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

Madelyn Schlaepfer, Ph.D., CEAP
Behavioral Health Director

800 Scenic Drive, Modesto, CA 95350

August 17, 2012

MHSOAC
1300 17th Street, Suite 1000
Sacramento, CA 95811

Dear Colleagues:

This is a cover letter for submission of the attached MHSA Annual Update for Fiscal Year 2012-13.

Continuously working from the BHRS Vision and Mission, MHSA General Standards, and input from stakeholders, this annual update was developed to include a report of progress on all approved MHSA programs and projects.

We understand, since the passage of AB100, there is no longer a review/approval process and that per statute AB1467, we are again required to submit annual updates and plan updates to MHSOAC. An acknowledgement that you have received the document is appreciated.

The annual update was posted for a 30-day public review and comment period, from June 5, 2012 to July 4, 2012. A public hearing was conducted by the local mental health board on July 5, 2012. In compliance with AB1467 amendment to statute, the Stanislaus County Board of Supervisors adopted the annual update and authorized the Auditor-Controller and Behavioral Health Director to sign the County Certification on August 7, 2012.

If you have any questions, please do not hesitate to contact me at (209) 525-6225 or Chong Yang, MHSA Planning Coordinator, at (209) 525-5324.

Sincerely,

Madelyn Schlaepfer, Ph.D., CEAP
Behavioral Health Director

cc: Chong Yang

Enclosures

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

DEPT: Behavioral Health and Recovery Services BOARD AGENDA # B-8

Urgent ☐ Routine ☑ AGENDA DATE August 7, 2012

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

SUBJECT:

Adopt the Fiscal Year 2012-2013 Mental Health Services Act Annual Plan Update and Approval to Authorize the Behavioral Health Director to Submit the Plan Update to the Mental Health Services Oversight and Accountability Commission

STAFF RECOMMENDATIONS:

1. Adopt the Fiscal Year 2012-2013 Mental Health Services Act (MHSA) Annual Plan Update.
2. Authorize the Behavioral Health Director to submit the Fiscal Year 2012-2013 MHSA Annual Plan Update to the Mental Health Services Oversight and Accountability Commission (MHSOAC).
3. Authorize the Auditor-Controller to certify that the County has complied with all fiscal requirements and that all expenditures are consistent with the MHSA.

FISCAL IMPACT:

MHSA funding is derived from a 1% tax on incomes over $1 million. Prior to Fiscal Year 2010-2011, MHSA funds were allocated to counties based on collections 2 years in arrears. Beginning July 1, 2011, counties no longer were given a set allocation. Instead, funds were distributed based on current income tax collections. The estimated amount to be received in Fiscal Year 2012-2013 is $14,452,280. This amount is included in the Department's Fiscal Year 2012-2013 Adopted Proposed Budget. There is no impact to the General Fund.

BOARD ACTION AS FOLLOWS:

No. 2012-415

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

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

I hereby certify that the foregoing is a full, true and correct copy of the Original entered in the Minutes of the Board of Supervisors.
CHRISTINE FERRARO TALLMAN
Clerk of the Board of Supervisors of the County of Stanislaus, State of California
By Elizabeth A. King

AUG 09 2012

BOARD OF SUPERVISORS ★ STANISLAUS COUNTY CAL. ★

ATTEST: CHRISTINE FERRARO TALLMAN, Clerk File No.

Stanislaus County
Behavioral Health and Recovery Services

Mental Health Services Act

Three-Year Program and Expenditure Plan

Annual Update FY2012-13

August 2012

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COUNTY CERTIFICATION

County: Stanislaus

County Mental Health Director	Project Lead
Name: Madelyn Schlaepfer, Ph.D., CEAP	Name: Karen Hurley, MFT
Telephone Number: 209-525-6225	Telephone Number: 209-525-6229
E-mail: mschlaepfer@stanbhrs.org	E-mail: khurley@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/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 2012/13 annual update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate.

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 FY 2012/13 annual update/update are true and correct.

Madelyn Schlaepfer, Ph.D., CEAP
Mental Health Director/Designee (PRINT)

Madelyn Schlaepfer Ph.D. 8-14-12
Signature Date

I certify that 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.

Kashmir Gill
Auditor-Controller/Designee (PRINT)
Asst. Auditor-Controller.

Signature 8/10/12
Date

Introduction

Stanislaus County Behavioral Health and Recovery Services (BHRS) is implementing approved plans for all components of MHSA and seeks to inform local stakeholders of the status of each plan by developing this report. This annual update includes brief descriptions of services and activities conducted between the dates of July 1, 2010 – June 30, 2011 (FY2010-11) and proposed services to continue in FY12-13 for all components of MHSA including Community Services and Supports (CSS), Prevention and Early Intervention (PEI), Workforce Education and Training (WE&T), Capital Facilities/Technological Needs (CF/TN), Innovation (INN), and Long Term Supported Housing (CSS Housing).

Target Audience:

All interested stakeholders in Stanislaus County were invited and encouraged to review the draft, attend stakeholder meetings, and offer comment on the update.

Changes in Annual Update this Year:

Why?

An annual report is required by MHSA statute (W&I Code 5847). For the first time since the passage of Proposition 63 (MHSA) in 2004, there were no guidelines for annual updates issued by California Department of Mental Health (DMH). This change occurred In March 2011 when Assembly Bill 100 was enacted. As a result, all counties were in transition from the past practice of following guidelines issued by DMH to local responsibility for the format of the report. Stanislaus County BHRS developed a new update/report that is more functional and valuable to our stakeholders, partners and us.

What?

The intent is to provide a progress report of each of the primary components of the MHSA: Community Services and Supports, Prevention and Early Intervention, Workforce Education and Training, Capital Facilities/Technology, and Innovation. The content of the report is very similar to past annual updates. It covers one complete year of services, the most recent full year of data available, delivered July 1, 2010 – June 30, 2011, and gives a forecast of services to be delivered July 1, 2011 – June 30, 2012. As in the past, numbers of individuals served are shown by language, ethnicity and age in the proportion they were served. Full Service Partnership outcomes are also reported using graphs to show program results. Highlights are included that may reflect success, challenges, and forecast for services in the coming fiscal year. A funding summary for FY2012-13 is also included showing budgeted amounts for each component.

How?

The format of the report this year is very different as we strived to make it easier to read and understand. To achieve this goal, we reduced the amount of repetition in narrative descriptions of programs. One brief description of each program is given in the program report section followed by featured information. Pie charts and bar graphs are included and have color added to illustrate the demographics of those served. We hope these changes improve accessibility of this annual report of MHSA programs.

Adopting a New Framework for Results:

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

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

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

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

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

Over the next several years, BHRS will be aligning our data collection methods with this approach and we expect to be showing trends or changes with performance measures. For agencies and programs, the performance measures involve showing how participants are better off for having received the service. As we refine our data collection methods to align with this approach, we expect to be able to track changes and discuss why the changes are the way they are.

Example of Program Results shown in RBA Framework

In adopting this framework, a better way to show effort and progress is needed as well. This year a simple table showing a "snapshot in time" of results produced in FY10-11 will be used. An example is shown below:

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

We want to be clear that this is not a comprehensive report of outcomes based on a fully implemented results accountability model.

It is however, an exciting first effort by BHRS to present program data in a way that lays a foundation for BHRS' commitment to reporting results that shows changes, tells the story behind the change, and bases decision making on continuous tracking, reflection, and analysis of the data.

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

In FY 11-12 and future years, the annual update and integrated plan will continue to report on progress related to this aspect of transformation at BHRS.

Next Steps:

Now that all components of MHSA are started throughout California, attention is on several key areas; 1) continuing to refine and report results produced by MHSA-funded programs both locally and statewide, 2) development of an Integrated Plan for MHSA that describes how it supports transformation of the public mental health system, and 3) attention to local planning for future funds with fiscal sustainability of programs and services during the economic downturn.

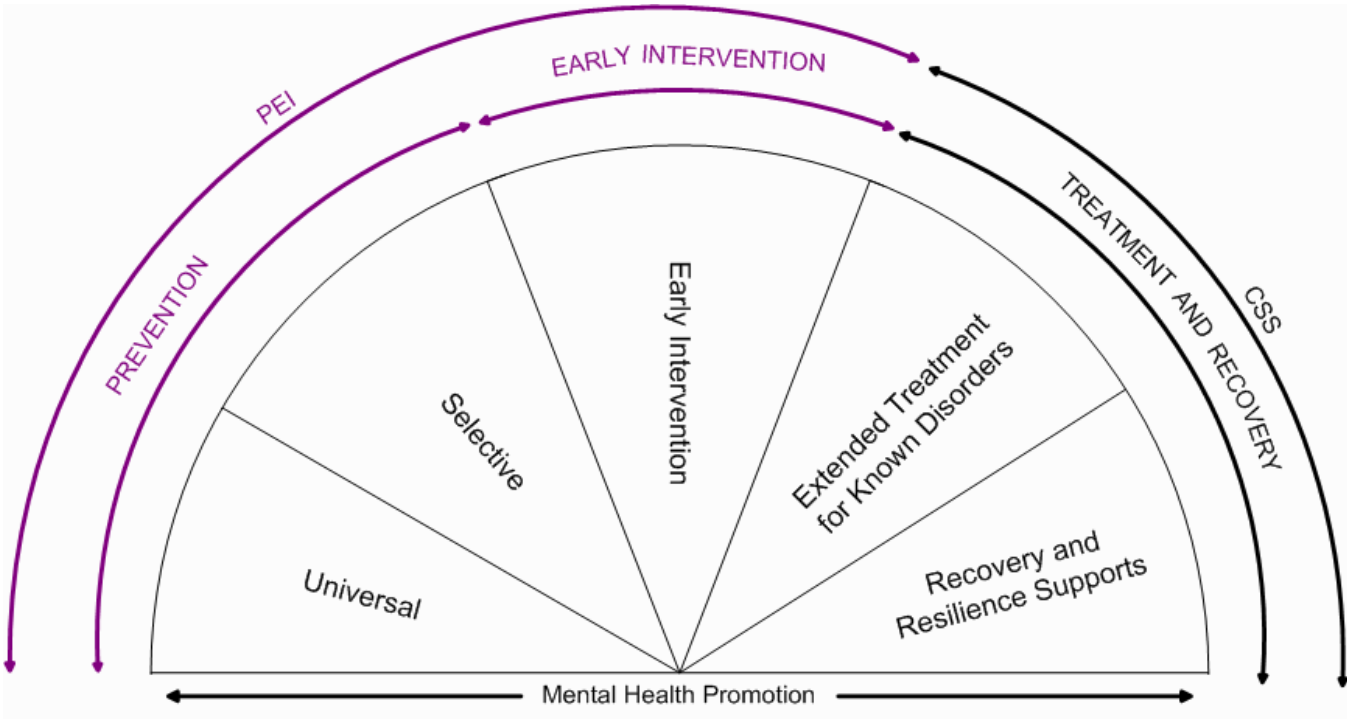
Results Accountability:

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

Legislative Changes and Integrated MHSA Plan:

By statute (W&I 5847), an Integrated MHSA plan is to be developed by counties based on existing approved plans. Though the statute does not specify, current interpretation throughout the state is that an integrated plan should include all components and show how all components of MHSA support overall system transformation. This year, a trailer bill (a.k.a. budget implementation bill) to the state budget and other legislation (S.B.1136) are expected to clarify and streamline administrative requirements and a statewide integrated plan approach in the MHSA. In doing so, some DMH guidelines that conflict with AB100 statute (a trailer bill to state budget in FY11-12 that amended MHSA) may be eliminated. Fine tuning of MHSA language may also eliminate unnecessary bureaucracy; establish local oversight and authority of counties to implement MHSA programs based on statute and local approval, and an integrated approach to state and local evaluation, accountability, and data collection/reporting methods. More will be known after the state budget and other legislative actions are settled later this year.

