners in their emerging programs.
  - *Manos Unidas*
    - ✓ Non- formal Father Involvement
      - ❖ Alfredo Navarro and Pumas Soccer Team. Alfredo is a dad who is constantly involved and training local soccer teams in his community. Alfredo is also an engaged Father Advocate along with other parents in the development of their local Fairview Park.
      - ❖ Jose Borroel is also an active Father Advocate and mentor to local youth from his community.
      - ❖ Juan Gonzalez has taken a proactive approach to seeking Father Groups where he can join to strengthen his relationship with his 15 year old daughter.
  - *Ceres Partnership*
    - ✓ Father Group every other month. This group is a closed group for the time being, but fathers seem to be growing in their cohesiveness with one another. Armando Lovera was featured in our latest newsletter and spoke about the impact the Father Group at Ceres Partnership and the Staff there has impacted his own experience as a father.
  - *Hughson Family Resource Center*
    - ✓ Thursday's Father Group. This is a newly launched group at the Hughson Family Resource Center, but its growth is improving. This is being led by Father Facilitator Alexis Lopez.
  - *Sierra Vista North Modesto*
    - ✓ Father Dinner is being planned. The intent is to keep it light and give fathers the opportunity to father with the support of their spouses and children. This is led by Maria Gutierrez and Alicia Mendoza as part of the ***Events Cohort.***
  - *The Bridge*
    - ✓ Fathers continue to gather informally with the support of Coordinator, Jean Kea. The youth council is being engaged with planning and supporting the Father Conference in 2017.
  - *Project Uplift*

- ✓ John Ervin continues to meet with Father in West Modesto and engaging them in African-American related topics of discussions. Fathers there also participate in a number of Field Trips to higher education institutions.

  - *On My Shoulders*
    - ✓ Keith Amador regularly facilitates a father support group with fathers who owe arrears to the state. Ongoing program on behalf of the Pathways to Self Sufficiency (PASS) program.

- **Newsletter**
  - The newsletter has been ongoing as a way to engage and inform network partners on the latest happenings. The last one included activities from October through November: Presentation on Parent Café, Recap of presenters from the Inland Empire Father Involvement Coalition, Community Father Interview, and a glimpse of the upcoming (FILN) meeting.

- **Learning opportunities for 2017**
  - In 2017 we will have a revisit from the Me-Wuk Tribal TANF Program (LeeAnn Hatton and Robin Balmer). JAN – Confirmed.
  - Dara Long Griffin, Founding Partner and VP of Parent and Public Engagement with Be Strong Families. FEB – Confirmed.
  - Mario Ozuna Sanchez and Osvaldo Cruz from the National Compadres Network.
  - Lamar Henderson, All Dads Matter Resource Center, Merced County, to assist in the FILN's launch of the Bootcamp for New Dads program
  - Revisit with the Inland Empire Father Involvement Coalition
    - ✓ Chair, Lester Duncan
    - ✓ Master Trainer of Nurturing Father, Jeff Tunnell
  - Learning Conversations on Father Impact from (FILN) partners

Project Challenges:

- Since the project was delayed for 6-7 months from the start, it has taken longer to begin to implement and assess our projected learning for the network members, partners and participants. We are only beginning to see initial data and feel we need more time to assess our overall learning related to this project.
- Internal Reflection: The process of mobilizing fathers in the community may have seemed slow at one point, but it has been progressing and we are seeing positive impacts.
- Developing the infrastructure of the Father Involvement Cohorts is taking time.
- There is an ongoing dialogue of what it means to be a father and about what it does not mean.
- We are learning ways in which wives can be a support factor in encouraging their husbands to take part in father groups.

Youth Peer Navigation Project (INN-15)
Operated by Behavioral Health and Recovery Services/Juvenile Justice

Summary: The Youth Peer Navigator Project is an integrated consumer and peer centered approach to help young people navigate through the Stanislaus County mental health services system and improve their well-being. Navigators will provide mental health education, linkages, and peer support to youth incarcerated in the Juvenile Justice facility, as well as other BHRS systems of care.

Learning proposed:

1. Is the Youth Peer Navigator service a measurable intervention tool for mental health recovery?
2. Is the Youth Peer Navigator service a measurable intervention tool for reducing criminal recidivism?
3. Will there be an increase from a baseline in client-identified protective factors, as prescribed by research of the "Search Institute" 40 Developmental Assets?
4. Will the Youth Peer Navigator service be more effective by providing initial contact services in facility custody or after family release?
5. Is there a correlation between Youth Peer Navigation and the successful completing of probation terms?

Strategy:

Consistent with Innovation guidelines, given by past and present state agencies, this project explores making a change to an existing practice in the field of mental health and improving the well-being of children. The Youth Peer Navigator project seeks to incorporate an adaption from current known best practices of existing Peer Navigator programs. These programs have not been used in a Juvenile Justice setting with youth.

Adaptive Dilemma:

Improving the well-being of children, Transitional Aged Youth (TAY) and Transitional Aged Young Adults (TAYA).

Project ends in FY17-18

Bi-Annual Report: January 01, 2016 - December 31, 2016

The Youth Peer Navigation Project is an integrated youth-centered approach to help young people with mental illness or serious emotional disturbance (SED) navigate through the Stanislaus County Behavioral Health service system and improve their mental health and well-being. Youth Peer Navigators (YPN) provides mental health education, connections to community resources, mentoring, and peer support. This project provides youth peer navigation services to children, transition-age youth (TAY), and transition-age young adults (TAYA) in Stanislaus County Behavioral Health and Recovery Services, Children's System of Care. This includes youth involved with Child Welfare (Katie A/ Pathways to Well-being), Juvenile Justice, and those youth involved with multiple service providers (special education & mental health, etc.). Special attention is given to youth who are at risk of or are currently hospitalized in a psychiatric treatment facility or in custody in Stanislaus County Juvenile Hall and the Juvenile Commitment Facility.

Housed through Behavioral Health and Recovery Services Juvenile Justice Behavioral Health, this project seeks to adapt the current best practice of Peer Navigation and pattern an innovative approach to impact the lives of children, transitional-age youth (TAY), and transition-age young adults (TAYA), and ages 6-19 years of age within the Stanislaus County Children's System of Care.

Program Description:

This innovation project is the direct result of input from youth involved in Stanislaus County's Juvenile Justice System. Youth involvement first took shape in 2013 when Juvenile Justice began incorporating a youth leadership program and chartered a chapter of "Youth in Mind"; a youth led non-profit advocacy organization for children, TAY, and TAYA mental health constituents. Offering peer support and community resources, the focus is on promoting mental health recovery, self-care management, well-

being improvement, advocacy, and stigma reduction. The Innovation Project Proposal was based on the input of youth and the following information that explains why the change to the existing mental health system is being proposed.

- Youth from low-income households are at increased risk for mental health disorders.[2]
- Youth involved in the child welfare and juvenile justice systems are at even higher risk for having a mental disorder.[1]
- An estimated 60-70% of youth entering California's Juvenile Justice system today suffer from mental health issues.[1]
- Over 50% of children and youth in the child welfare system have a diagnosable mental health condition.[2]
- Youth of color experience disparities in prevalence and treatment for mental health issues.[2]
- Many youth also face co-occurring substance abuse and mental health problems.[3]
- The ability to navigate through the mental health system is vital to wellness, recovery, and resiliency for children, TAY, and TAYA, yet can be difficult and confusing for both youth and caregivers. [3]

According to research from the Ontario Centre of Excellence for Child and Youth Mental Health, peer involvement in mental health services, with peers taking on a mentorship role and working alongside case managers and youth to help them navigate the system, is used extensively in cancer care and in adult mental health care. Some findings conclude that the benefits of patient navigation include reduced hospitalization rates, better services to marginalized populations, and improved quality of life for individuals.

Having lived experience and having navigated the mental health system, Youth Peer Navigators can also help youth overcome access issues due to personal factors, including cultural and spiritual barriers, lack of transportation, language barriers, concerns about confidentiality, not knowing where to go, feeling embarrassed about asking for help, and distrust of service providers.

As Youth in Mind members have lived experience and have themselves struggled with navigating the mental health system, the group theorized that having a peer to support the journey towards recovery would lead to more timely and appropriate linkages, along with more positive mental health outcomes.

Many youth served in Children's System of Care (CSOC) have not successfully been engaged by traditional methods of treatment. As a result, they can become more seriously ill, have more aggressive behavior, and have higher rates of re-incarceration or re-institutionalization. This project is designed to increase the quality of services, including better outcomes through youth peer support in multiple areas of the Children's System of Care (CSOC). Although peer navigation is not new, most of the evidence regarding peer navigations effectiveness is in the area of medical health, substance use, and adult mental health. We are interested in learning about the effectiveness of ***youth*** peer navigation in multiple settings of the Children's System of Care, as well as learning what aspects of ***youth*** peer navigation are most beneficial to youth of multiple ages

On April 15, 2015, a full-time Clinical Services Technician was hired to help lead this project and a recruitment to hire two part-time Community Aids to fill the Youth Peer Navigator positions began. Our two Youth Peer Navigators were hired on September 21, 2015.

Project Elements:

6.1 CONTRACTOR shall hire two part-time Extra Help-Community Aides as "Youth Peer Navigators" to provide CSOC clients with help navigating the behavioral health system.

The Youth Peer Navigator Project went through a diligent selection process before hiring the two Clerical Community Aides to serve as Youth Peer Navigators. Through July 20, 2015 through August 10, 2015 five individual candidates were interviewed. From those five candidates two were offered a second

1. Berkeley Center for Criminal Justice (2010), Juvenile Justice Policy Brief Series: Mental health issues in California's juvenile justice system

2. Kataoka, Zhang, and Wells (2002), Find Youth Info, Prevalence of Mental Health Disorders Among Youth

3. Ontario Centre of Excellence for Child and Youth Mental Health (January 2012), Evidence-in-Brief: Peer Navigators in youth mental health services

interview and they were both selected for employment. The process took longer than we expected due to the fact that we were very particular in making sure that our candidates had a good balance of lived experience and competence. Miguel Nunez-Sandoval and Ricardo Maravilla-Garcia both started on September, 21 2015 as Youth Peer Navigators.

At first the YPN team consisted of the 3 male staff. In March of 2016 there was a transition within the Youth Peer Navigator team and Vanessa Ray was hired on as a YPN. This added a new perspective and dynamic to the team. With the addition of Vanessa we hoped to better serve our female population. The biographies of the current Youth Peer Navigators are included below:

Gloria Arroyo, Clinical Service Technician II comes from a family with a history of incarceration, gang affiliation, domestic violence, and drug addiction. Her parents were drug addicts most of her life, at the age of 14 she started using herself. She dropped out of high school her freshman year and lived a dangerous lifestyle. At the age of 19 she became pregnant with her first child; at that point in time in her life she knew it was time for change. Realizing herself she was repeating the same cycle of trauma, she vowed to break the cycle for herself, kids, and other at risk youth in her community. Soon after giving birth she enrolled herself in an independent study program and obtained her high school diploma. She is currently completing classes to obtain an A.A. in Human Services and Sociology, a Psychosocial Rehabilitation Certificate, and her certification in Drug and Alcohol Counseling. She currently gives back to the youth of her community by working with this population and also volunteers in many different organizations in her community to empower our youth to break the cycle.

Vanessa Ray, Youth Peer Navigator comes from a family with a background of incarceration, gang affiliation, domestic violence, drug abuse and mental health issues. After her parents' divorce at the age of eight she was left to raise herself. Becoming a product of her environment, she found herself struggling with depression, anxiety and a drug addiction. At the age of 17 she made a poor choice that would have her serving two years in the California Youth Authority. Her incarceration came as a blessing in disguise. This was her way out, her chance to turn her life around. She took the opportunity for self-improvement and used it to her advantage. She gained her GED as well as work experience through the fire camp program. She also discovered her passion for helping others. She believes that with some positive influence and guidance, youth could prosper beyond their given environment. She has volunteered at multiple non-profit organizations focusing on Native American women, veterans, and at risk youth. She is currently attending Modesto Junior College in order to receive her AA in Human Services and plans to transfer to pursue a career in Psychology**.**

Ricardo Maravilla-Garcia, Youth Peer Navigator is a graduate from Thomas Downey High School and has lived in Modesto for almost 13 years. Born in Merced, he is the oldest of three and is the son of Mexican immigrants. He is currently looking to pursue his education with the goal of becoming a History Professor specializing in Military History. At the age of 12, he was diagnosed with depression secondary, to living through domestic violence from the age of 4 to the age of 10. He witnessed his younger brother going through the Juvenile Justice system, and has also seen his two older step-brothers get incarcerated and eventually be deported back to Mexico. Due to his experiences, he has really focused on helping others and improving his community. He believes more opportunities need to be created for youth. He currently works with Juvenile Justice Behavioral Health as a Youth Peer Navigator. He also volunteers with a local non- profit that works in the areas of education, immigration, and other issues that affect his community. "I believe youth have a voice and a power. Too many times they do not receive the support that they need to succeed in their lives. It is our responsibility to walk alongside them and share our experiences with them."