In an effort to begin to include local stakeholders, a local approach to thinking about how an integrated plan could look is proposed in The Mental Health Intervention Spectrum Diagram. The diagram was adapted from Mrazek and Haggerty (1994) and Commonwealth of Australia (2000) for use by California counties to show the continuum of mental health intervention in PEI plans. This diagram was referenced in PEI guidelines, a framework for design of PEI plans throughout the state. The diagram shows the spectrum of services (regardless of funding source) and all MHSA components that reach across the service system in various ways.



Workforce Education &Training - Capital Facilities/Technological Needs - Innovation - Long-term Supportive Housing

Future Funding: Fiscal Year 2012-2013 Funding Summary:
Starting in FY12–13, the distribution of Mental Health Services Act funds will take place on a monthly basis (W&I Code Section 5892(j)(5)). Counties will be 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 combination of Workforce, Education and Training, Capital Facilities/Technological Needs or Prudent Reserve.

Though BHRS will be receiving monthly payments, Mental Health Services Act is a volatile funding source due to the way in which taxes are paid. In the past, there has been an approximate 2 year lag time from collection to distribution to counties. In the future, payments to counties will be made on a cash available basis which could lead to cash flow issues that are not yet known. Taking all of this into account, BHRS will plan for fiscal year 2012 – 2013 by following the recommendation put forth by California Mental Health Director's Association, which is to prepare the FY12-13 budget to include an increase. BHRS is planning for up to a 15% increase in the annual allocation. This will allow BHRS to keep programs and projects at the level they are currently funded. If a larger budget increase materializes throughout the fiscal year, BHRS with stakeholder input can begin to strategically restore reductions from previous years or possibly consider expansions.

Immediately following this section, an estimated budget for FY2012-13 is included. It reflects the best estimates available for MHSA funds in the coming year.

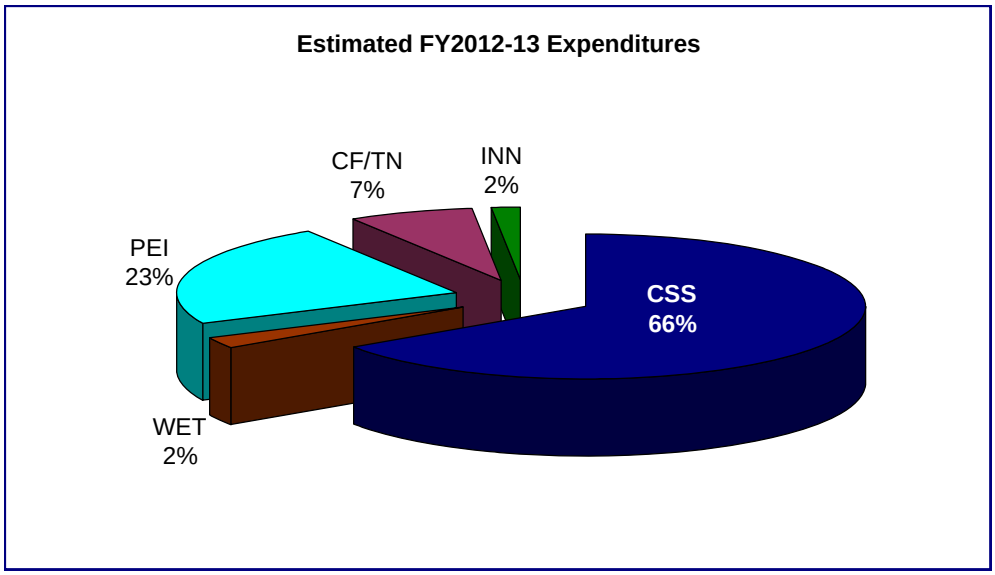
FY 2012/13
MHSA FUNDING SUMMARY

County: Stanislaus **Date:** 4/24/2012

	MHSA Funding					
	CSS	**WET**	**CFTN**	**PEI**	**INN**	**Local Prudent Reserve**
A. Estimated FY 2012/13 Component Allocations						
1. Estimated Unspent Funds from Prior Fiscal Years	$2,855,638	$884,240	$2,614,578	$4,787,412	$2,996,973	
2. Estimated New FY 2012/13 Funding	$10,983,733			$2,745,933	$722,614	
3. Transfer in FY 2012/13[a/]						
4. Access Local Prudent Reserve in FY 2012/13						
5. Estimated Available Funding for FY 2012/13	$13,839,371	$884,240	$2,614,578	$7,533,345	$3,719,587	
B. Estimated FY 2012/13 Expenditures	$10,983,733	$327,185	$1,513,509	$4,274,692	$1,323,495	
C. Estimated FY 2012/13 Contingency Funding	**$2,855,638**	**$557,055**	**$1,101,069**	**$3,258,653**	**$2,396,092**	

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

D. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2012	$500,000
2. Contributions to the Local Prudent Reserve in FY 12/13	$0
3. Distributions from Local Prudent Reserve in FY 12/13	$0
4. Estimated Local Prudent Reserve Balance on June 30, 2013	$500,000



Community Planning & Review

BHRS and its partner agencies in MHSA implementation are continuously seeking diverse cultural input and lived experience perspectives through processes that include, but are not limited to, workgroups, steering committees, feedback on training opportunities, volunteerism, Workforce Development Council and the Prevention Early Intervention Implementation Collaborative and other stakeholder meetings.

Who Participated:

Initially, BHRS staff prepared and compiled program reports to develop a draft of the update to be presented for public review/comment. The MHSA Representative Stakeholder Steering Committee (RSSC) was convened on May 30, 2012, and the annual update presented along with information about future funding contingencies and anticipated planning processes.

Per Title 9 of the California Code of Regulations, sections 3300 and 3315, the Representative Stakeholder Steering Committee is comprised of all required sectors and partner organizations including, but not limited to, consumers of services and family members, social services, education, underserved communities, providers of health care, contract providers of public mental health services, representatives from diverse communities, law enforcement, courts, probation, education, health care, faith-based community, labor organizations, Stanislaus County Chief Executive Office, BHRS staff, Area Agency on Aging, and regional geographical areas of Stanislaus County including the South and Westside of the county.

Representative Stakeholders' role includes giving important input on all plans and updates as well as sharing information about MHSA plans with other members of their represented community or group. RSSC meetings include key stakeholders and are open to all stakeholders.

Handouts given at the stakeholder meeting are posted on the BHRS MHSA website for general stakeholder access.

Local Review Process:

This annual update was posted for 30-day public review and comment from June 5, 2012 – July 4, 2012. Notification of the start of public review and access to copies of the update were available through these methods:

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

- ✓ BHRS Cultural Competency Newsletter

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

June 15, 2012, 10:30am-11:30am – PEI Community Room, 1904 Richland Avenue, Ceres, CA

June 19, 2012, 4:00pm-5:00pm – Redwood Room, 800 Scenic Drive, Modesto, CA

Comments were solicited through a Comment Form attached to the document; informational meetings; required public hearing; via the Stanislaus County MHSA website and via e-mail, fax or U.S. mail to Karen Hurley, MFT, MHSA Planning Manager.

The public comment period concluded with a public hearing held at the Mental Board Meeting on Thursday, July 5, 2012, 5:00 p.m., at Behavioral Health & Recovery Services, 800 Scenic Drive, Redwood Room, Modesto, California, 95350.

All community stakeholders were invited to participate. All public comments were considered and substantial comments included, if any.

Substantive Comments and Response:

No comments were received.

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

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

Stanislaus County had ten CSS programs operating during FY10 -11, including four Full Service Partnership (FSP) programs, four General System Development (GSD) programs, and two Outreach and Engagement (O&E) programs. Each type of program has a unique approach that incorporates MHSA values of cultural competency, community collaboration, wellness, recovery/resiliency, client/family driven services, and an integrated service experience for clients and their families.

What follows are more descriptions of the CSS component and programs funded to provide services by each type of CSS funding. This section includes component budget information, program descriptions, demographics of those served, and highlights from services delivered in FY10-11.

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

Individual and program results include reduction in incarceration, homelessness, and psychiatric hospitalizations, frequent emergency room visits and avoidable medical hospitalization.