Key Activities:

A) Interview and establish trust with clients:

During the period of January1, 2016 through December 31st, 2016 the Youth Peer Navigators have used different strategies such as Motivational Interviewing and active listening to engage and establish rapport and trust with the clients. It is a crucial part of our endeavor to make sure that we are able to connect with our clients on a different level than clinical providers. We understand that trust is one of the most important, if not the most important factor to any relationship. And if we were going to be working with youth, they have to trust us first. Youth Peer Navigator's personal experiences allow them to create a safe, non-judgmental environment, where clients are able to open up and speak freely which allows us to establish trust with the youth and families that we serve.

B) Provide peer support and mentoring:

One of the distinct aspects of the YPN project is that the staff has lived experience. This characteristic and the fact that the program is voluntary to the clients, allows staff to provide support in a way that differs from other mental health professionals. YPNs are able to come from a place of shared experience with the knowledge to overcome challenges faced as at-risk youth. This combination enables YPN staff to provide guidance and navigation through the mental health and juvenile justice systems, as well as other support and mentoring activities. These activities include, but are not limited to; provide emotional support, listen to youth's experience and failures, explain the role of professionals and agencies, coach youth in positive communication with parents, friends, and professionals, provide transportation to mental health and other appointments, and advocate for youth.

C) Provide mental health education and awareness:

During the reporting period the Youth Peer Navigators have taken a Mental Health First Aid course in order to provide clients with mental health education and also mental health awareness. It is important that our clients be provided education around resiliency, developmental assets, the different mental health settings, roles of professionals, and services available to them. We have learned that our clients sometimes lack understanding of mental health issues and positive coping strategies. The Youth Peer Navigators strive to provide psychoeducation to our clients around the importance of wellbeing and different strategies to achieve that.

D) Increase access to quality mental health services:

One of the main goals of YPN's is to connect youth to quality mental health services. Some of the youth referred to the YPN's are already connected with mental health services. In order to assist these clients' YPN's provide support through psycho-education surrounding the mental health process, the roles of mental health professionals, signs and symptoms of mental health diagnoses, and so on. YPN's also provide support by listening to clients' experiences and help them process their sessions. As for clients that are not yet receiving services, YPN's provide resource and referrals to a variety of mental and behavioral health agencies. Once clients have been connected, YPNs guide youth through the process by providing support, education, transportation, and advocacy. For example, throughout the engagement process YPN learned that client had a history of trauma and was presenting with signs of depression and anxiety. YPN provided psycho-education around the signs and symptoms of depression and anxiety as well as self-disclosed that YPN also suffered from the same diagnosis and found counseling to be beneficial. This encouraged client to seek counseling and YPN was able to connect client to Juvenile Justice Behavioral Health for on-going treatment and support. In other instances, some clients come to the project aware of their need for services but unfamiliar with the process. Our staff has connected clients to Juvenile Justice Behavioral Health, Women's Haven Center, as well as assisted with transportation to Aspiranet, Sierra Vista, Center for Human Services, and other needed support services.

E) Connect youth with community resources:

During the reporting period the Youth Peer Navigators have been able to connect youth too many different community resources and supports. It is understood that one of the protective factors for adolescents is social connectedness. By expanding the amount of resources and connections that youth have we are creating an environment where clients can thrive. Research also shows that these are the factors that create healthy environments for the optimal development of all children. One of the most used community resources is Juvenile Justice's Youth Leadership and Drop-in Center, "The Spot". This may be due to the fact that the YPN's work out of the center and are located on the same campus as the juvenile probation department and also Peterson Alternative Center for Education (PACE). PACE is a continuation school that offers students on-campus and also independent study learning which many of the youth that we serve attend.

F) Youth Peer Navigators have received the following trainings:

- Mental Health First Aid
- Youth Mental Health First Aid

- Peer Mentoring Training
- Law and Ethics
- WISE Peer Support 101
- A.R.T (Aggression Replacement Training)
- 40 Developmental Assets model
- EHR (electronic health record)
- CPR/ First-Aid
- Cultural Competency
- Youth Co-Occurring Mental Health and Substance Use
- Motivational Interviewing
- In house boundaries, confidentiality, HIPAA
- Outdoor Youth Connection
- Mentoring Summit
- Strength Based Case Management
- Understand and Address Self Harm

6.2 CONTRACTOR shall serve a target number of 30 clients during the two-year Innovation project.

On 10/25/15 we received our first referral and officially began working with clients. Since that time we have received 85 referrals, 39 of which continue to remain open for services, 25 which have received services and are closed, 21 of those referrals were not opened due to either no contact or denying services. Out of the 85 clients that were referred, 47 of the clients were original referred from Juvenile Justice Behavioral Health, 27 of the referrals came from Family Partnership Center, 5 of the referrals were from Sierra Vista Child and Family Services, and 3 were from Aspiranet. Youth and Family Services, School Based Services, and Child Welfare each had 1 referral respectively. Out of 39 clients that we currently have open; we are serving 12 females and 27 males. Out of these 39 clients that are open, 19 of our clients are Hispanic/Latino, 16 are Caucasian, and 4 are African American. The demographic and age breakdown below are for all the clients that took part in the Y.P.N. program.

Age	Sex	Ethnicity
1 - 20yo client - 1%	16 - female clients - 19%	38 - Caucasian clients - 44%
10 - 19yo client - 12%	69 - Male clients - 81%	32 - Hispanic Clients - 38%
22 - 18yo clients - 26%		11 - African American - 13%
14 - 17yo clients-16%		2 - Filipino - 2%
5 - 16yo clients - 6%		1 - Native American - 1%
9 - 15yo clients - 11%		1 - Laotian - 1%
7 - 14yo clients - 8%		
10 - 13yo client - 12%		
4 - 12yo client - 5%		
3 - 11yo client - 6%		
1 - 8yo client - 1%		

Part of the data we collected was the amount of contacts that were documented in the electronic health record and the contact types. The contacts types that we have documented are as follows: Public Assistance, Case Management, Recreation, Individual Outreach, Job Readiness Training, Planning, Youth Leadership Center, General Counseling, Transportation, and Parent Contact. To this date we have had 918 contacts.

Public Benefits Assistance	Case Management	Recreation	Individual Outreach	Job Readiness Training	Planning	Drop In Center	General Counseling	Transportation	Parent contact
7	86	49	559	8	12	14	20	99	64

Referrals:

For the current reporting period there were a total of 85 referrals made to the Youth Peer Navigator program. 69 of the referrals were male clients, 16 of the referrals were female clients. The client's ages ranged from 8 to 20 years old. The age breakdown is as follows:

- 8 years old = 1 client
- 11 years old = 3 clients
- 12 years old = 4 clients
- 13 years old = 9 clients
- 14 years old = 7 clients
- 15 years old = 9 clients
- 16 years old = 5 clients
- 17 years old = 14 clients
- 18 years old = 22 clients
- 19 years old = 10 clients
- 20 years old = 1 client

Our data shows that the majority of clients served were above the ages of 16 years old. We expected the population that we served to be in this age range because of the situations and circumstances that youth may be in.

Referral Sources:

The YPN program accepts referrals from multiple county programs as well as some partnering agencies. There was a majority of referrals from the Juvenile Justice program. We believe that since the YPN program has an office located on the same campus as Juvenile Justice this may have something to do with the high number of referrals from this particular program. Forty-Seven of the referrals came from the JJBH program, 27 of the referrals were from Family Partnership Center, 5 were from Sierra Vista Child and Family Services through BHRS, and 3 were from Aspiranet. Youth and Family Services, School Based Services, and Child Welfare each had 1 referral respectively.

Opened Clients:

During the reporting period the YPN project was able to open a total of 64 clients out of the 85 referrals. As of this date we have 39 clients currently open to the program and we have had to create a waiting list, as the need for YPN services is greater than our capacity.

Closed Clients:

Of the 64 clients opened during the reporting period, 25 of those clients were closed to the YPN program. Out of the 25 closed clients, the majority of them were closed with a successful transition. Only a few were closed due to no progression in this program, or because of lack of contact and engagement, or due to relocation outside of county.

Never Opened:

The YPN project had a total of 21 referrals that were never opened. The 21 referrals that were never opened consisted of 11 clients who refused services, 8 of the clients were difficult to engage and/or we were unable to make contact, 1 client went on the run, and 1 of the clients was sent to placement before we could open her.

Ethnicity:

We served clients of the following ethnic populations:

- 32 Latino/Hispanic clients
- 38 Caucasian clients
- 11 African American clients
- 2 Filipino clients
- 1 Native American client
- 1 Laotian client

Services:

During the reported time the YPN project was able to provide 918 services as indicated by the electronic health record. The breakdown of the services is as follows:

- 559 - Individual Outreach/Engagement
- 86 - Case Management
- 64 - Parent Contact
- 99 - Transportation
- 20 - Counseling General
- 49 - Recreation
- 12 - Planning
- 14 - Drop-In Center
- 8 - Job readiness Training
- 7 - Public Benefits Assistance

In conclusion the YPN served a total of 64 youth during the reporting period. The YPN was able to provide a total of 918 services for the clients. The demographics showed that there is a majority of male clients of Caucasian ethnicity.

Success Stories:

Client is a 13 year old Hispanic male referred to us by the Family Partnership Center. The referral was made due to client having a difficult time at home, the lack of having positive male role model, and having an increased interest with gangs and the gang culture. Client was opened to youth peer navigation services and has been able to form a positive bond with his YPN. The navigator and client have built such a good rapport that staff is able to talk to client about very sensitive subjects and also provide client with safe coping tools in a non-traditional manner. Client is the oldest child in his family and has several younger siblings who are females. Client was struggling with sisters because of his aggression. Client has been given different coping tools to use to replace his aggression and also client has a positive and safe place to utilize when he needs to get away from home. Client has had the opportunity to go on outings and see what other youth leadership groups in the county are working on. This has allowed client to engage with his peers in a leadership role and assist staff on future youth leadership events and activities. Client and mother report they have seen a significant decrease in his aggressive behavior. Staff at the leadership center also reports that he is well behaved and respectful. Client utilizes the Youth Leadership Center almost at a daily basis and has formed several friendships with his peers. Client has greatly benefited from the navigation services provided and is truly a success story as demonstrated by

his improved ability to manage his emotions, his engagement in positive relationships with peers, and his demonstrated youth leadership.

Client is a 16 year old Caucasian female who was referred to the Youth Peer Navigation Program after her 4th hospitalization in a 6 month period. The referral was made because the client was having a hard time connecting with her therapist and treatment team and was unable to remaining stable enough to remain out of a psychiatric hospital for any length of time. Client had several crises between her frequent hospitalizations and her family struggled to keep her engaged in counseling and in school. She was on independent studies, could not keep up with her school work, had no social interactions, and was engaging in self-injurious behavior on a very regular and consistent basis. This client was living in a very small home with several family members who were dealing with their own legal and mental health issues. For this reason, family member were not able to provide the support that this young woman needed and craved. This resulted in the treatment team referring the client to YPN's services at the recommendation of the Inter-Agency Resource Committee. After being opened to the Youth Peer Navigation Project, the client was hesitant to engage at first, as she felt that relationships with those in a helping profession had led to consequences for her and family members through CPS reports and hospitalizations. As the YPN learned more about her creative interests and her longing to be connected to peers, the YPN was able to engage her in activities such as a beading group at the Peer Recovery Art Project, Stanislaus Youth in Mind, The Youth Leadership and Drop-In Center at Juvenile Justice, and other socialization opportunities such as Josie's Place. As the client began feeling more confident in her socialization skills, she was able to return to school and received some extra support from her teachers. This allowed her to bring her grades up and make up some of the credits she had fallen behind in. She began participating in Seeking Safety treatment groups and a vocational program called Work for Success through the Maddux Youth Center where she learned about safe coping strategies and obtained needed vocational training. This client has had no hospitalizations after being open to the Youth Peer Navigation Program through Juvenile Justice and continues to utilize safe coping skills and attend various community supports on her own when she feels she needs additional supports. She is truly a success!

6.3 CONTRACTOR shall incorporate best practices to help increase protective factors using the 40 Developmental Assets framework.

The Developmental Assets® are 40 research-based, positive qualities that influence young people's development, helping them become caring, responsible, and productive adults. Based in youth development, resiliency, and prevention research, the Developmental Assets framework has proven to be effective and has become the most widely used approach to positive youth development in the United States and, increasingly, around the world. The framework has been adapted to be developmentally relevant from early childhood through adolescence.

Who needs them? Why are they important?

Over time, studies of more than 4 million young people consistently show that the more assets that young people have, the less likely they are to engage in a wide range of high-risk behaviors and the more likely they are to thrive. Research shows that youth with the most assets are least likely to engage in four different patterns of high-risk behavior, including problem alcohol use, violence, illicit drug use, and sexual activity. When they have higher levels of assets, they are more likely to do well in school, be civically engaged, and value diversity.