Full Service Partnership Programs in Stanislaus County in FY10-11:

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

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

General System Development Programs in Stanislaus County in FY10-11:

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

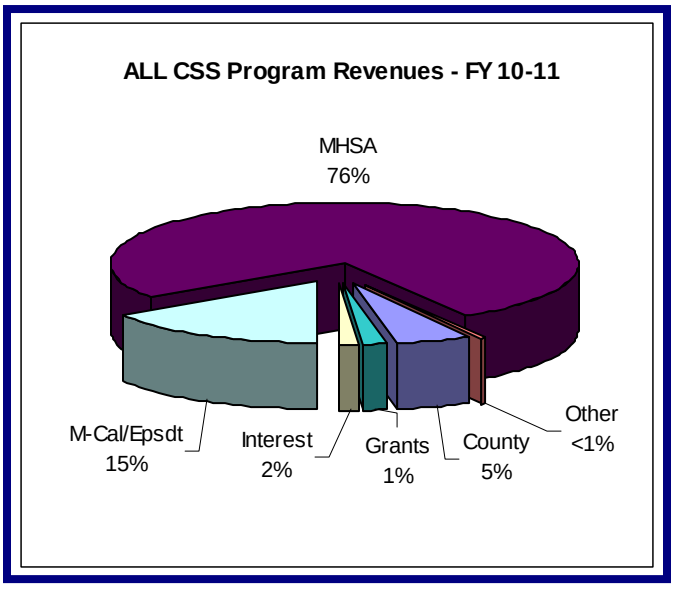
Outreach & Engagement funded programs were established in recognition of the special activities needed to reach diverse underserved communities that have high needs and are disproportionately unserved by traditional types of mental health services. Strategies include community outreach by diverse community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

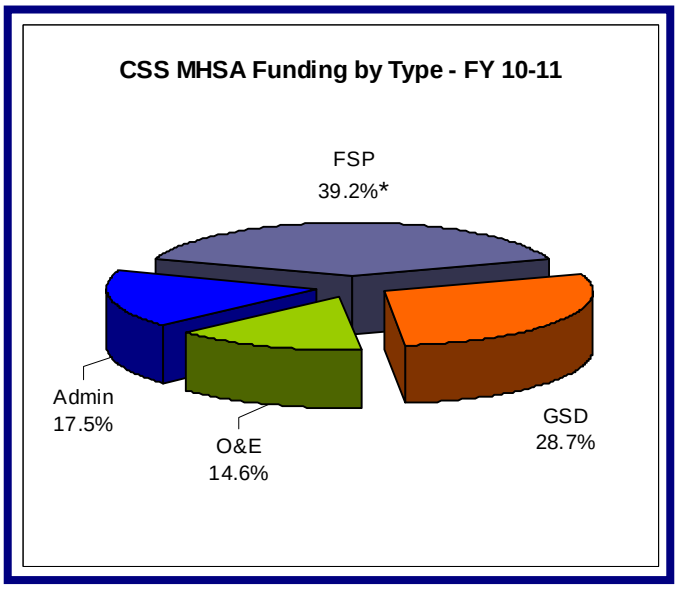
Outreach & Engagement Programs in Stanislaus County in FY10-11:

- O&E-01 – Outreach and Engagement to Diverse Communities
- O&E-02 - Garden Gate Respite

CSS Budget & Expenditures	
FY 10/11 Total Requested MHSA Funds	**FY 10/11 MHSA Funds Expended**
$11,219,584	**$9,290,395***

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





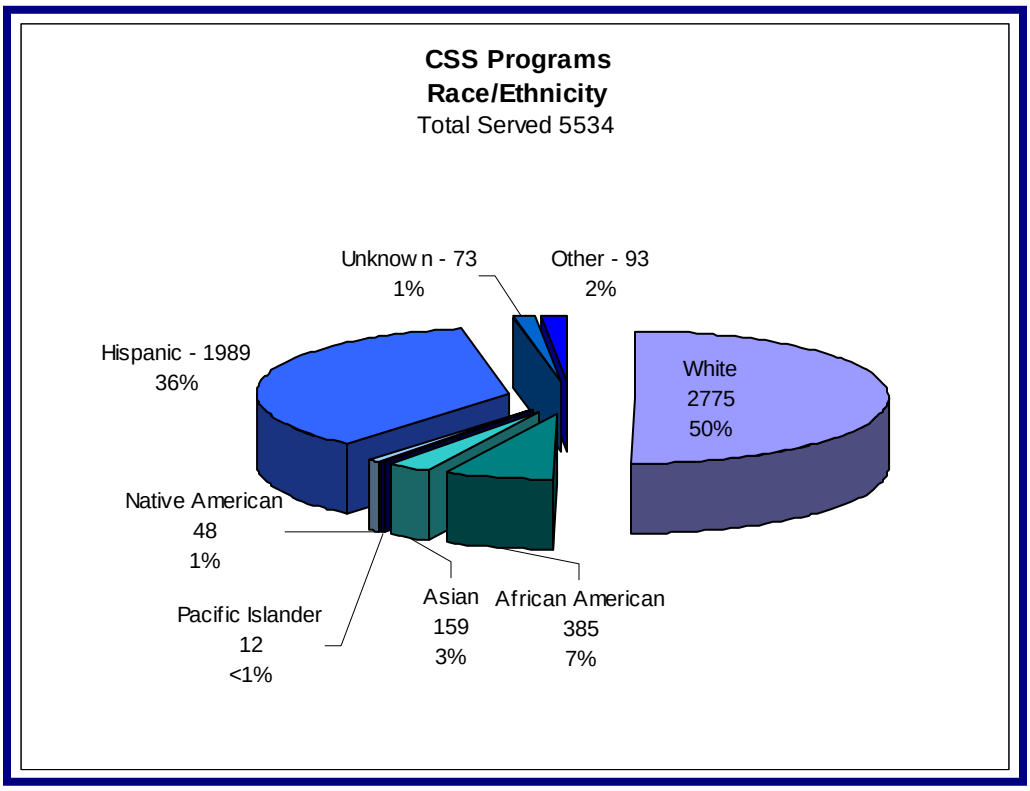
*State mandates that 51% of CSS funds must be allocated to FSP. As allowed by DMH, FSP program Medi-Cal revenues were used to meet the 51% FSP requirement.

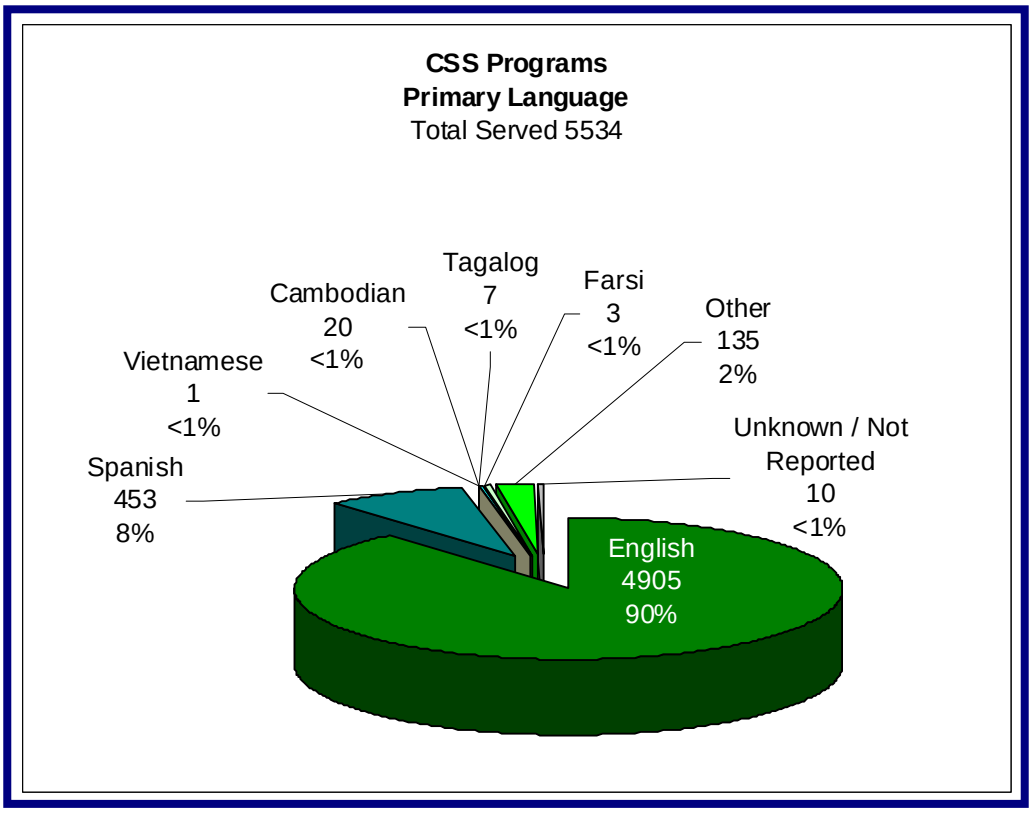
CSS Demographics

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

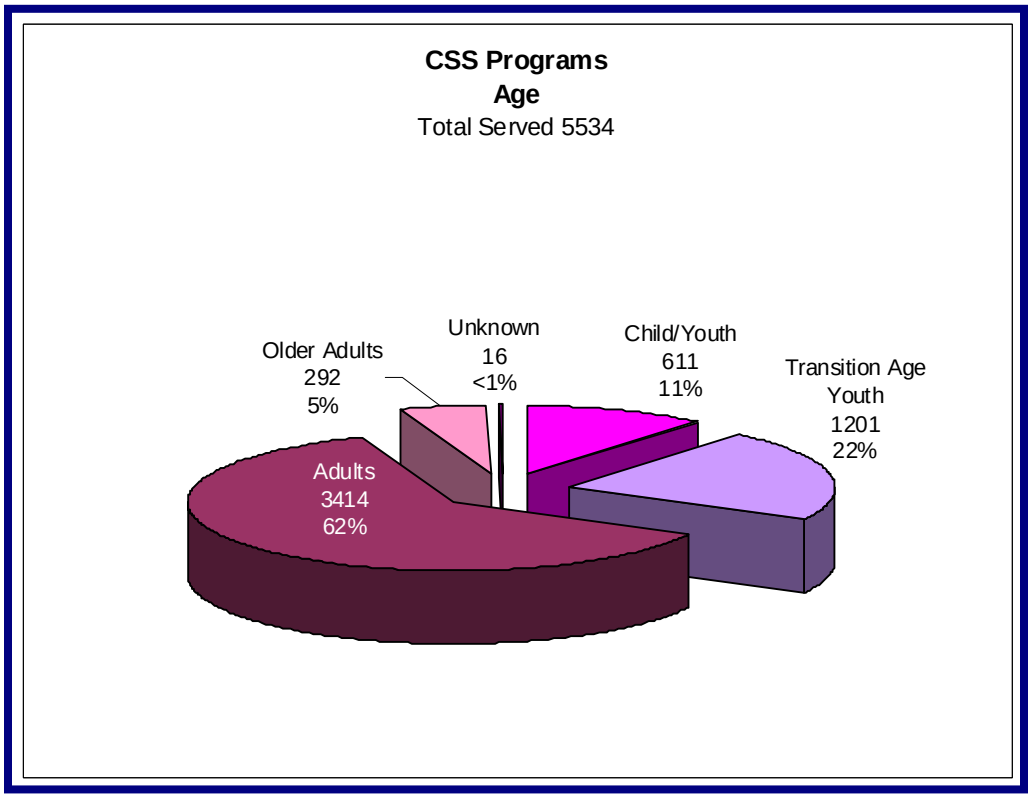
MHSA data collection and reports that focus on how many individuals were served by each program and whether programs were meeting service targets shows how much is being done. Data collected about service recipient characteristics that describe age, gender, race, where they live and primary language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

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





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



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

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

Stanislaus Homeless Outreach Program (SHOP) offers three full service partnership tracks that provide services to diverse unserved and underserved populations: Westside SHOP, Partnership Telecare Recovery Access Center (TRAC), and Josie's Telecare Recovery Access Center (TRAC). Full service partnership strategies include integrated, intensive community services and supports with 24-hour-a-day, 7-day-a-week availability with a known service provider. SHOP utilizes a "housing first" approach with recovery and client- and family-centered focus that inspires hope.