The positive power of assets is evident across all cultural and socioeconomic groups of youth in the United States as well as other parts of the world. Furthermore, levels of assets are better predictors of high-risk involvement and thriving than poverty, family structure, or other demographic difference. However, the average young person experiences fewer than half of the 40 assets. Although we are still capturing data elements through the YAP's survey, we are expecting to see an increase in the assets that our clients have. Some of the areas we expect to see are in the support area specifically around the external assets. The external assets are divided in four categories that are as follows: Support, Empowerment, Boundaries & Expectations, and Constructive use of time. Some of the specific external assets that we expect to see changes in are as follows:

- **#3 other adult relationships - Young person receives support from three or more nonparent adults.**

- **#7 Community Values Youth - Young person perceives that adults in the community value youth.**
- **#8 Youth as Resources - Young people are given useful roles in the community.**
- **#14 Adult Role Models - Parent(s) and other adults model positive, responsible behavior.**
- **#15 Positive Peer Influence - Young person's best friends model responsible behavior.**
- **#16 High Expectations - Both parent(s) and teachers encourage the young person to do well.**
- **#17 Creative Activities - Young person spends three or more hours per week in lesson or practice in music, theatre, or other arts.**
- **#18 Youth Programs - Young person spends three or more hours per week in sports, clubs, or organizations at school and/ or in the community.**

The internals assets focus on individual qualities that guide positive choices and develop a sense of confidence, passion, and purpose. By supporting youth with many of their external assets we expect to see a growth in the youth's confidence, motivation, and responsibility. Also by having a YPN the youth get the opportunity to explore and learn about many different resources available to them. The relationships the youth forms with the YPN and the resources available help youth grow their social competencies. Being exposed to pro-social activities and having a positive role model can help the youth shape a positive identity and see themselves in a different light. Many of the youth that we work with have never had a positive role model. Many of the youth that we engage with come from challenging situations. Many do not have supportive home environments and come from disadvantage communities. The youth themselves come to believe that they are never going to amount to anything more than their current circumstances. The YPN can advocate and help them see that with school, community engagement, responsibility, and a sense of purpose and belonging they can achieve whatever they set themselves out to achieve. Part of the YPN role is to help clients' goal plan and work alongside clients to show them that with the proper support their goals are attainable.

6.4 CONTRACTOR shall provide additional activities or strategies specified in MHSOAC-approved project plan.

YPN's met with the performance outcomes and data management team on several occasions. The meetings were held to collaborate and plan the development of tracking forms and outcomes measures. The learning that was involved during these meetings included the creating of tracking tools such as the U-drive. The U-Drive is a shared drive available to select number of individuals working on the YPN project. It allows for an ease of collaborations between the YPN's, outcomes team, and project supervisor. This drive allows the YPN's to access all of the documents necessary to implement the project. Along with the U-drive, part of the learning was obtaining a shared understanding of the timeframes being used to document and track the data acquired. Another learning opportunity that came from our meetings was the creation of referral codes, weekly navigation forms, codes used for electronic health record, documentation standards, and the YPN journaling process. Most forms took several revisions due to the fact that when we began using forms, we found elements that we were unable to capture correctly. The forms are continuously updated to make sure we are capturing the correct data. To this date we are still looking to improve the way we capture data in order to get the most information from this project.

6.5 CONTRACTOR will evaluate the effectiveness of the Innovation project including the following:

(a) Increased access and/or quality of mental health services

The majority of our clients referred have already been connected with mental health services. Our job then becomes to increase access by providing transportation to necessary mental health appointments and referring clients to additional mental health support. So far YPN's have made a total of 91 referrals. Out of those 91 referrals, 12 made appointments and 40% engaged at least once with that referral. We also work to increase the quality of mental health services by supporting clients in the engagement process and encouraging them to continue on their journey to wellness and recovery. Our total weekly encounters have added up to 1,216. Our average number of weekly encounters is 14.

6.6 CONTRACTOR shall provide assessment tools to clients to evaluate the project and determine if clients have increased their developmental assets and improved their emotional health and wellness.

The Youth Peer Navigation project utilizes the Youth and Program Strengths survey (YAPS) to measure the 40 developmental assets of each client. The 40 developmental assets are divided into to two categories; Internal and External. Each category consists of building blocks to healthy development as determined by the Search Institute. Some examples include support, commitment to learning, positive identity, and empowerment. This survey allows the youth to speak to their individual experiences and answer based on their unique interpretations giving this project an overview of our population's family, community, school, and social life. The survey also captures the clients' experiences with the program. YAPS are distributed upon first meeting with client and every four months after in order to gauge the effectiveness of the program in enhancing the youths' assets. In addition, information is being collected through Stanislaus County Behavioral Health and Recovery Services electronic health record.

6.7 CONTRACTOR will work collaboratively with BHRS to participate in an Innovation project learning collaborative and participate in annual report planning to the MHSOAC

To this date the YPN project has collaborated and met with BHRS to discuss learning on 7 separate occasions: 6/22/15, 6/29/15, 7/20/15, 9/30/15, 10/16/15, 1/08/16, and 12/19/2016. At each meeting we have been able to express that the learning the program is going through such as but not limited to, missing elements that needed to be captured, possible evolution of forms, and challenges with forms or questions. One of the first meetings the team had was to get the necessary training on how to use the Youth and Program Strengths (YAPS) survey. This survey includes the full youth viewpoints on the asset-rich nature of their school, program, peers, communities, families, and themselves. The survey captures Internal Developmental Asset categories and External Developmental Asset categories. In order to administer the YAPs effectively and to fidelity the YPN's were provided training on the assessment tool. The training addressed the expectations, how to administer the survey, and the documentation required. We learned how to input the survey into an electronic format so that it would be submitted directly. The training went over the script we should use and how to address questions from our clients. The script comes from the Search Institute fidelity methods and has to be implemented word for word. One of the challenges that we addressed was the amount of time between YAPs survey. We realized that the clients

we serve have a high level of instability in their lives. Originally we were going to administer the YAPS survey every 6 months or bi-annually, but we realized if the client were to leave before the 6 months were reached, we would not have the data necessary to show any changes. After some discussion we agreed on administering the YAPs every 4 months. This would allow enough time so that the clients would not be overwhelmed with the survey frequency, but still allow us to capture any changes. Along with the 4 month surveys we also administer closing YAPs regardless of the timeframe client receives their first survey. This allows us to capture any change before closing a client from program. We also discussed at our last meeting how important it is to make sure that the Y.P.N. team captures what they are learning, so as the program grows and/ or staff changes, the program does not continue to make the same errors. The staff discussed how important the outcomes are to this program. We discussed a few new ways to help improve the capture of outcomes, such as updated forms, and adding spread sheets that collect data. Lastly we discussed how we need to make sure we are collecting the proper data for the final report as we continue. We talked about how we need take the proper steps to make sure all of the relevant data is collected in the next six months as the project comes to an end.

Contribution to Learning:

A. Are Youth Peer Navigators effective within various mental health settings in engaging youth and their families in navigating the mental health system? Are the navigators most effective in specific settings?

Youth Peer Navigators have been shown to be effective in various mental health settings. YPN have been able to assist youth and their families around navigating the mental health and juvenile justice system. One of the key elements that the project focuses on is building rapport with the clients and the client's family. It is important that the families we serve understand the role of the YPN and what services they can provide. Once we establish rapport with the client and their family we are able to have more meaningful interactions and can begin to help the clients navigate the various mental health systems. The Youth Peer Navigators have been able to connect a 17 year old Hispanic male client, who has mono-lingual Spanish speaking parents, to needed mental health services. The YPN was able to make contact with client's parent while the client was in juvenile hall and assisted the family with setting up appointments with a mental health clinician. This was done in advance so that when client was released he would be able to get assessed for needed mental health services. Another example of how YPN help engage and navigate with clients is that of 14 year old, Caucasian male who was having conflicts with his parents. After having a conversation with his caseworker, the YPN assigned decided to speak to his parents about participating in family counseling. Once parents agreed to participate, the YPN spoke with client to ensure that he was okay with engaging in family counseling. One of the settings that the YPN have been most impactful in is the Juvenile Justice setting. To this date the YPN project has received the majority of their referrals from Juvenile Justice Behavioral Health. We believe that we have had greater success linking clients from the Juvenile Justice system because of the close partnership the YPN project has with JJBH and that the YPN project is house at JJBH right outside of Juvenile Hall. This allows YPN more access directly when the clients are in custody and upon their release. As the program has continued, there has been a slight increase in referrals from other agencies in the Child System of Care due to the outreaching of the YPN. Over the course of the program, the clients that have been referred were currently opened to other agencies, thus increasing the collaboration between the other agencies and the YPN

B. Do Youth Peer Navigators help youth connect to natural and community supports?

The YPN have been able to link clients to multiple resources and help clients identify natural supports and resources in their own communities. Through one-on-one interactions, and in partnership with our clients, the YPN are able to help clients determine what resources are available to them in their natural communities. The interaction with clients also allows YPN to learn more about their needs, the goals they have, the resources they are already utilizing, and the support that they need. Part of the process that YPN use is goal setting to help identify what type of community supports and resources the YPN can connect clients with. One of the examples is that 100% of the clients currently open have been connected to Juvenile Justices Youth Leadership and Drop-in Center "The Spot". The Spot is a resource that is highly used due to the approximation to probation and to Juvenile Hall. The YPN engage any referrals that are

currently in custody to ask them to come by the Youth Leadership Center upon their release. Apart from the Youth Leadership Center, The YPN's are in charge of researching what local resources are available and how youth can get connect to these resources. Once the clients are connected to needed services, the YPN help to ensure that transportation is not a barrier and can help provide transportation when needed. An example of this is the youth peer navigators helping an 18 year old, Caucasian male, to connect with a community housing and shelter program when he was released from juvenile hall This helped this young man to avoid becoming homeless and on the streets in bad weather. This young man was eventually linked to a transitional housing program for his more long-term housing needs.

C. Do Youth Peer Navigators contribute to increased protective factors? If so, which protective factors?

The Youth Peer Navigator Project helps to increase and strengthen protective factors in the youth that we serve. The factors that YPN help increase are Social Connectedness, Social and Emotional Competence, and Concrete Support in Times of Need. One of the ways that YPN help increase protective factors is by introducing clients to new peers in different settings outside of school. This allows clients to interact with peers and spend time in positive youth development programs. The work YPN have been doing for the project allows them to bring together youth who are all going through different struggles. This allows clients to see that by surrounding themselves with other youth who are struggling they can be of support to each other. The YPN project helps to increase social and emotional competence by helping clients identify stressors, anxieties, identify positive coping strategies and assist clients with concrete support in times of need. When YPN engage clients, they meet them where they are at. The YPN lived experience helps them identify, and connect easier with the youth. This makes mentoring a much smoother process and allows the rapport to build. The YPN also gives the client a positive role model to engage with, and once rapport is established, someone to guide them. One example of how YPN help increase protective factors is that of an 18 year old male client that was homeless. YPN assisted him in his time of concrete need, connected him with temporary shelter and then helped him connected to a transitional living program. When clients are engaged in creative activities and are held to higher expectations they are able to thrive.

D. Do Youth Peer Navigators contribute to the reduction of criminal recidivism?

Youth peer navigators have been able to contribute to the reduction of recidivism in the majority of our clients. YPN engage clients to establish themselves as mentors for the youth they serve. The YPN want to ensure that the youth they serve understand that their role is one of support. With the exception of 10 clients, 27 clients are involved with Juvenile Probation. Out of these 27 clients, we have had 5 clients who have been re-incarcerated. Of the 5 clients who have been re-incarcerated, only 1 has been re-incarcerated with a new charge. The 4 other clients were re-incarcerated because of a probation violation. 3 out of the 4 re-incarcerations were due to the client participating in the drug court program at Juvenile Justice. This program is for clients on probation who have substance use issues. This is very strict curriculum with high accountability that uses Juvenile Hall as sanctions.

E. Do Youth Peer Navigators contribute to the reduction of re-hospitalization?

We do believe that the YPN program contributes to the reduction of re-hospitalization. We have had 10 clients whom were referred to the YPN program with recent hospitalizations. Out of the 10 youth, only 3 have been re-hospitalized after working with YPN's and other mental health programs. Since most of our clients that have been hospitalized are connected to mental health teams already, the YPN's function as an outlet that helps them de-stress and re-focuses on more therapeutic actives in a less clinical environment.

F. Does age play a role in improved outcomes for youth participating in this project?

We have not seen any real indicator that age plays a role in improved outcomes for youth participating in this project. We have various clients that have had an improvement in the outcomes, yet there is no consistent trend that would indicate that a particular age group has had more improvement than another. However, as the program continued we did see that the way the Y.P.N. implemented the approach to achieve the goals differed depending on the age of the

youth. For instance a younger youth could gain many socialization skills from attending the Youth Leadership Center with a Y.P.N. On the other hand an older youth could gain interpersonal communication skills from going to D.M.V.to make/attend an appointment; although both youths are learning appropriate life skills, the approach differs. We will continue to evaluate if age plays a role in improved outcomes.

Challenges:

During the reporting period there was a lot of learning and growing for the project. Part of the process of starting up an innovations project is to work through the many challenges that the YPN have faced. After overcoming the initial challenges of hiring Community Clerical Aides, developing and implementing forms to collect data and providing the proper training, we were able to focus on the learning that comes with engaging with clients. In order to track these challenges and maximize YPN learning potential, the Youth Peer Navigation team kept weekly and daily journals. These journals allow YPNs to record their challenges, successes, areas of improvement and milestones. One of the main challenges YPN's faced was learning our exact role when it came to the type of services we provided. When we began receiving referrals, we took on clients with more concrete needs such as employment, connecting to Modesto Junior College, and receiving I.D's and birth certificates. With the intention to build our caseload, we accepted those referrals and provided those types of services. Once our caseload we at capacity and the referrals came pouring in, we had to reassess our referral process to better meet the needs of the population we originally intended the program for; youth in need of mental health services. This posed as a challenge because we had to shift our approach and our engagement took on a different form. With the high need for Youth Peer Navigators becoming apparent, we decided to expand our caseload and began managing up to 16 clients per staff. Though YPN weekly meetings, Strength Based Case Management training and peer support between staff, we learned to manage clients with different levels of need. This presented another challenge. With a higher caseload and clients with a higher level needs, we have come to the conclusion that the program would function more effectively if all three staff were full time. Part time staff hours are insufficient for required meetings, trainings, documentation time, travel time and providing quality services. Emphasis is expressed on quality because client and clinical teams have expressed frustrations in availability of staff. In many circumstances clinical teams rely on YPN's for support in transporting clients to mental health appointments. With minimal hours it is common for these appointments to fall outside of staff's scheduled time. Also, the engagement process suffers when staff is unable to spend the necessary amount of individual time per client. With this adjustment we feel the program would excel. A few other challenges we encountered included, being able to contact clients that don't have a phone or have inconsistent contact information. This has been a prominent issue with our older population. We have also had a difficult time engaging with clients who are unsure of their interests and hobbies. We've attempted to resolve this by using interest surveys and engaging clients in youth centers.

Summary:

Since the reporting period began we have served a total 67 clients. Clients have been referred from several different agencies in the Children System of Care .The learning questions that are being answered are as follows:

a) Are Youth Peer Navigators effective within the various mental health settings in engaging youth and their families in navigating the mental health system? Are the navigators most effective in specific settings?
b) Do Youth Peer Navigators help youth connect to natural and community supports?
c) Do Youth Peer Navigators contribute to increased protective factors? If so, which protective factors?
d) Do Youth Peer Navigators contribute to the reduction of criminal recidivism?
e) Do Youth Peer Navigators contribute to the reduction of re-hospitalization?
f) Does age play a role in improved outcomes for youth participating in this project?

The YPN program has been operational since 2015. During this time, the YPN has been successful providing clients with appropriate resources and services. From the time YPN has started, we have served 67 clients. From those clients, 29 had been incarcerated. Of those incarcerated, only 6 have been re-incarcerated since participating in the YPN program. Ten clients that have been referred to us were previously hospitalized, and of those, only 3 have been re-hospitalized. The YPN have learned a substantial amount and are actively looking to grow in their capacity. Based on client outcomes and testimonies from referring agencies, it is evident that the program is moving in the right direction.

FSP Co-Occurring Disorders Project (INN-16)
Operated by Behavioral Health and Recovery Services

Community Agency Implementing:
Behavioral Health and Recovery Services/Stanislaus Recovery Center

Program Description:
This is a Full Service Partnership (FSP) project. The focus is adults who have both mental illness and co-occurring substance use disorder to insure treatment/primary care is provided to address potential risks to reduce homelessness, criminal justice involvement, acute psychiatric hospitalizations, and institutionalization.

Targeted Population:
Adults with both serious mental illness and co-occurring substance use disorder

Strategy:
This project explores making a change to an existing mental health practice/approach, including adaptation for a new setting or community/treatment options for people struggling with both substance abuse and mental illness.

Primary Purpose:
Increase the quality of mental health services, including better outcomes.

Learning Proposed:

a) Will clients be successfully engaged by receiving a combination of services through this new FSP?

b) Will using stage-based treatments for both mental health and SUD concurrently lead to improved outcomes for clients participating in the FSP project?

c) What engagement strategies and interventions will emerge from this concurrent stage-based approach that is most effective for this population?

d) While utilizing the concurrent stage-based approach, what practices/processes are most effective from staffs' perspective?

e) Will access to integrated primary care positively affect outcomes?

f) Will employing an integrated "Housing First" approach positively affect outcomes?

g) Will co-locating this FSP on an SUD/Co-Occurring treatment site lead to increased peer support, SUD treatment follow through and linkages to mental health and SUD resources?

Highlights:
- A total of eight (8) individuals were served in this learning project.
- Unique to Stanislaus County as the first CSS-FSP program designed within an INN project; Population served is described in the project plan as some of the most challenging consumers in our system.
- Assertive community treatment approach necessitates a high level of contact with clients; Effect on project team is to be deeply drawn into the "drift" that is the river of delivering services and working with clients intensively to produce good outcomes.
- "Learning Meetings" were developed to devote considerable time to ongoing discussion and examination of whether the activities/services are staying true to the proposed learning objectives as set forth in the approved INN plan; Meetings had value for program staff.
- FSP staff found tremendous value in utilizing the "Learning Meeting" as an opportunity to grow as a team and a program; Meetings allowed staff the time to discuss cases in depth and to obtain a

clinical presentation of each case utilizing a "co-occurring lens" as set forth in the approved INN project.

- FSP staff reported utilizing the "Learning Meeting" as a "think tank" for brainstorming application of Mental Health Recovery Treatment Stages (MHRTS) and Substance Abuse Treatment Stages (SATS).
- Staff reported value in allowing the time to familiarize themselves with each case and proposed plans for treatment; Opportunity for any member of the team to engage with a client and follow the same treatment plan and approach.
- Staff reported utilizing the "Learning Meeting" to learn interventions and ideas about change and to continue to grow in critical thinking as providers.
- Assertive community treatment approaches are often, by nature, fast-paced with little time to communicate with team members regarding the needs of clients; "Learning Meetings" allowed staff time to develop better communication which is essential to providing services to the most challenging consumers in the BHRS system.

Challenges:

- Space issues of this program led to a slow, chaotic start up.
- Lack of having a permanent psychiatrist provider created a very slow difficult client enrollment.
- Change in leadership created some challenges as well.

Project ends in FY 2018-19

Suicide Prevention Innovation Community Project (INN-17)
Operated by Behavioral Health and Recovery Services

Program Description:
Create a collaborative of various sectors of the community to review data, inventory existing efforts, brainstorm ideas, and develop a targeted Strategic Plan to more effectively address the problem of suicides in Stanislaus County.

Learning Proposed:

a) Through collective efforts, will the group develop a shared understanding of suicide data in our county? If so, how will the shared understanding impact suicide prevention planning?

b) Can a collaborative use data and combined information from multiple sources to develop a suicide prevention strategic plan that the community will support and embrace?

c) What methods are most effective in increasing suicide prevention awareness in Stanislaus County?

d) Will the collaborative impact the rate of suicide in Stanislaus County? Will specific demographic groups be impacted?

Strategy:
Introduce a new mental health approach that has been successful in a non-mental health context or setting; It uses the concept of the Collective Impact model to achieve positive results.

The three year project has a budget of up to $630,000.

Primary Purpose:
Increase the quality of mental health services, including measureable outcomes.

Project ends in FY 2019-20

MHSA AND HOW IT'S CHANGING LIVES

From direct services to prevention and early intervention to peer support, MHSA funded programs have impacted thousands of people in Stanislaus County. Here are some personal individual stories of **hope and recovery.**

Community Services and Supports (CSS)

FSP-02 - Juvenile Justice

"Maggie" is an 18 year old Hispanic/Asian female who is diagnosed with Anxiety Disorder. She has struggled with symptoms which interfered with her ability to function at home, school, and the community. Not being able to cope with symptoms and family stressors led to her being referred to our program by her probation officer. With intensive case management and individual therapy, Maggie was able to work on psycho-social stressors and help direct her treatment.

She successfully completed probation directives and was dismissed in May 2016. Maggie is currently enrolled in "Come Back Kids", working on her goal to obtain her high school diploma. In September 2016, she began working full time, and has been able to advocate for herself in asking for continued services including medication services. By working on building upon her resilience and her capacity to recover quickly, client has been able to overcome very difficult situations, including several different incidents in which she was at risk of becoming homeless.

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"Marco" is a 17 year old Hispanic male who began participating in our program about a year ago. He had recently been released from Juvenile hall and was struggling with his transition as he had recently moved to Stanislaus County. His family is involved with gangs and believed that selling drugs to help support his large extended family in the home was appropriate for their child, as the three generations of family living in the home had never had any type of employment.

Marco himself was using substances to cope with the hardships his family was experiencing, the new stress of probation and his already existing depression and anxiety. Marco was determined to get clean and work on developing himself so that he could break the cycle of addiction and poverty in his family. Marco began attending group, participating in outings and speaking to the community about his story and his determination to change. Marco began volunteering within our program to gain work experience.

Within a year he went from volunteering to gaining employment through the Police Activity League working with youth in an after school program and has maintained steady employment since. Being just shy of 18 years old, Marco has worked to help his family pay rent and bills, purchased his own car, got off of probation, and is continuing his journey of success without using substances.

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** Note: Some personal stories have been edited for content and length. Client names have been changed for confidentiality reasons.*

O&E-02 - Garden Gate Respite

This personal story was written and provided by a client of GGR.

Around August 16th, 2015, my life was in utter disrepair. I had been through a situation in my family life that for my own safety led to me being homeless. I had prior experience with Garden Gate because I had worked there around 10 years ago, so I already knew what kind of facility it was and what they had to offer. Never did I think that someday I would be utilizing their services. So naturally I had some reservations, pride mostly. When I stayed there it ended up being for around 2 weeks. This was my first experience in any shelter setting, as a client, and by the end of my stay I couldn't wait to leave to get back to my "regular" life. My life had many twists and turns through the next year. The problems in my family had become worse than ever and the terror had taken me to a place that I almost didn't return from. Not to mention this whole time I was battling a very severe drug addiction. After multiple trips in and out of PHF and SBHC, I finally found my strength to get clean, but my trauma from home persisted.

Finally towards the end of October 2016, my battle was over. I had won the fight. At that point I know I had no choice but to completely abandoned the place I called home because it was a house of horror for me. From that day I went directly to the crisis center to try and gain some kind of direction for my future from there I was faced with the decision of going back to Garden Gate or the mission. At the advice of my Telecare worker, and an ultimatum from my mother, I hesitantly decided to return to Garden Gate. Not saying I felt right at home at first but the interactions I had with staff made me feel like I could be comfortable here as my temporary home. There was one person in particular that really make an everlasting impact on my life. Her name is Jill. She had 25 years sober and was somebody I just got a feeling about. I knew I could trust her with my thoughts and emotions regarding my traumatic experience and addiction recovery. She took the time to help me try and start working my steps to stay clean and sober through the teaching of NA. I know she can't be my sponsor now because of certain regulations and rules but believe me she has filled such a void in my life. I will wait the 2 years and she'll be my forever sponsor.

I got to Garden Gate on October 20, 2016 with not much certainty on where I would be after 7 days was over. With the help of my peer navigator, Tiffany, and Fanny, from TRAC who came to see me just about every day at my temporary home, I now know what my future is looking like. I will be doing 12 weeks of IOT at SRC and will have 2 months stay at a sober living rent free so I can start getting my life back on track. When this all started, I couldn't even imagine that life could be this way. You can go through trials and tribulations but if you just keep fighting you will get to better times. I now know the values of reaching out for help. I am grateful.

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"Beth" was referred by MPD after her discharge from DBHC due to high risk of victimization. She expressed needs of SUD treatment and stated drug of choice was meth. Beth said her mother had been primary support/care provider but that she had committed suicide recently and was contributing to her current lack of stable housing. Beth needed a safe environment and was encouraged to attend peer support groups and 12-step meetings in the community. Struggling with on-going anxiety and paranoia, Beth appeared somewhat developmentally delayed. Referrals were provided for case management with VMRC, Payee services (CEPS), to help manage finances, Golden Valley Health Center for primary care, and DRAIL for disability support. APS was engaged due to her being re-victimized. She entered another room and board and ended up at SRC. There she connected with TRS for mental health treatment and is much more stable, living in a safe room and board, and working on getting dentures.

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FSP-07 - Turning Point Integrated Service Agency (ISA)

"Mary" was a 57 year old female client, who after 16 reported years of living in Transitional Board and Cares, Board and Cares, and Room and Boards, just recently moved into her own apartment. Mary had been open to the ISA program since 2009, and in that time has required intensive case management and rehab services to help her maintain her placement level and work on her recovery goals. While Mary still struggles with active delusions, she has made progress in recognizing those delusions and not making

choices based on them. She has also struggled with substance abuse, since the use of substances is tied in with some of her delusional thinking. But with the support from staff and the education and training they have provided her with, along with her hard work and self-determination, Mary has been sober and free from substances for almost a full year. She is loving her new apartment and adjusting to independent living very well. If she continues on this path, she will be ready for discharge to a regional team within the year.

"John" is a 21 year old male who came to the ISA program in February of 2016. He was opened to the program from Doctors Behavioral Health Center due to continued aggressive behaviors and the inability to take care of his basic needs. He was placed on a LPS conservatorship and discharged to a locked setting. After a few months in the locked setting and some behavior modification used by the staff, John is now living in a Transitional Board and Care in the community and doing very well. He enjoys going to groups and actively engaging in activities with peers his own age. There have been no aggressive behaviors or concerns for months. If he continues on this path, his conservatorship will probably be dropped and he will be able to continue his path of recovery to independent living, which is his self-identified goal.