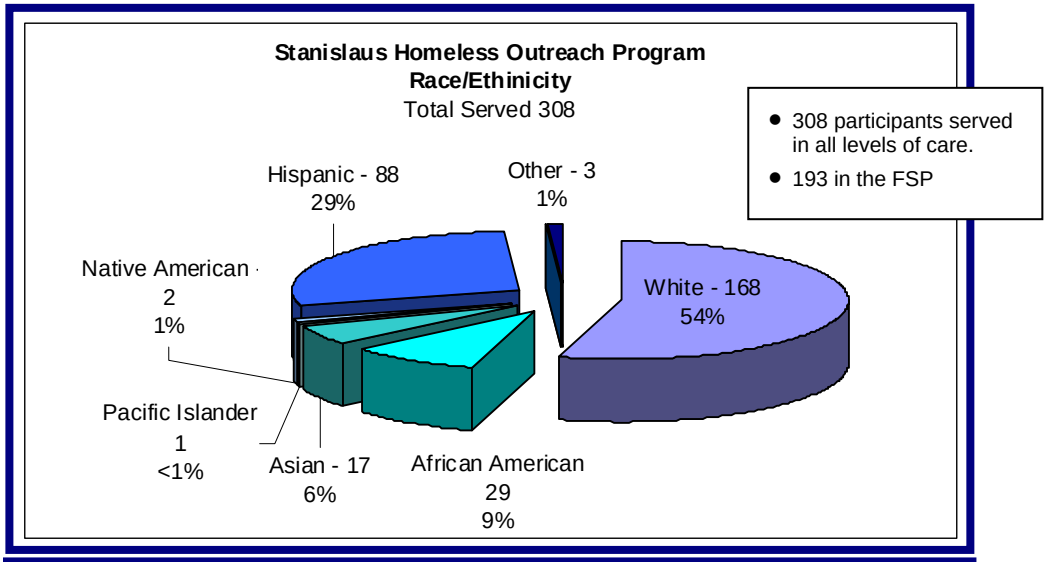
Three levels of care are available in the program: Full Service Partnership, Intensive Support Services, and Wellness/Recovery. This allows individuals to enter the program at an appropriate level of service for their need and then move to less or greater intensities of service as needed. Funded by General system development funds, Intensive Support Services is called Fast TRAC and the wellness/recovery is called Wellness TRAC. Group support led by clinical service staff are offered to a significant number of individuals as are peer-led wellness/recovery support groups. All levels of care include a multi-disciplinary approach. Graduated level of care allows more individuals to access the full service partnership level of service when needed. To ensure effectiveness, the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS), an assessment tool developed by community psychiatrists for determining appropriate level of care in outpatient services is utilized.

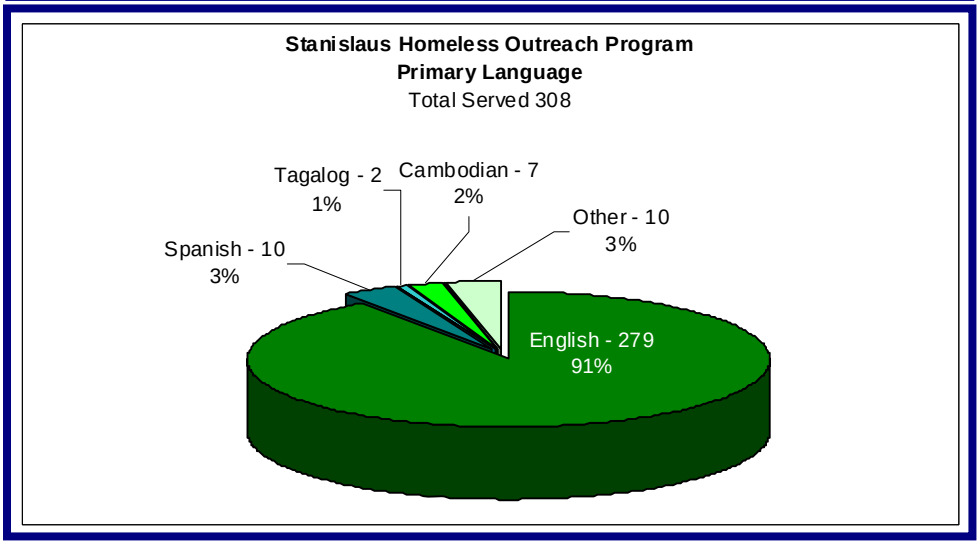
Collaboration with other agencies continues to be an important approach to reducing disparities and achieving an integrated service experience for consumers and family members. Collaboration occurs with agencies including but not limited to, Turning Point Community Programs, Salvation Army, United Samaritans Homeless Services, Golden Valley Health Clinics (a Federally Qualified Health Clinic), and the Modesto Police Department.

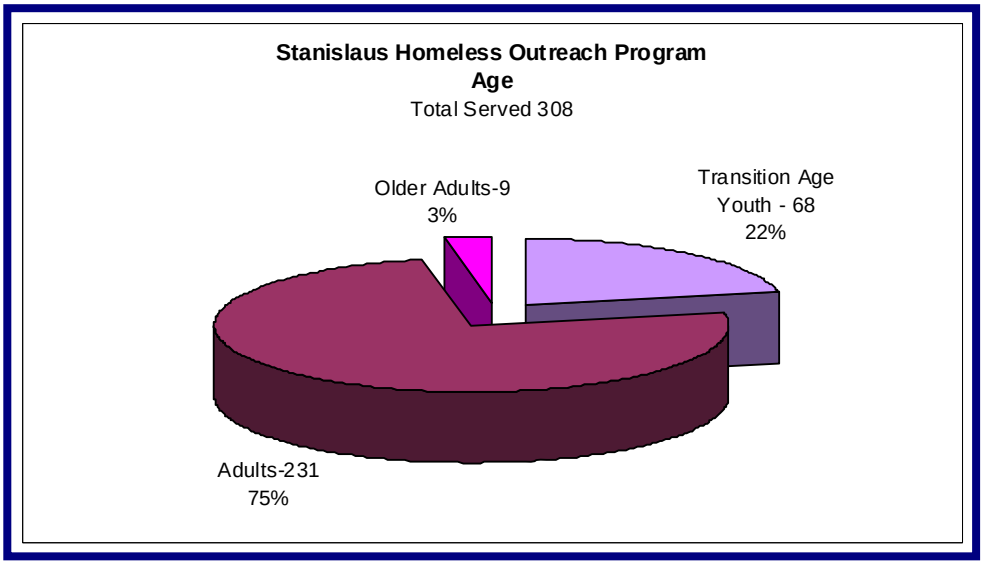
There are no proposed changes in the population to be served, service targets or funding levels in FY12-13.

Estimated number of individuals projected to be served in FY12-13 is 233; 128 in Full Service Partnership and 105 in Intensive Support Services and Wellness/Recovery.

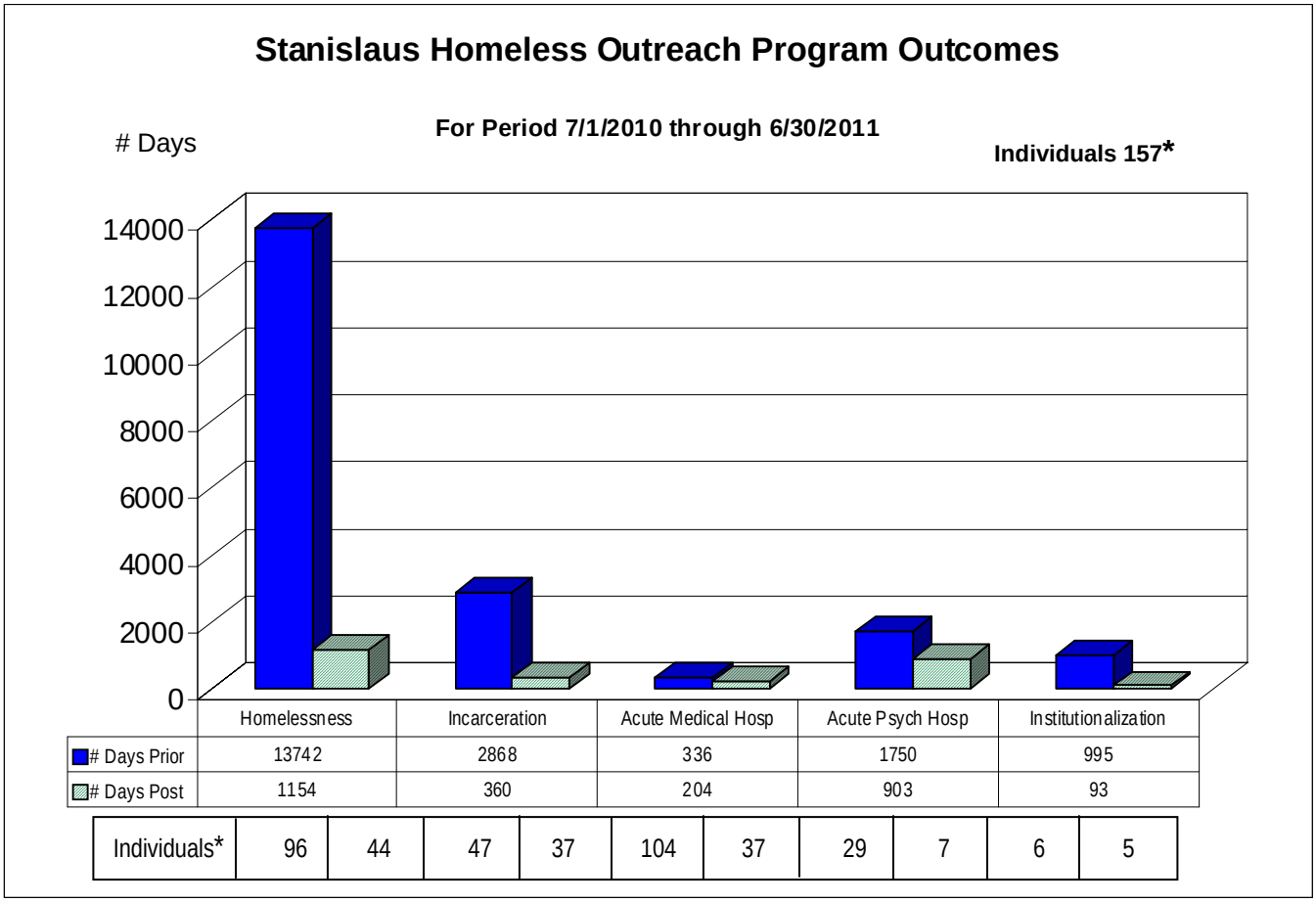
Demographics







Highlights



Days Prior – Number of days during 12 months prior to enrollment
Days Post – Actual number of days after enrollment to program

* Refers to number of individuals contributing to days

^ - In order to compare one year historical data to post data, a computation called annualization must occur. Annualization is determined by taking the # of days of the calendar year and dividing into the # of days enrolled.