GSD-02 - Community Emergency Response Team (CERT) and Warm Line

This personal story was written and provided by a client of CERT/Warm Line and Peer Navigators

I arrived at the CERT 23 hour stay, broken and felt rather helpless. I had no family or support in the area. I had lost everything, my children, family, friends, my home, car, dignity and self-worth. I was giving up on life! When I had told CERT about not having any support they had called Turning Point Peer Navigators to come speak with me. That's when I met Shane and Jason. I was not in the right state of mind as I was feeling down and hopeless. Shane and Jason were very compassionate, funny and made me feel that I could easily talk to them. I'll never forget Shane for sharing a little part of his trials and tribulations it gave me hope! It made me more comfortable to open up because of similarities. It also gave me a bit of faith!

As Shane started out as my Peer navigator he was always there with positive support and resources! Though he cracked a few jokes here and there he always made me think! Think about my goals and what I really wanted in life. He motivated me to start making positive changes in my life. Thank you Shane!
Shane had told me that there was a new woman peer navigator that would be continuing my case as they like to put the men with men and the women with women. At first I didn't want to change navigators as I built a somewhat peer support relationship with Shane. I was just not comfortable with any kind of change in my life yet. Well, this is when I met Fanny. My first impression of Fanny was a very cheerful warmhearted woman. Fanny is always smiling, making me laugh, and made me feel good about myself!

When I needed her support Fanny was always there! ALWAYS! She always made me feel important and always picked me up for all my appointments. She let me vent about things that were going on, gave me advice, spoke up for me when I couldn't, reminded me of appointments, saved numbers and addresses. Always amazing! Thank you Fanny! With your support I have turned my life around. I am 6 months clean, no longer homeless and have a job. I received help from everyone at Turning Point. Everyone was always helpful. Gave me good advice and gave me the support I needed! Turning point BECAME MY FAMILY! I had to take a moment to write this letter (and this applies to every single one of you!) I cannot thank you enough for the genuine, loving care I received from day one. You were the warmest, hardest working, calming and wonderful staff I have ever met. How incredibly grateful I am, and will forever remember you guys. Thank you, Your Grateful Client.

This personal story was written by a member of the Peer Navigator program

"I just wanted to thank Turning Point from the bottom of my heart, in particular Jason but most important, Shane. I don't believe but I know that if Shane didn't go out of his way to come find me and help me, I would be dead." When I went to DBHC (Doctor's Behavioral Health Center) I was ready to kill myself. I was very suicidal. Shane came and found me when I was at the PHF (psychiatric health facility) and asked me if I was willing to let them try and help. I told him I could use all the help I could get. I'm good at

reading people and I could tell that not only could Shane relate cause he had been there but that he really cared. I love Turning Point, Jason and Shane. I say it all the time I owe my life to them.

FSP-06- High Risk Health and Senior Access

“Jane” is a 37 year old female diagnosed with major depression, substance use disorder and numerous medical problems. She has had numerous hospitalizations both medical and psychiatric. The High Risk Health (HRH) team is using a united approach to engage and build a trusting relationship with her.

Jane is a Diabetic type #1. When she was first introduced to HRH, her glucose level ranged from 1200-1400 and low as 20-30. Currently she has less frequencies and her blood sugar rarely drops lower than 49. Prior to receiving mental health and substance use disorder services, Jane reports she did not want to live. She felt fearful, helpless, and hopeless.

She received case management services regularly, attends groups here at HRH, checks in with our nurses and makes all of her scheduled appointments. Jane no longer feels helpless and hopeless. She has hope in her life today. She comes to our clinic with a smile anticipating someday living on her own and continuing mental health services.

GSD-05 - Consumer Empowerment Center

This individual began services with the Empowerment Center as one who was experiencing significant hardships due to his mental health diagnosis (schizophrenia) and substance-use history. He also had a history of serving prison time and had been estranged from his family. He also experienced homelessness often due to his inability to manage a job or retain income consistently. He had difficulty establishing healthy relationships and shared that he typically would break the law to be taken to jail so he would have a place to get medication and shelter.

He began services with our center in January 2014. When he came to the EC, he was recently released from Doctor’s Behavioral Health Center for attempting suicide. The EC was a location to follow up with on his discharge paperwork. He shared that he was tired of the life he was living and that he just needed a chance to show what he could offer and not have his past be a factor in his ability to participate. He also struggled with homelessness, addiction and mental illness. The presentation when he first came to the EC was that of a very broken man who was hopeless and felt that he no longer mattered to anyone in the world.

We opened up services to him and over the course of the next 2 years; he applied for Social Security Benefits and volunteered with the EC. He participated in support groups daily and took pride in mopping the main room and supporting others that had similar challenges. He transitioned from staying on the streets to staying in a garage. He applied for General Assistance while he awaited his Social Security claim and began getting his food stamps again.

He built his recovery back up and began celebrating his sobriety as milestones. After a year volunteering and through his consistency and dependability, he was offered a position with EC for Career Exploration; a temporary assignment of 20 hours a week to polish skill capacity and build up work experience for potential permanent employment in the community. He applied and received the scholarship for GED classes and began working toward that goal. After working for several months, his son reached out and offered to introduce him to his grandchildren and “test the water” to see if he would stick around to get to know them. His son shared he was afraid of letting his kids get close, because he didn’t want to see them hurt if he left again.

After several months of working and rebuilding relationships with family and learning to trust others, life threw a curve ball at him. His landlord wanted to raise the rent. His landlord made peculiar demands and eventually gave him a deadline to leave within 2 months. His son struggled with personal issues and was in between jobs. He found himself wanting to support his son, but he as he attempted to reach out and give “fatherly advice” his son lashed out at him and told him he would never earn the “father role” and distanced himself. At work, changes within staffing transitions weighed on him and began to corrode the positive momentum he found. His scholarship He found himself tempted to use and began to think about how he would get it. He relapsed with alcohol and felt he could not face those he supported at work any longer.

He brought his fears and challenges to his supervisor and shared the recent events. Guidance was given to him to follow up with an Employee Assistance Program. Additional support to adjust his schedule to accommodate his needs and follow up with his primary doctor for further recommendations were also put in place. Weekly check-ins with supervision became part of his schedule. He also reached out to the folks in his life he identified as mentors, within Learning Quest, Stanislaus Literacy Center and the EC. Through his commitment to check-ins, gaining more time in sobriety and consulting with his Primary doctor, his medications were adjusted. He has shared that his “detour” in recovery was not the way it would have typically been for him. As his past “self”, he shared that he would have “gone all out and crashed and burned” and most likely would have ended up back in Prison.

By 2015, he was offered a permanent position with Turning Point Community Program’s ISA program as a janitor. He also received his Social Security benefits and works closely with his case manager with Ticket to Work to ensure his benefits are appropriate to his work and mental health. He also qualified for HUD funded housing in a permanent home. He graduated from Learning Quest with his GED, top of his class. Today, he has gone on to speak and share his experiences at several panels and shared his story to Darrell Steinberg in Sacramento. He is set to share his story to a group of new AB109 probationers.

He is currently in enrolled at MJC and is part of a program that educates first responders and law enforcement in situations that involve Mental Health or Substance use issues. He has moved on from janitor at ISA and is now a Peer Support Specialist with Warm Line. He continues to come to the EC on a weekly basis and connect with members and support them. He shares this is where it all started because he was given a chance to show what he could do. He shares he has learned so much about himself and how to get through things differently than what he has done before.

Prevention and Early Intervention (PEI)

PREVENTION

“Isabel” has made tremendous strides since becoming a part of this program. She was encouraged by the staff Promotora to come and be a part of the Promotora group. Before coming to the group, Isabel said that she was shy and withdrawn, not knowing many people and not being able to speak English. We learned that she had been injured and was unable to properly care for her family for months due to the injury. Isabel’s self-esteem was low and she was becoming depressed.

Isabel was reluctant to join the group because she had a young child. When she was told that she could bring her child, she decided to come. She completed the Promotora training and received her certificate. Isabel says that she learned many things about her own mental health and ways to not be stressed, so her self-esteem has increased and she is more confident than ever. She was excited to share what she learned about mental health with her family and neighbors.

Isabel’s desire to improve her wellbeing and become a U.S. citizen led her to enroll in ESL classes. She then passed the GED exam and enrolled in Junior College. Her goal is to continue her ESL learning and eventually get a degree and possibly become a Social Worker. With these successes, she feels that it is her responsibility to encourage and empower other women like herself to do the same. Because of Isabel’s example, three more women from the group are improving their wellbeing and have enrolled in the ESL classes.

EARLY INTERVENTION

Brief Counseling Intervention

"Grace" was experiencing homelessness, staying in the streets by choice. She had a history of anxiety and Post Traumatic Stress Disorder, and prior to receiving behavioral health services, never received any type of counseling. When the clinician first met her, Grace was frustrated, distressed, emotional, anxious, and overwhelmed by her situation.

The clinician was able to assist Grace in drafting a "pet letter" to allow her pet to stay with her as a way for her to cope with her symptoms. During a recent session, Grace was able to express how great she felt to be heard and supported as a woman without any judgment. She also mentioned that she is happy to be surrounded by strong women who listen and support her while she participates in services.

SUICIDE PREVENTION PROGRAMS

Central Valley Suicide Prevention Hotline

A 20 year old female caller contacted CVSPH because she had recently been experiencing suicidal thoughts. She had attempted suicide before by slitting her wrists and had been hospitalized. In the very recent past, she had been hospitalized because of her suicidal thoughts. The caller informed the hotline responder that she possessed cutting blades within close proximity and that this was her preferred method to end her life.

In order to ensure that the caller not harm herself or take any impulsive action with the blades, the responder requested that the young woman throw the blades away or at the very least put them out of reach. The caller agreed to the responder's request, and then proceeded to share more details about her life and her current crisis. Eventually, the discussion moved to exploring options for the caller to cope with stress and keep herself safe, which included continuing to take psychotropic medication and rescheduling a therapy appointment. A follow up call was also scheduled for two weeks later.

Upon reconnecting with the caller two weeks later, she stated that she was doing better, following her plan and focusing on happy thoughts. The responder informed the young woman that she may re-contact the hotline anytime she needs to. The caller thanked the responder.

Workforce Education and Training (WET)

The helpful thing about the services I received from the CASRA Program is being able to have books for my main classes saves me money and that saved money can go to other books that CASRA does not provide…I appreciate what the CASRA staff has done to help me complete my goals to receive my certificate. Keep doing what CASRA is doing! It helps in so many ways.

I love the CASRA Program. The staff is amazing. Being in the CASRA Program was the best opportunity I have had.

They have helped me with the books and transportation so that I can get to school. And if I needed anything they are willing to help if they can.

The staff has been very helpful. Thank goodness they helped me this semester with a parking pass and book. It helped me be a successful student. I really appreciate it. GOOD JOB ☺

I appreciate the knowledge, support, and direction I have received from the CASRA personnel.

CASRA is totally supporting me with school and has really helped me reach out to the community. Meme has totally supported me a great deal and has been there for me every step of the way. I have nothing negative to say about CASRA at this point. I would not be where I am at in life without their support.

I want to comment on the staff: All of the staff members have been fabulous in helping me with not only my application process, my long-term educational goals, but also in being there when I needed their advice on certain course-load questions; for example in taking certain classes that would not overburden me and set me up for failure. In my interactions with Meme in particular, they have been very valuable in the selection process of my classes. Three cheers for the CASRA program!

Technological Needs/Capital Facilities (TN/CF)

“George” has become a regular at the computer lab, visiting almost every week. He had never used Google, nor had he ever used Google Instant Street View. One day, the MHSA Support Technician asked him, “Where do you want to go today?” She explained, “We can travel right here, and go sightseeing.” Since George was born and raised in Sweden, he was excited to learn that he could look around his old neighborhood, and wanted to look at the home he grew up in. When the image came on the screen, he could not believe it.

George makes sure he sets appointments every week, looking forward to his computer sessions. One of his providers recently shared with the MHSA Support Technician, “Oh my gosh – you won’t believe how well he is doing since he has been spending time in the lab!” This success story illustrates how the technical assistance provided in the Consumer Computer Labs can positively affect individuals receiving mental health services.

Innovation (INN)

“Robert” is a 13 year old Hispanic male referred to us by the Family Partnership Center. The referral was made due to client having a difficult time at home, the lack of having positive male role model, and having an increased interest with gangs and the gang culture. Robert was opened to youth peer navigation services and has been able to form a positive bond with his YPN. The navigator and client have built such a good rapport that staff is able to talk to client about very sensitive subjects and also provide client with safe coping tools in a non-traditional manner. Robert is the oldest child in his family and has several younger siblings who are females.

Robert was struggling with his sisters because of his aggression. He has been given different coping tools to use to replace his aggression and also has a positive and safe place to utilize when he needs to get away from home. Robert has had the opportunity to go on outings and see what other youth leadership groups in the county are working on. This has allowed him to engage with his peers in a leadership role and assist staff on future youth leadership events and activities. He and mother report they have seen a significant decrease in his aggressive behavior.

Staff at the leadership center also reports that he is well behaved and respectful. Robert utilizes the Youth Leadership Center almost at a daily basis and has formed several friendships with his peers. He has greatly benefited from the navigation services provided and is truly a success story as demonstrated by his improved ability to manage his emotions, his engagement in positive relationships with peers, and his demonstrated youth leadership.

“Patty” is a 16 year old Caucasian female who was referred to the Youth Peer Navigation Program after her 4th hospitalization in a 6 month period. The referral was made because the client was having a hard

time connecting with her therapist and treatment team and was unable to remaining stable enough to remain out of a psychiatric hospital for any length of time.

Patty had several crises between her frequent hospitalizations and her family struggled to keep her engaged in counseling and in school. She was on independent studies, could not keep up with her school work, had no social interactions, and was engaging in self-injury behavior on a very regular and consistent basis. She was living in a very small home with several family members who were dealing with their own legal and mental health issues. For this reason, family member were not able to provide the support that this young woman needed and craved. This resulted in the treatment team referring the client to YPN's services at the recommendation of the Inter-Agency Resource Committee.

After being opened to the Youth Peer Navigation Project, Patty was hesitant to engage at first, as she felt that relationships with those in a helping profession had led to consequences for her and family members through CPS reports and hospitalizations. As the YPN learned more about her creative interests and her longing to be connected to peers, the YPN was able to engage her in activities such as a beading group at the Peer Recovery Art Project, Stanislaus Youth in Mind, The Youth Leadership and Drop-In Center at Juvenile Justice, and other socialization opportunities such as Josie's Place.

As Patty began feeling more confident in her socialization skills, she was able to return to school and received some extra support from her teachers. This allowed her to bring her grades up and make up some of the credits she had fallen behind in. She began participating in Seeking Safety treatment groups and a vocational program called Work for Success through the Maddux Youth Center where she learned about safe coping strategies and obtained needed vocational training.

Patty has had no hospitalizations after being open to the Youth Peer Navigation Program through Juvenile Justice and continues to utilize safe coping skills and attend various community supports on her own when she feels she needs additional supports.
She is truly a success!

For more information about BHRS/MHSA funded programs, please visit our website at
http:///www.stanislausmhsa.com/

Attachment 2

COMMUNITY SERVICES AND SUPPORTS MENTAL HEALTH SERVICES ACT (MHSA)

WELLNESS RECOVERY RESILIENCE

INFORMATION SHEET

What are Community Services and Supports (CSS)?

CSS is one of five components of Proposition 63, the Mental Health Services Act (MHSA) passed by California voters in 2004. It provides funds for direct services to individuals with severe mental illness.

CSS is the largest component of the MHSA. The focus is community collaboration, cultural competence, client and family driven mental health services and systems, and wellness for recovery and resilience. CSS also provides integrated service experiences for clients and families, as well as serving the unserved and underserved. Housing is included in the CSS component.

CSS Results:

- Elimination of disparity in access
- Improvement of mental health outcomes for racial/ethnic populations and other unserved and underserved populations

Strategies: Full Service Partnership, General System Development, Outreach & Engagement

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What is a Full Service Partnership (FSP)?

FSP programs provide wraparound services to consumers. They provide integrated services to the most unserved or underserved and those at high risk for homelessness, incarceration, hospitalization, and out-of-home placement. MHSA mandates that the majority of CSS funding must be used for services to this population. This FSP strategy is a "whatever it takes" approach to engaging service recipients as partners in their own self care, treatment, and recovery. The ACT (Assertive Community Treatment) model provides comprehensive community based psychiatric treatment, rehabilitation, and support.

FSP Results:

- Decreased incarcerations
- Decreased psychiatric hospitalizations
- Decreased medical hospitalizations
- Decreased homelessness
- Increased employment

FY 15-16 FSP Programs:

- **Westside Stanislaus Homeless Outreach Program (SHOP)**
- **Juvenile Justice**

- **Integrated Forensic Team**
- **High Risk Health & Senior Access**
- **Turning Point Integrated Services Agency**

What is General System Development (GSD)?

The GSD strategy focuses on increasing capacity to provide crisis services, peer/family supports, and drop-in centers for individuals with mental illness and serious emotional disturbance. These programs are focused on reducing stigma, encouraging and increasing self-care, recovery and wellness, and accessing community resources. The goal is to increase overall well-being and decrease the need for more intensive and expensive services.

GSD Results:

- Decreased stigma
- Increased self-care
- Increased access to community resources
- Decreased need for extensive and expensive services

FY 15-16 GSD Programs:

- **Josie's Place Transitional Age Young Adult Drop-In Center**
- **Community Emergency Response Team/WarmLine**
- **Families Together at the Family Partnership Center**
- **Consumer Empowerment Center**
- **Crisis Stabilization Unit (CSU)/Operational Costs**

●●●●●

What is Outreach and Engagement (O&E)?

O&E funded program strategies focus on special activities needed to reach diverse underserved communities. Services include community outreach to diverse community based organizations. Crisis-oriented respite housing was also established to avoid unnecessary incarceration, provide short-term housing, and linkages to services.

O&E Result:
Diverse and underserved communities are reached

FY 15-16 O&E Programs:

- **Supportive Housing Services (Includes Garden Gate Respite, Intensive Transitional Housing, Vine Street Emergency Housing, and Supportive Housing Services/Transitional Board and Care)**

- **Outreach and Engagement to unserved/underserved populations**

PREVENTION AND EARLY INTERVENTION MENTAL HEALTH SERVICES ACT (MHSA)

INFORMATION SHEET

What is Prevention and Early Intervention? (PEI)
Prevention and Early Intervention is one of five components of Proposition 63, the Mental Health Services Act (MHSA) passed by California voters in 2004. California's historic commitment to prevention and early intervention through Prop 63 moves the mental health system towards a "help-first" instead of a "fail-first" strategy. PEI identifies individuals at the risk of or indicating early signs of mental illness or emotional disturbance and links them to treatment and other resources. PEI creates partnerships with schools, justice systems, primary care, and a wide range of social services and community groups and locates services in convenient places where people go for other routine activities. Twenty percent of Stanislaus County MHSA funding is dedicated to Prevention and Early Intervention (PEI) programs.

PEI Results:
- Prevent mental illness from becoming severe and disabling
- Reduced stigma & discrimination
- Increased timely access to underserved & unserved populations
- Decreased negative outcomes that may result from untreated mental illness
  - Suicides
  - Incarcerations
  - School failure or dropouts
  - Unemployment
  - Homelessness
  - Reduction of children removed from their homes
  - Reduce prolonged suffering

PEI Strategies:
PEI programs may employ one or more of the following strategies:
- Outreach and engagement
- Access and linkage to treatment
- Screening and referral
- Improve timely access to Mental Health services
- Provide services in convenient accessible and culturally appropriate settings
  - Primary Health Care
  - Schools
  - Family Resource Centers
  - Community-based Organizations
  - Places of Worship
  - Shelters, etc.

FY 15-16 PEI Restructuring Plan

Prevention Programs

- NAMI- Training and Education
- Peer Recovery Art Project - Adult & Social Connectedness
- RAIZ Promotoras Program
  - Aspira Net - Turlock

    - Center for Human Services - Ceres, Newman, Patterson
    - Oak Valley Hospital District - Oakdale
    - Riverbank Unified School District- Riverbank
    - Sierra Vista Child and Family Services - North Modesto/Salida, Hughson
    - West Modesto King Kennedy Center - West Modesto
- Stanislaus County Office of Education - Training and Education
- Youth Leadership Initiative
    - Center for Human Services - My Life Plan
    - Sierra Vista Child and Family Services - The Bridge
    - Sierra Vista Child and Family Services - Hughson Youth
    - BHRS- South Modesto Youth Leadership
    - West Modesto King Kennedy Center- Leadership for the Future
- BHRS- Friends are Good Medicine
- BHRS- Prevention Community Trainings
    - Mental Health First Aid
    - ASIST

<u>Early Intervention Programs</u> *mainly Brief Intervention Counseling services (BIC)
- Aging and Veteran Services - Older Adult Services
- Catholic Charities (BIC)
- El Concilio (BIC)
- Golden Valley Health Center (BIC)
    - Integrated Behavioral Health
    - Corner of Hope
- Parents United - Child Sexual Abuse Treatment Services
- Sierra Vista Child and Family Services - LIFE Path, Early Psychosis
- School Behavioral Health Integration
    - Center for Human Services - Resiliency and Prevention Program, RaPP
    - Sierra Vista Child and Family Services - Creating Lasting Student Success, C.La.S.S
    - BHRS-School Based Services, School Consultation
    - BHRS- Aggression Replacement Training, ART
- West Modesto King Kennedy Center (BIC)

<u>Outreach Programs for Increasing Recognition of Early Signs of Mental Illness</u>
- Each Mind Matters Campaign/Know The Signs
- Gallo Center for the Arts Stigma Reduction

<u>Stigma Discrimination Reduction Programs</u>
- Each Mind Matters Campaign/Know The Signs

<u>Suicide Prevention Programs</u>
- Each Mind Matters Campaign/Know The Signs
- KingsView - Central Valley Suicide Prevention Hotline
- Imagen, LLC

<u>Statewide Initiative</u>
- CalMHSA Contribution

WORKFORCE, EDUCATION AND TRAINING (WE&T) MENTAL HEALTH SERVICES ACT (MHSA)

WELLNESS · RECOVERY · RESILIENCE

INFORMATION SHEET

What is Workforce, Education and Training (WE&T)?

The Workforce, Education and Training component of MHSA provides funding to help improve and build the capacity of the public mental health workforce. It's designed to help counties develop and maintain a competent and diverse workforce capable of effectively meeting the mental health needs of the public. WE&T funds are a one-time allocation and do not provide direct service. The goal is to develop a diverse and well-trained mental health workforce skilled in delivering a culturally competent integrated service experience to clients and their families. Equally important are community collaboration efforts to increase protective factors.

WE&T Results:

- Increased supply of licensed and non-licensed professional county mental health staff
- Increased diversity of public mental health workforce
- Improved quality of incoming public mental health workforce
- Improved quality of existing public mental health workforce
- Expanded capacity of existing public mental health workforce to meet county's diverse needs

WE&T Strategies:

- Expansion of the capacity of postsecondary education
- Forgiveness and scholarship programs and stipends
- Junior High through college student career development and outreach
- Regional partnerships with educational systems
- Outreach to recruit diverse workforce
- Culturally competent training curriculum development
- Promotion of employment of mental health consumers and family members
- Incorporation of consumer/family viewpoint and experiences in trainings
- Inclusion of diverse and underrepresented in mental health provider network

WE&T Services/Activities Include:

- Support for course offerings, stipends, bus passes, and field placements to build mental health provider knowledge and skills
- Supervision workshops, clinical supervision, and internships
- Outreach to junior high through college students about public mental health careers
- Support consumers/family to volunteer in public mental health
- Provide educational and financial stipends
- Training of existing workforce in community collaboration skills, resiliency and recovery, treatment of co-occurring disorders, including consumer/family perspectives and cultural competency

FY 15-16 WE&T Programs:

- **Workforce Development**
- **Consumer Family Member Training and Support**
- **Expanded Internship and Supervision**
- **Outreach and Career Academy**
- **Consumer and Family Member Volunteerism**
- **Targeted Financial Incentives to Increase Workforce Diversity**

CAPITAL FACILITIES/TECHNOLOGICAL NEEDS (CF/TN) MENTAL HEALTH SERVICES ACT (MHSA)

INFORMATION SHEET

What are Capital Facilities and Technological Needs?

The Capital Facilities (CF) and Technological Needs (TN) component of MHSA provides funding for building projects and increasing technological capacity to improve mental health service delivery.

CF funds may be used by counties to acquire, develop, or renovate buildings or purchase land to be used for the delivery of MHSA services to individuals with mental illness and their families or for administrative offices.

TN projects are designed to increase client and family empowerment by providing tools for access to health information and tools that allow clients and family members to communicate with providers. TN projects should aim to modernize information systems to ensure quality of care, parity, operational efficiency, and cost effectiveness.

Capital Facilities Results:

- Expansion of the capacity/access of existing services or provision of new services
- Increase in peer-support and consumer-run facilities
- Development of community-based, less restrictive settings that will reduce the need for incarceration

FY 15-16 Capital Facilities Projects:

- **Crisis Stabilization Unit (CSU) - Architectural design**

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Technological Needs Results:

- Increase mental health care transparency and accountability
- Strengthening of secure client and family access to health information that is culturally and linguistically competent
- Increase in quality of care, parity, operational efficiency, and cost effectiveness
- Support of uniform interoperability standards

FY 15-16 Technological Needs Projects:

- **Electronic Health Record System**
- **Consumer Family Access to Computing Resources Project**
- **Electronic Data warehouse**
- **Electronic Document Imaging**

INNOVATION
MENTAL HEALTH SERVICES ACT
(MHSA)

INFORMATION SHEET

What is Innovation?

Innovation is one of five components of Proposition 63, the Mental Health Services Act (MHSA) passed by California voters in 2004. It provides funds and evaluates new approaches in mental health. An Innovation project contributes to learning about and addressing unmet needs rather than having a primary focus on providing services.

It's an opportunity to "try out" new approaches that can inform current and future practices/approaches in communities. Like all MHSA components, Innovation projects must be guided by MHSA values of community collaboration, cultural competence, a client/family driven mental health system, a wellness, recovery, and resilience focus, and integrated service experiences for clients and families.