Example of Program Results Shown in RBA Framework	
• 308 individuals served by all levels of care combined • 142 individuals served in intensive supports (Fast TRAC) and wellness/recovery (Wellness TRAC)	How Much?
• Average length of treatment in highest level of care is 12.5 months • Average length of treatment in lower levels of care is 18.5 month • 81% (9/11) of service recipients in Josie's TRAC stated in annual survey "Overall, I am satisfied with the services I received"	How Well?
• 7 participants gained employment in FY10-11 • A homeless individual was engaged in services, reunited with family, has housing and health benefits • 87% (7/8) of service recipients in Josie's TRAC stated in annual survey "I am better able to take care of my needs."	Is Anyone Better Off?

CSS - Juvenile Justice (FSP-02)

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

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

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

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

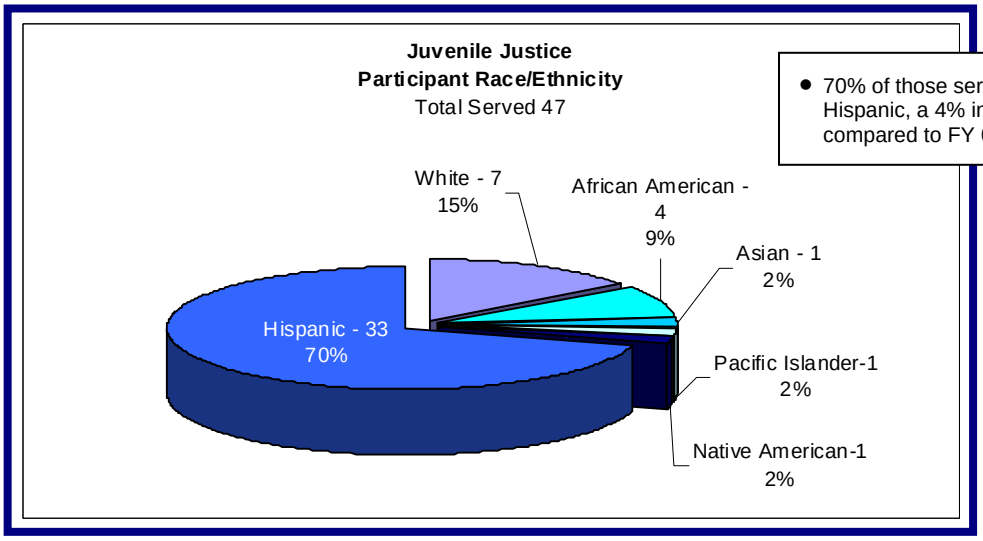
Aggression Replacement Training and Seeking Safety are evidence-based models employed to teach youth alternative behaviors that are healthier. Parent support group is offered to families who wish to receive support in navigating the juvenile justice system or support in improving parenting skills. Three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

In FY10-11, 78% of youth entering the program were identified at the time of intake as having a substance abuse issue and 78% were identified as having some sort of trauma at time of intake assessment.

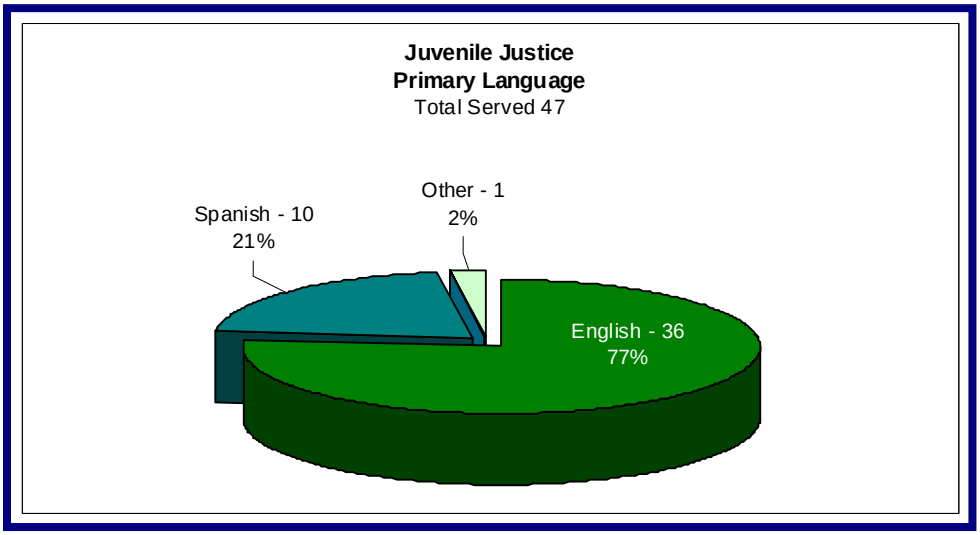
There are no proposed changes in the population to be served, service target or funding levels in FY12-13.

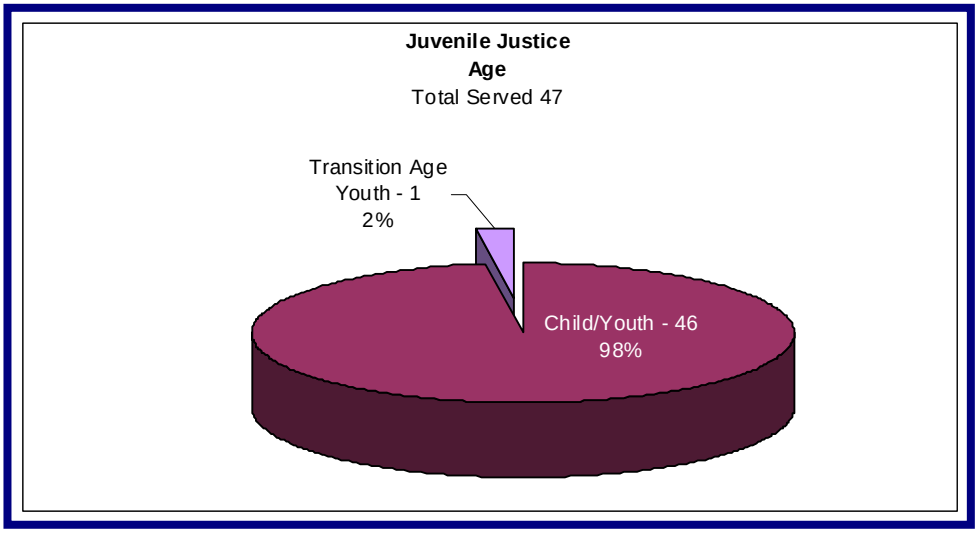
Estimated Number of individuals projected to be served in FY12-13 is 25; 13 child/youth and 12 transition age youth.

Demographics



- 70% of those served are Hispanic, a 4% increase compared to FY 09/10.





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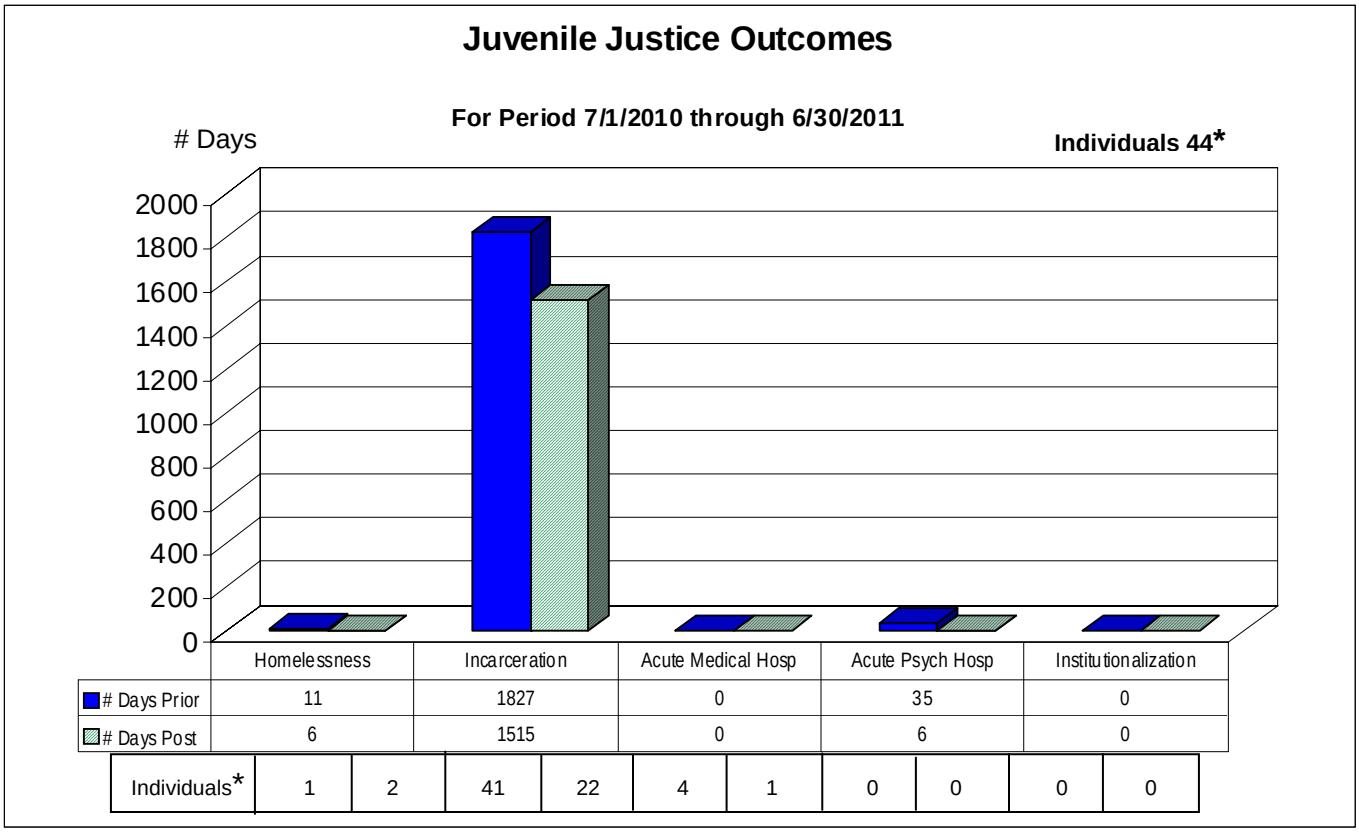


	Homelessness	Incarceration	Acute Medical Hosp	Acute Psych Hosp	Institutionalization
# Days Prior	11	1827	0	35	0
# Days Post	6	1515	0	6	0

Individuals*	1	2	41	22	4	1	0	0	0	0

Days Prior – Number of days during 12 months prior to enrollment
Days Post – Actual number of days after enrollment to program
* Refers to number of individuals contributing to days
^ - In order to compare one year historical data to post data, a computation called annualization must occur. Annualization is determined by taking the # of days of the calendar year and dividing into the # of days enrolled.

Example of Program Results Shown in RBA Framework	
• 47 youth were served in FY2010-11 • 12 parenting groups offered in FY10-11	How Much?
• 21% of those served are Spanish speaking • 18% of youth served had an out of home placement at any time during the year. • 90% (10/11) of youth stated in annual survey "Overall, I am satisfied with the services I received" • 81% (9/11) of youth stated in annual survey "I helped choose my treatment goals"	How Well?
• 6 youth were dismissed from probation • 4 youth gained employment • 1 youth successfully returned home from out of home placement • 1 youth dismissed from probation returned to regular high school campus	Is Anyone Better Off?

CSS - Integrated Forensic Team (FSP-05)

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

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

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

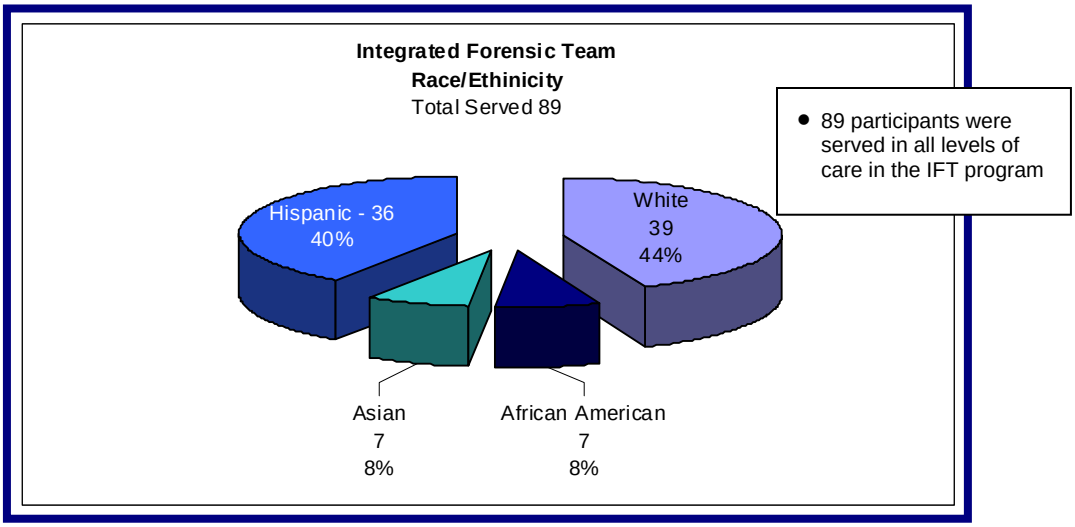
Collaboration with partner agencies is central to reducing disparities and achieving an integrated service experience for consumers and family members. In addition to law enforcement agencies and probation, collaboration occurs with agencies including but not limited to, Turning Point Community Programs,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

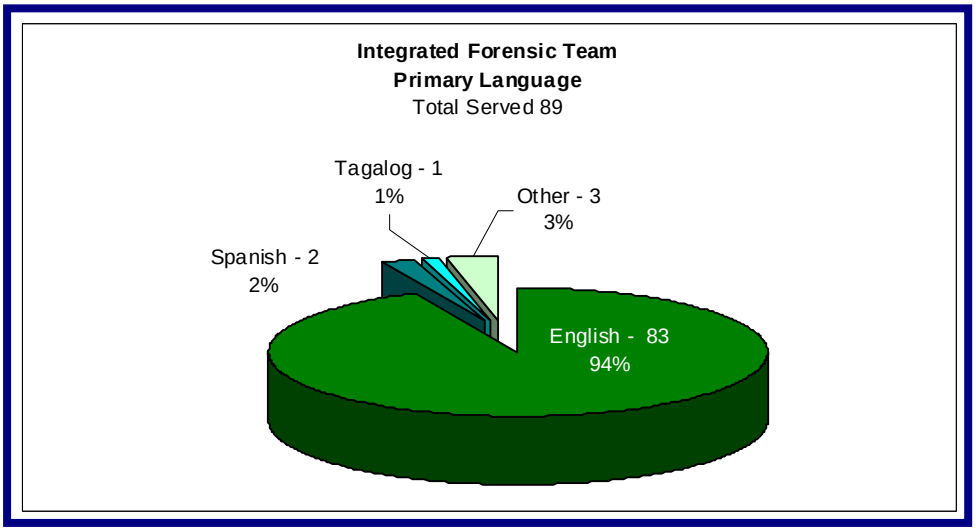
A combination of Full Service Partnership (FSP) and General System Development (GSD) funds provides 3 levels of care; Full Service Partnership, Intensive Support Services, and Wellness/Recovery. This allows individuals to enter the program at an appropriate level of service for their need and then move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

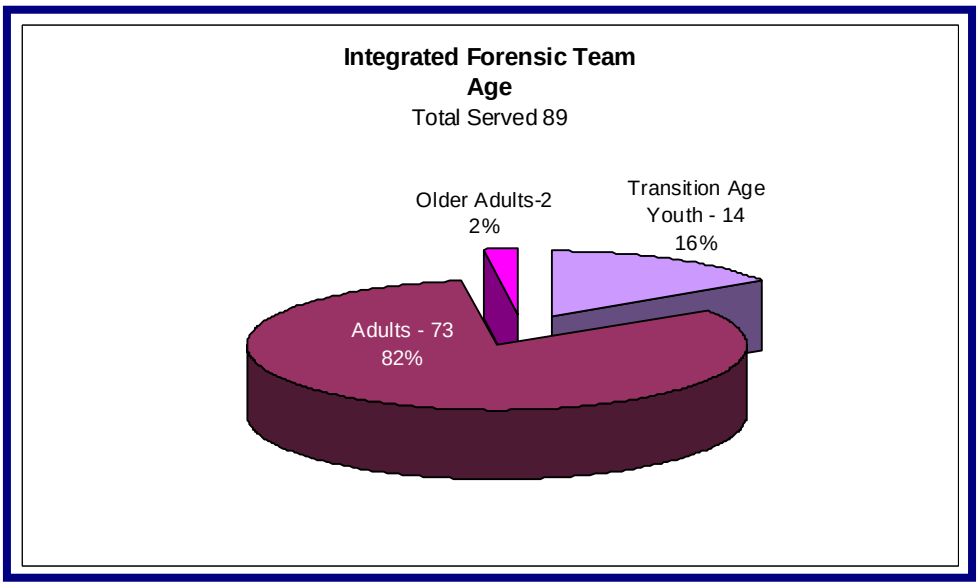
There are no proposed changes in the population to be served, service target or funding levels in FY12-13.

Estimated number of individuals projected to be served in FY12-13 is 80; 40 full service partnership level and 40 in intensive support services or wellness/recovery levels.

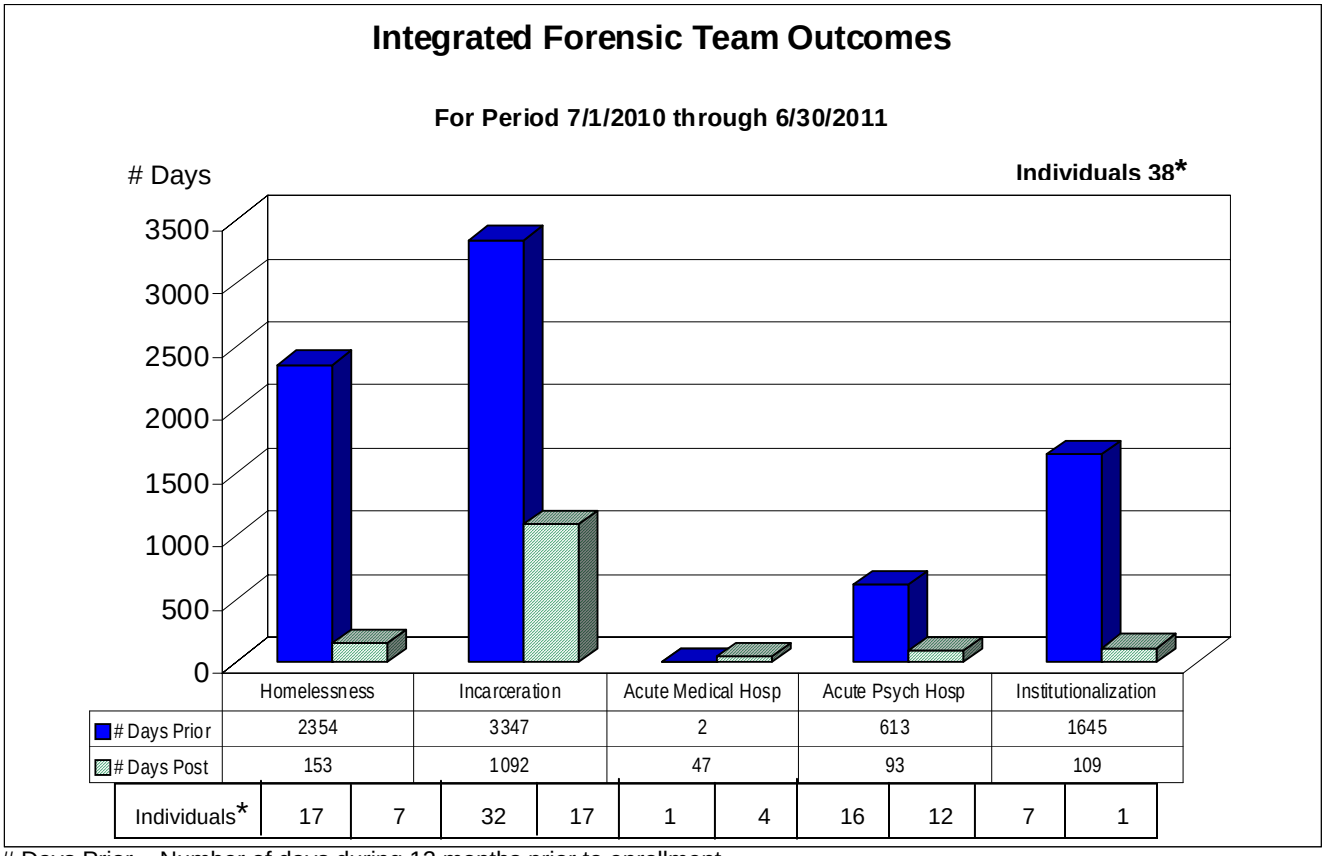
Demographics







Highlights



Days Prior – Number of days during 12 months prior to enrollment
Days Post – Actual number of days after enrollment to program

* Refers to number of individuals contributing to days

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Example of Program Results Shown in RBA Framework	
• 89 individuals were served by IFT • 53 individuals were served in FSP level of care • 36 individuals served in Intensive and Wellness levels of care	How Much?
• 40% of those served were Hispanic • 16% of those served were transition age young adults	How Well?
• Two women from very different backgrounds/culture in the program achieved quality of life improvements including independent living with assistance from BHRS Housing/Shelter Plus Care, return to work or school and re-engaged with family and other supportive social connections. • 68% (11/16) of service recipients stated in annual satisfaction survey “my housing situation has improved”	Is Anyone Better Off?