Innovation Results:

An innovative project may affect virtually any aspect of mental health practices or assess a new or changed application of a promising approach to solving persistent, seemingly intractable mental health challenges (Section 9, Part 3.2, 5830c). In other words, Innovation projects are developed to target a mental health adaptive dilemma, or a challenge that cannot be resolved through habitual or known responses. The result we hope to achieve is the ***development of new best practices in mental health*** by

- Increasing interagency & community collaboration for mental health services or supports
- Increasing quality of mental health services
- Increasing access to underserved populations
- Increasing access to mental health services, including, but not limited to, services provided through permanent supportive housing

Innovation Strategies:

Innovation projects may employ one of the following strategies to contribute to learning.

- Introduces new mental health practices/approaches that have never been done before
- Makes a change to an existing mental health practice/approach, including adaptation for a new setting or community
- Introduces a new application to the mental health system of a promising community-driven practice/approach or a practice/approach that has been successful in non-mental health contexts or settings
- Participate in a new housing program designed to stabilize a person's living situation while also providing supportive services on site.
- Innovation projects may impact individuals, families, neighborhoods and communities

FY 15-16 Innovation Projects:

- **Father Involvement**
- **Youth Peer Navigators**
- **FSP Co-Occurring Disorders**
- **Suicide Prevention**

MENTAL HEALTH SERVICES ACT BOARD OF SUPERVISORS PRESENTATION

ANNUAL UPDATE FY 2017-18

THREE-YEAR PROGRAM AND EXPENDITURE PLAN

AUGUST 8,2017

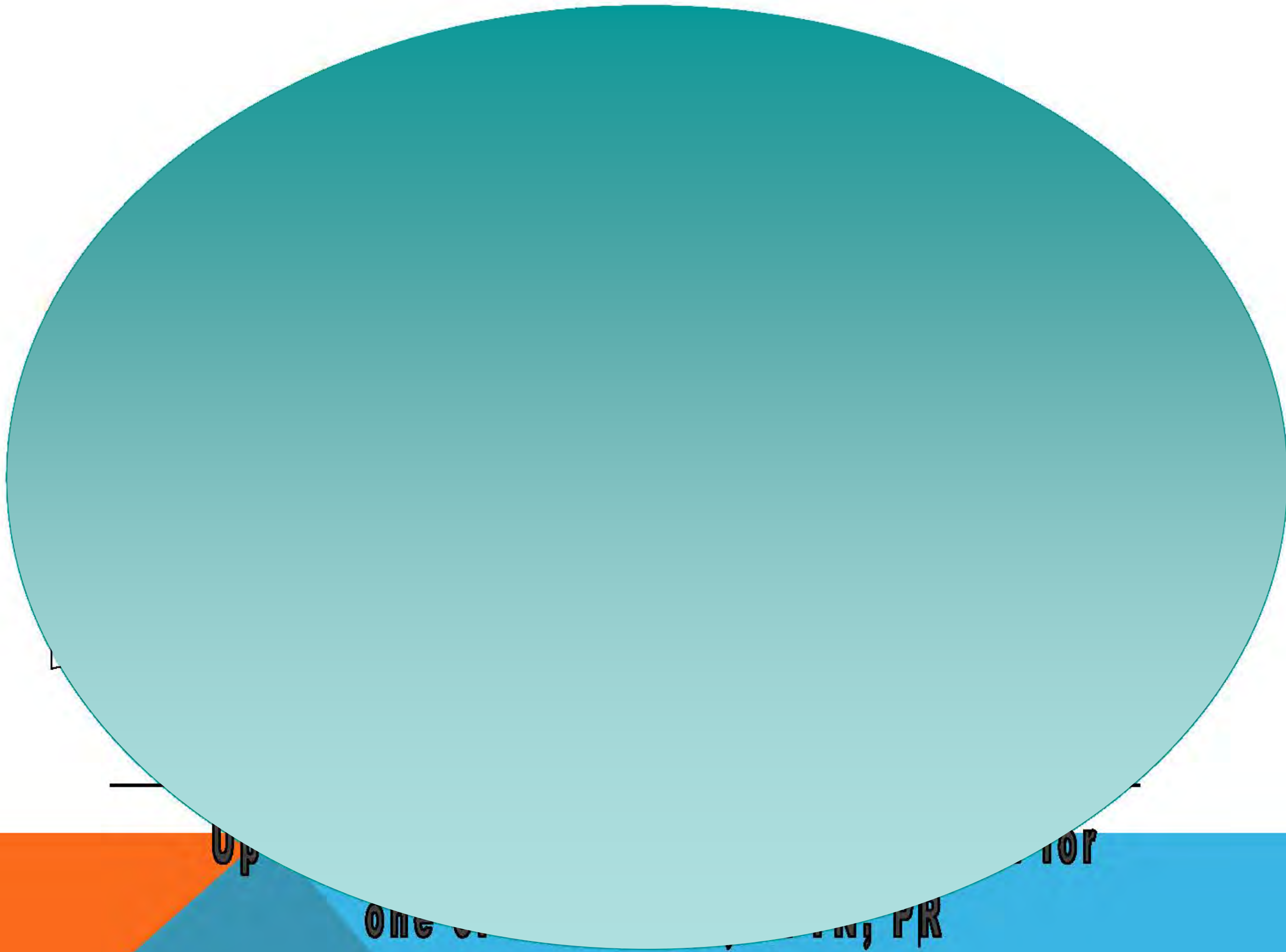
"Stay afraid, but do it anyway. What's important is the action. You don't have to wait to be confident. Just do it and eventually the confidence will follow."

- Carrie Fisher, Actress, Writer, Mental Health Advocate

MHSA COMPONENTS

- Community Services and Supports
- Prevention and Early Intervention
- Workforce Education and Training
- Capital Facilities/Technological Needs
- Innovation

MHSA FUNDING

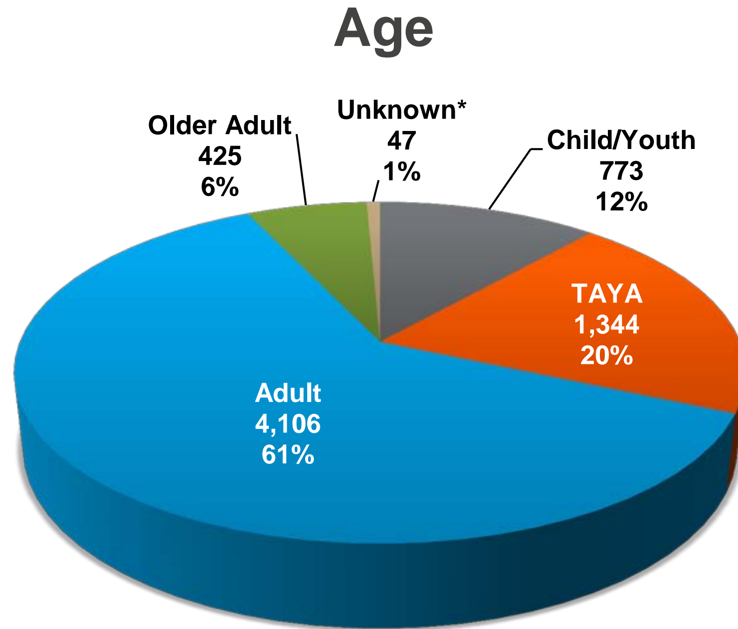


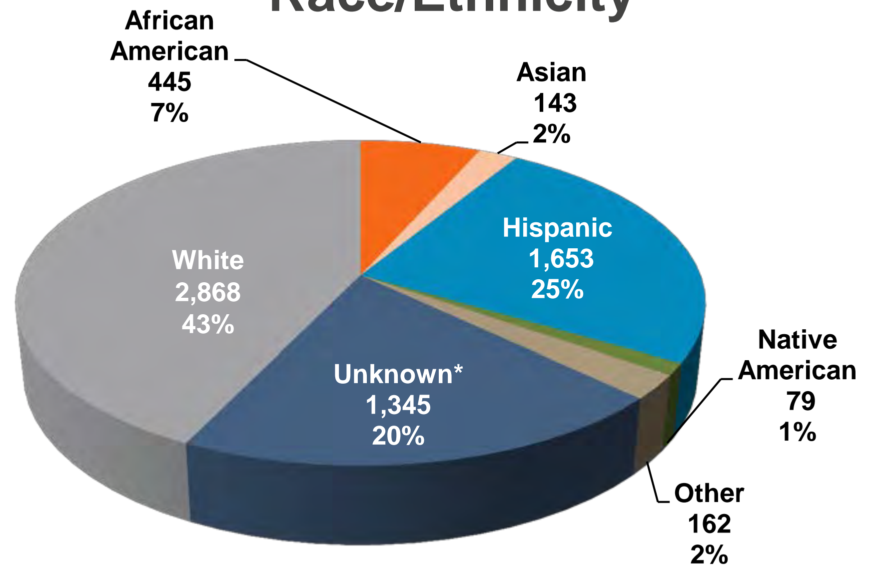
MHSA EXPENDITURE PLAN FY 2016-17 SUMMARY

FUNDING COMPONENT	BUDGETED EXPENDITURES	PERCENTAGE
Community Services and Supports	$20,064,065	68%
Prevention and Early Intervention	$5,263,610	18%
Innovation	$1,928,393	7%
Capital Facilities and Technological Needs	$1,243,702	4%
Workforce Education & Training	$763,395	3%
TOTAL	$29,263,165	100%

Community Services & Supports
FY 2015-16

TOTAL SERVED: 6,695





* Unknown values due to some types of services (non-treatment services)

Community Services & Supports
FY 2015-16 12 Programs

Full Service Partnerships (FSP)

- FSP-01 Stanislaus Homeless Outreach Program (SHOP)
- FSP-02 Juvenile Justice
- FSP-05 Integrated Forensic Team
- FSP-06 High Risk Health and Senior Access
- FSP-07 Turning Point Integrated Services Agency

FSP OUTCOMES

FSP- 01 Stanislaus Homeless Outreach Program

7/1/2015 – 6/30/2016

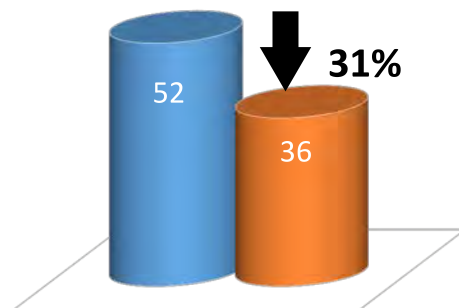
244* active partners in FY 2015-16

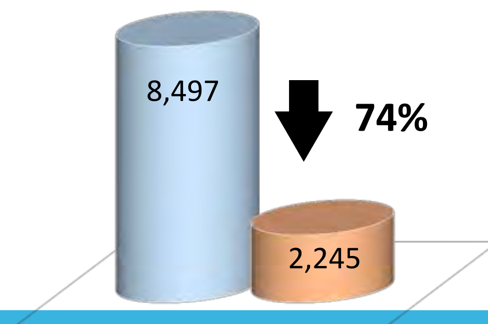
- All outcomes based on the partners who were active in FY 2015-16 *and* in the program at least one year: n=180 (74% of the active partners)
- Partners who were active in FY 2015-16 and in the program at least two years: n=109 (45% of the active partners)

***Individuals who completed a Partnership Assessment Form**

FSP- 01 OUTCOMES

Homelessness
n=180

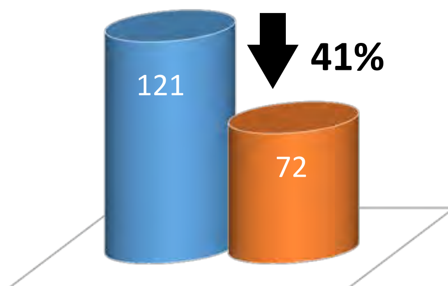




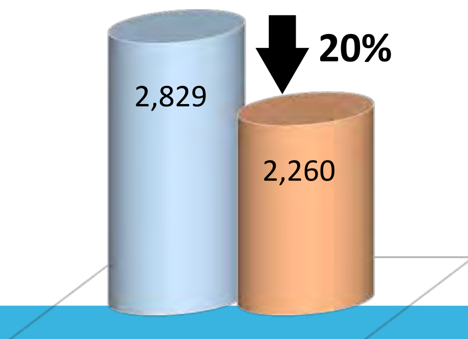
FSP- 01 OUTCOMES

Psychiatric Hospitalization
n=180

■ # partners hospitalized 1 year prior to enrollment ■ # partners hospitalized 1 year post enrollment



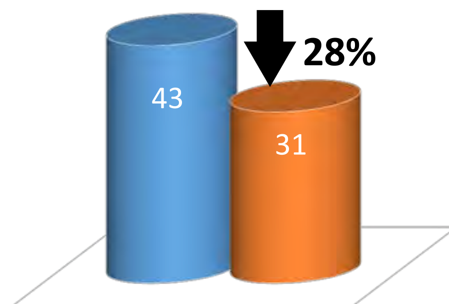
■ # days hospitalized 1 year prior to enrollment ■ # days hospitalized 1 year post enrollment



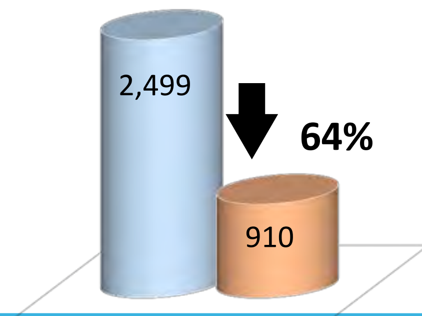
FSP- 01 OUTCOMES

Incarceration
n=180

■ # partners incarcerated 1 year prior to enrollment ■ # partners incarcerated 1 year post enrollment