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

Operated in FY10-11 by Behavioral Health and Recovery Services in the Forensics System of Care/Public Guardian

High Risk Health and Senior Access is a newly consolidated FSP program of two previously approved full service partnerships: Health Mental Health Team and Senior Access and Resource Team. The new FSP became operational in FY10-11. It will serve the same target population and utilize the same strategies with a key addition of graduated levels of care in the consolidated program. Target populations includes transition age young adults (18 – 25 years), adults (26 - 59 years) and older adults (60+ years) who have significant, ongoing, possibly chronic, health conditions co-occurring with Serious Mental Illness (SMI). Older adults may also have functional impairments related to aging. Outreach and services are focused on engaging diverse ethnic/cultural populations and individuals. As well as those who have mental illness and are homeless, at risk of homelessness, at risk of institutionalization, hospitalization or nursing home care or frequent users of emergency rooms.

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

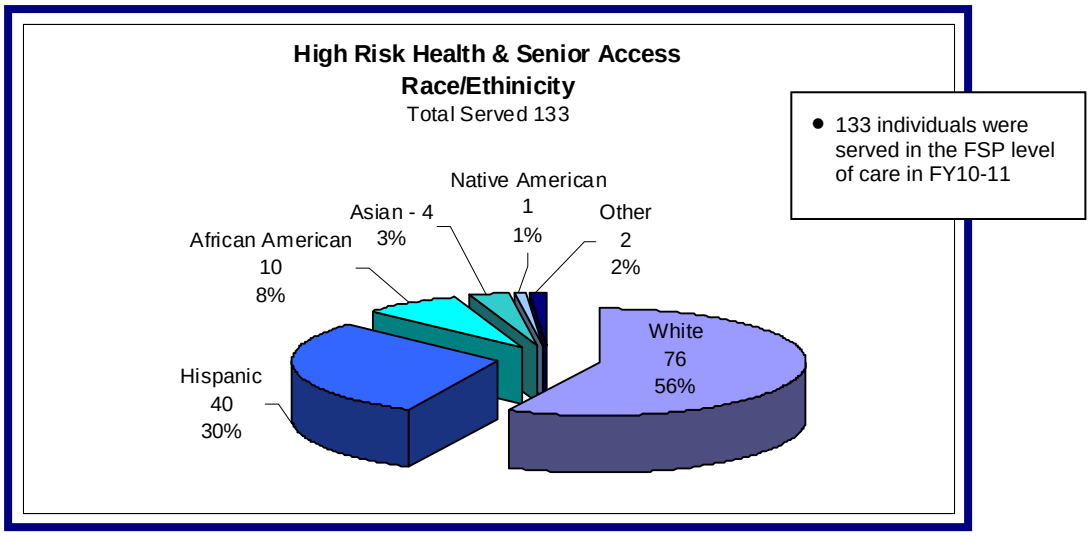
A combination of Full Service Partnership (FSP) and General System Development (GSD) funds provides 3 levels of care; Full Service Partnership, Intensive Support Services, and Wellness/Recovery. This allows individuals to enter the program at an appropriate level of service for their need and then move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

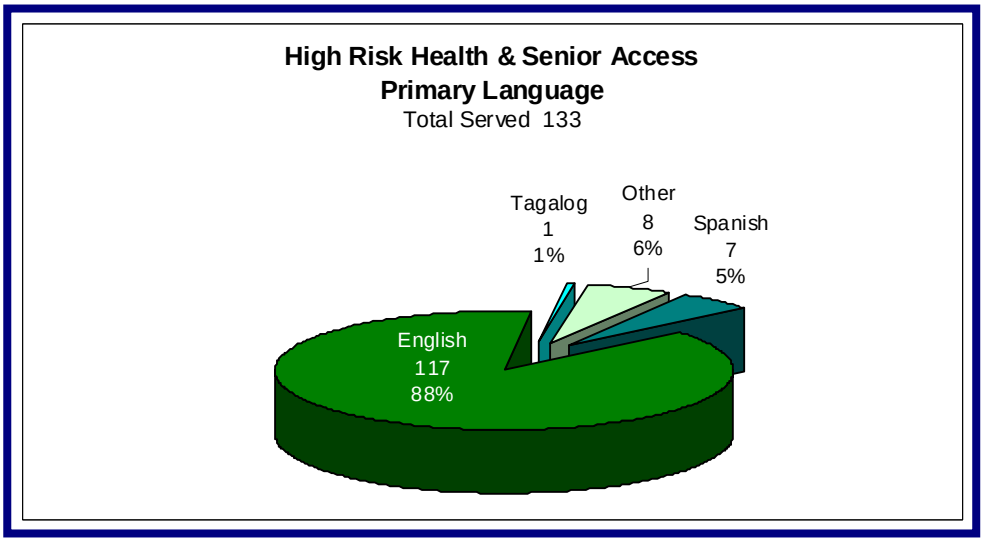
In FY10-11, the Senior Access and Resource Team and Health/Mental Health Team met regularly to integrate into one team: High Risk Health and Senior Access. Team meetings addressed the diverse ranges of topics involved in such a venture including staff placement and responsibilities, the types and number of groups best suited for this merger, and how the teams could best work together to promote recovery, resiliency, and wellness among service recipients

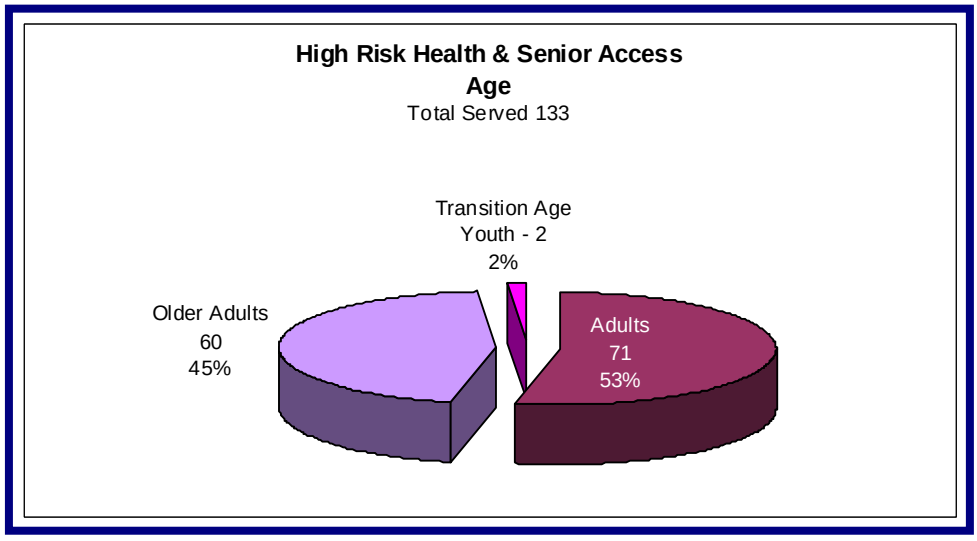
There are no proposed changes in the population to be served, service target or funding levels in FY12-13.

Estimated number of individuals projected to be served in FY12-13 is 110; 50 adults (ages 26–59) and 60 older adults (age 60+).