■ # days incarcerated 1 year prior to enrollment ■ # days incarcerated 1 year post enrollment



FSP- 01 OUTCOMES

Incarceration	
Difference between # of days prior to enrollment and # of days post enrollment	1,589
Average daily rate	$92

- Number of incarceration days avoided was **1,589**, for a total estimated cost savings of **$146,000**

Acute Psychiatric Hospital	
Difference between # of days prior to enrollment and # of days post enrollment	569
Average daily rate	$1,021

- Number of hospital days avoided was **569**, for a total estimated cost savings of **$580,000**

Community Services & Supports FY 2015-16

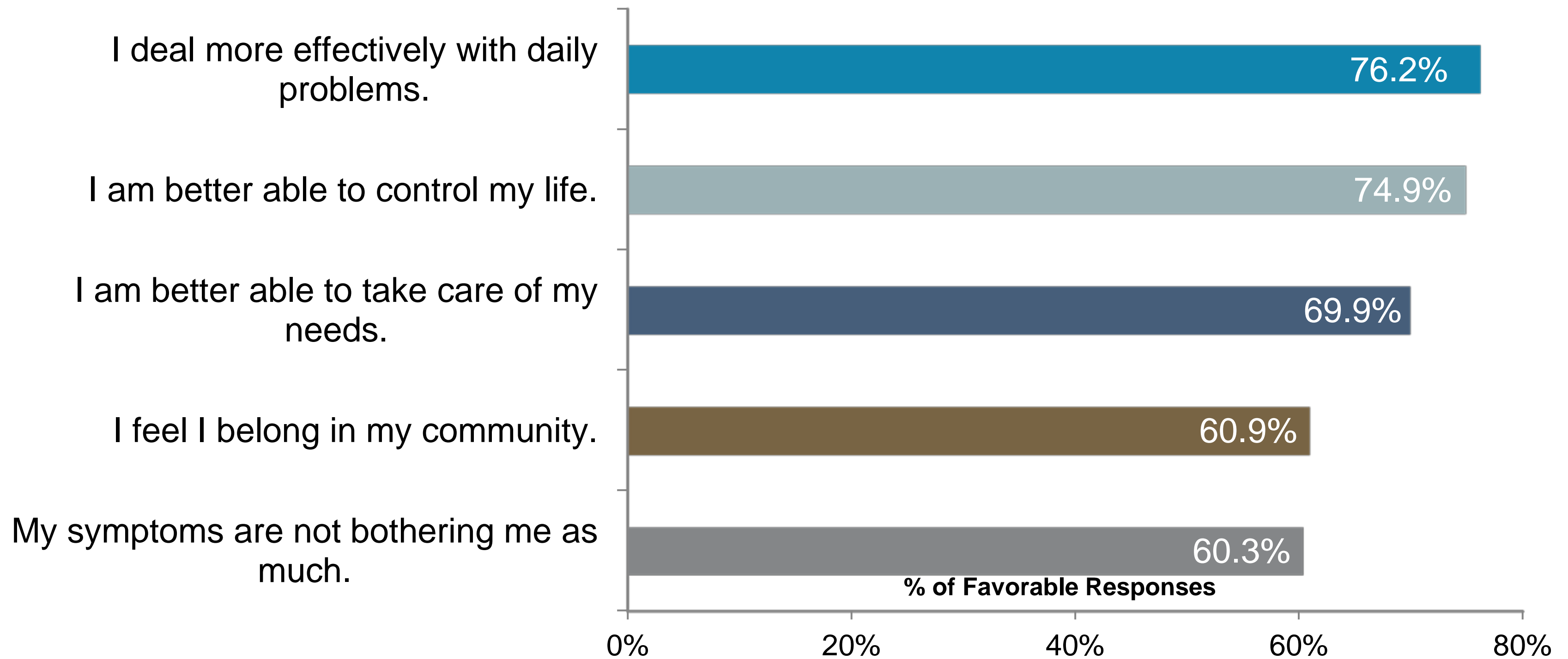
General System Development (GSD)

- GSD-01 Josie's Place 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
- GSD-06 Crisis Stabilization Unit (CSU)/Operational Costs

Community Services & Supports FY 2015-16

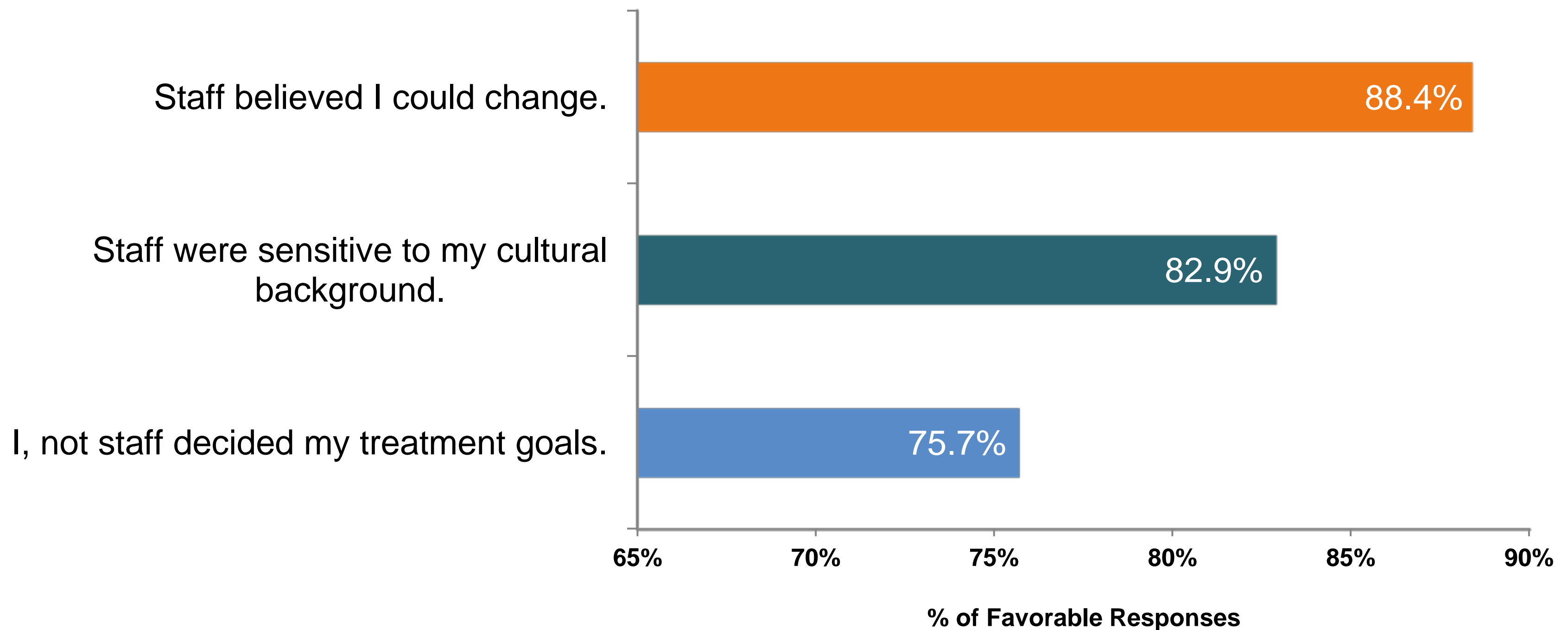
Outreach and Engagement (O&E)

- **O&E-02 Supportive Housing Services**
  - Garden Gate Respite
  - Intensive Transitional Housing
  - Vine Street Emergency Housing
  - Supportive Housing Services/Transitional Board and Care
- **O&E-03 Outreach and Engagement**
  - Services to underserved/unserved populations



* This survey was developed through a collaborative effort of consumers, the Mental Health Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

**Josie's Place, CERT and Warm Line, Empowerment Center, Juvenile Justice, Integrated Forensics Team, Telecare, Housing(O&E), Employment (O&E), and Garden Gate Crisis (O&E). * November 2015 & May 2016 Consumer Perception Survey.



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Prevention and Early Intervention FY 2015-16 6 Programs

- Prevention Programs
- Early Intervention Programs
- Outreach Programs for Increasing Recognition of Mental Illness
- Stigma Discrimination Reduction Programs
- Suicide Prevention Programs
- CalMHSA Statewide Initiative

Prevention and Early Intervention FY 2015-16

- 20,579 PEI services were provided (includes mental health screenings, support, peer and volunteer development)
- 3,037 individuals were engaged in prevention services
- 1,686 individuals received brief counseling intervention services
- 1,968 individuals trained in stigma reduction, suicide prevention, or recognizing mental illness

Workforce Education & Training FY 2015-16 6 Programs

- Outreach and Career Academy
- Consumer Family Member Training and Support
- Targeted Financial Incentives to Increase Workforce Diversity
- Expanded Internship and Supervision
- Workforce Development
- Consumer and Family Member Volunteerism

Workforce Education & Training
FY 2015-16

- 118 volunteers contributed 23,712 hours
- Total dollar value to department (at $23.07 an hour) equaled $547,044
- 7 volunteers hired by BHRS/12 BHRS sites in volunteer program
- 87 trainings held with 2,385 attendees

Technological Needs
FY 2015-16 4 Projects

- Electronic Health Record (EHR)
- Consumer Family Access to Computing Resources
- Electronic Data Warehouse
- Electronic Document Imaging

Technological Needs FY 2015-16

- 667 staff utilized the Electronic Health Record (EHR)
- 114 staff (83 BHRS and 31 contracts) trained on EHR
- 444 medication services provided via Telepsychiatry

Innovation

- Contribute to learning and serve one or more purpose
  - Increase access to mental health services
  - Increase access to mental health services for underserved groups
  - Increase quality of services
  - Promote interagency/community collaboration
- Project applications submitted to MHSOAC for approval

Innovation

On-Going Projects

- FSP Co-Occurring Disorders
- Suicide Prevention

Projects Ending in FY 2016/17

- Father Involvement
- Youth Peer Navigators

Projects Ended in FY 2015-16

- Wisdom Transformation Initiative
- Garden Gate Innovative Respite

MHSA STAKEHOLDER RECOMMENDATIONS FROM APRIL 14, 2017 MEETING

- BHRS New Staffing
- Funding Contributions for New Programs
- Continuation of New Programs
- Housing Projects

BHRS NEW STAFFING
(DEFERRED TO FINAL BUDGET)

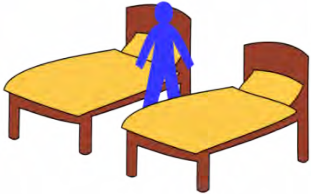
1. Manager of Ethnic Services - $143,794 per year

2. Mental Health Clinician for Integrated Forensic Team - $124,913 per year

3. Staff Services Analyst for Prevention and Early Intervention - $108,073 per year

FUNDING CONTRIBUTIONS FOR NEW PROGRAMS (APPROVED IN PROPOSED BUDGET)

1. Initial Outreach and Engagement Program - Up to $118,404 per year



2. Crisis Residential Beds/Multi-County Collaboration - $275,393 per year

CONTINUATION OF PROGRAMS (APPROVED IN PROPOSED BUDGET)

1. Crisis Intervention Program for Children and Youth
   - Funded through October 31, 2017- $210,354
   - Funding earmarked for possible continuation - $420,707

2. Youth Peer Navigators - $42,000 per year

MHSA HOUSING

Master Plan for Permanent Supportive Housing

- April 26, 2016 - BOS approved Master Plan for Permanent Supportive Housing Funds
- $1.1 million for construction, rehabilitation, and acquisition of permanent supportive housing
- Leveraging of funding – mixed use population
- Almost one year into the three years to spend funds

HOUSING PROJECTS

Supportive Housing Complex – Kestrel Ridge, 416 E. Coolidge Avenue, Modesto

- Population: Adults/Older Adults/Transition Age Youth with severe mental illness
- Results: Reduce homelessness for persons with SMI; Improve the well-being of individuals with SMI
- Estimated Funding Amount: $250,000 one-time

- **Will return to BOS for approval of project in the future**

HOUSING PROJECTS

Supportive Housing Complex – Leonard Avenue, 1406 Leonard Avenue, Modesto

- Population: Adults/Older Adults/Transition Age Youth with severe mental illness
- Results: Reduce homelessness for persons with SMI; Improve the well-being of individuals with SMI
- Estimated Funding Amount: $850,000 one-time

- **Will return to BOS for approval of project in the future**

Recommendations

1. Adopt the FY 2017-18 Mental Health Services Act (MHSA) Annual Update and Three-Year Program and Expenditure Plan
2. Authorize the Behavioral Health Director to sign and submit the FY 2017-18 MHSA Annual Update and Three-Year Program and Expenditure Plan to the Mental Health Services Oversight and Accountability Commission (MHSOAC)
3. Authorize the Auditor-Controller or her designee to sign the Annual Update certifying that the fiscal requirements on the certification form have been met.

"Never give up on someone with a mental illness.

When "I" is replaced with "We", Illness turns into **"Wellness."**

- Shannon L. Alder, Author

- Questions?