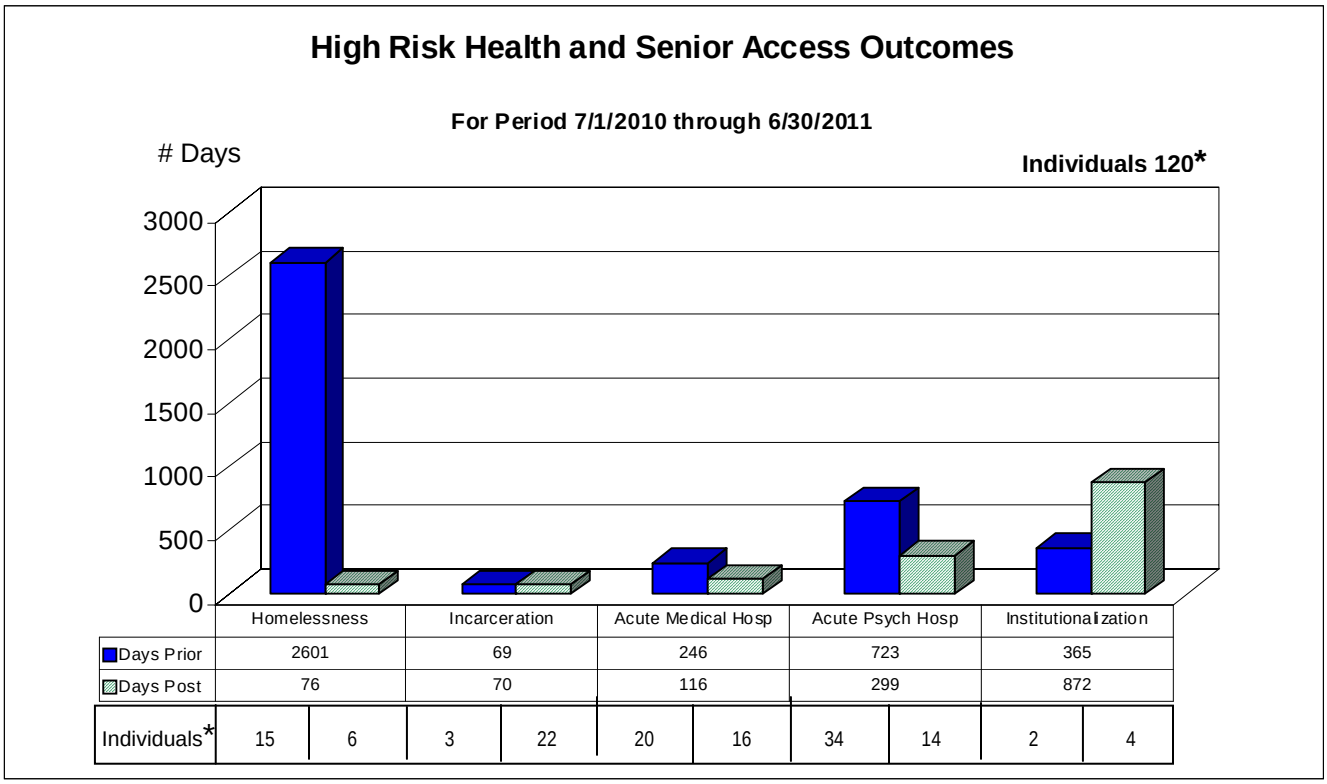
Demographics







Highlights



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Example of Program Results Shown in RBA Framework	
• 133 individuals served in FY10-11 • 54 individuals completed satisfaction surveys	How Much?
• 40% of service recipients were Hispanic • 5.9% of service recipients are from the Westside of the county • 91% (49/54) of service recipients stated in annual satisfaction survey “Staff believed I could change.”	How Well?
• 61% (32/53) of service recipients stated in annual satisfaction survey “I am better able to handle things when they go wrong.” • 75% (39/39) of service recipients stated in annual satisfaction survey “In a crisis, I would have the support I need from family and friends.”	Is Anyone Better Off?

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

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

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

Josie's Place is a membership-driven "clubhouse" type model that also has service teams in the center: Josie's Place Intensive Services and Supports (ISS) and a Full Service Partnership (FSP) called Josie's TRAC (operated by Telecare Recovery Access Center). Services are offered in English, Spanish, Laotian, and Thai languages at all levels of service. Seeking Safety groups as well as Aggression Replacement Training groups were offered as part of the array of services at the Center. In FY10-11, two youth who have lived experience as a consumer or family member were employed at the center. They conduct groups to support youth to process what is going on in their world with relationships of all types. Sometimes the groups do outings and support each other around development of social skills and related coping skills. The groups are open to both youth who receive mental health services and those who only use the drop in center for support.

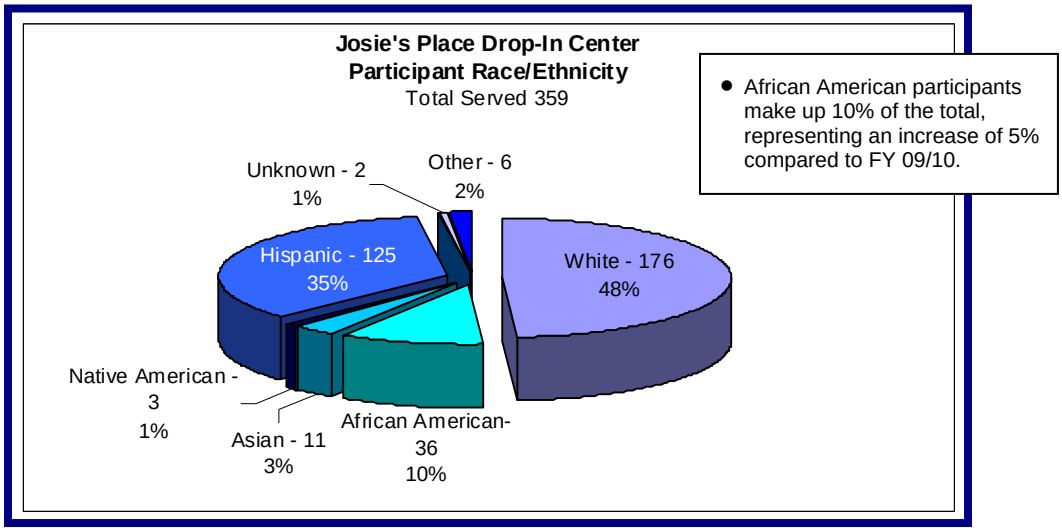
In addition, Stanislaus County Transitional Aged Young Adult Partnership (STAY) is a key collaborative that brings together BHRS, Community Service Agency, Probation, Health Service Agency and other key community providers working with transitional aged young adults to strengthen collaborative efforts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

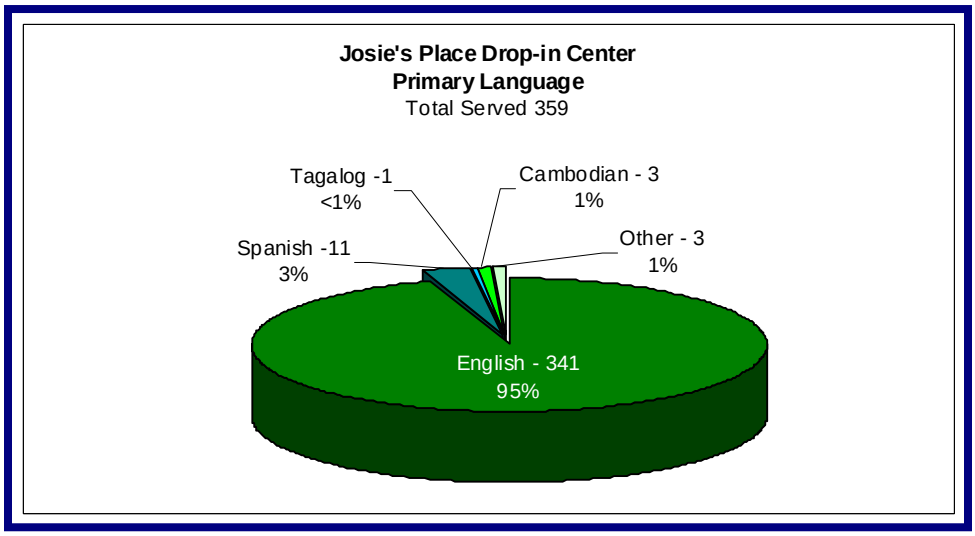
The Young Adult Advisory Counsel (YAAC), a consumer based counsel, provides leadership opportunities for the young adults and a greater voice in the daily activities and operating Josie's Place Drop-in Center overall. Because of an earlier recommendation by YAAC, more peer support and groups were established.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

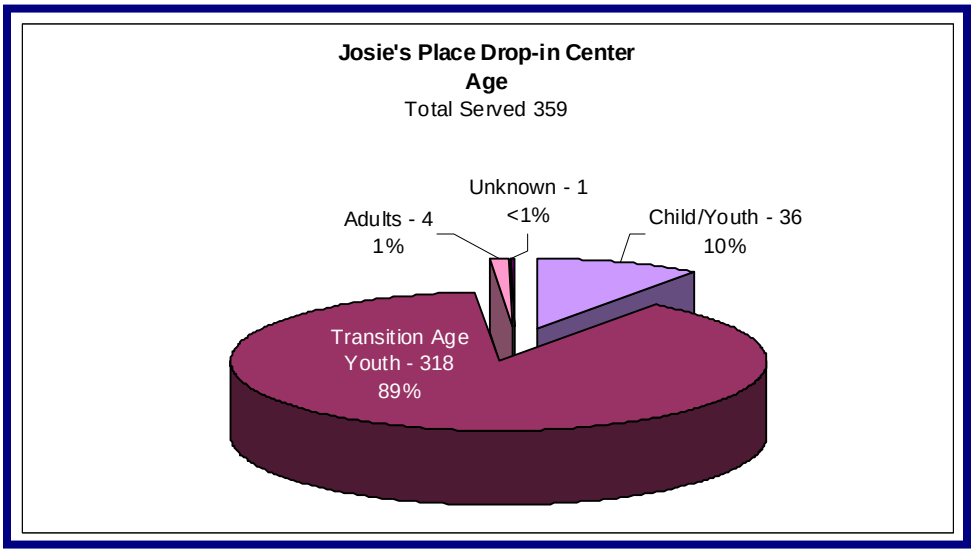
There are no proposed changes in the population to be served, service target or funding levels in FY12-13.

Estimated number of individuals projected to be served in FY12-13 is 250.

Demographics







Highlights

FY10-11 was an exciting year at Josie's Place. Services continued to be provided to the 18-25 year old young people in our county. New collaborations with community partners were developed to provide more variety of activities and groups to young people including Family Resource Centers, Faith Based communities, and The Heifer Project.

In FY10-11, Young Adult Advisory Counsel (YAAC) focused on projects related to business ventures designed to work on leadership and life skills:

YAAC Shak a snack vending business in the drop-in center. After considering what type of enterprise they could establish an in-house snack "Shak" was chosen. All aspects of the business were included in the learning venture; purchase of packaged food items, inventory control, keeping up with supply and demand, marketing, managing the YAAC bank account and even scheduling/working the "Shak".

Fundraising efforts became important in FY10-11 to earn money for activities and retreats that would foster growth and team development of YAAC. Their efforts, so far, have been car washes and snack sales. Sufficient funds were raised for a trip to the Museum of Tolerance in Los Angeles, Hollywood Walk of Fame, and dinner out. Many of the youth had never traveled out of Stanislaus County. The accomplishment, fun and learning opportunity of it was maximized as they made all the travel arrangements, budgeted and paid for travel expenses, and executed the trip with no major issues.

Transition Aged Youth (TAY) Leadership Conferences YAAC has taken on leadership roles within the county and have collaborated on the first of 2 TAY leadership conferences in Stanislaus County. Youth were actively involved in all parts of the business in putting on a conference; from idea phase through planning and implementation and conducting break out sessions at the conferences. This was an excellent learning opportunity and accomplishment within the TAY community at Josie's Place.

Example of Program Results Shown in RBA Framework	
• 900 members total have joined Josie's Place since 2006 • 359 individual members participated in FY10-11	How Much?
• 10% of members who participated in FY10-11 were African American • 90% (10/11) of youth stated in annual satisfaction survey "staff believed I could change"	How Well?
• 87% (7/8) of youth stated in annual satisfaction survey "I am better able to do things that I want to do" • Youth in leadership roles are participating in three statewide conferences: Un-convention in Los Angeles, an LGBTQ Conference in San Francisco and a Children's Services Conference in Pacific Grove	Is Anyone Better Off?

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

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

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

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

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

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

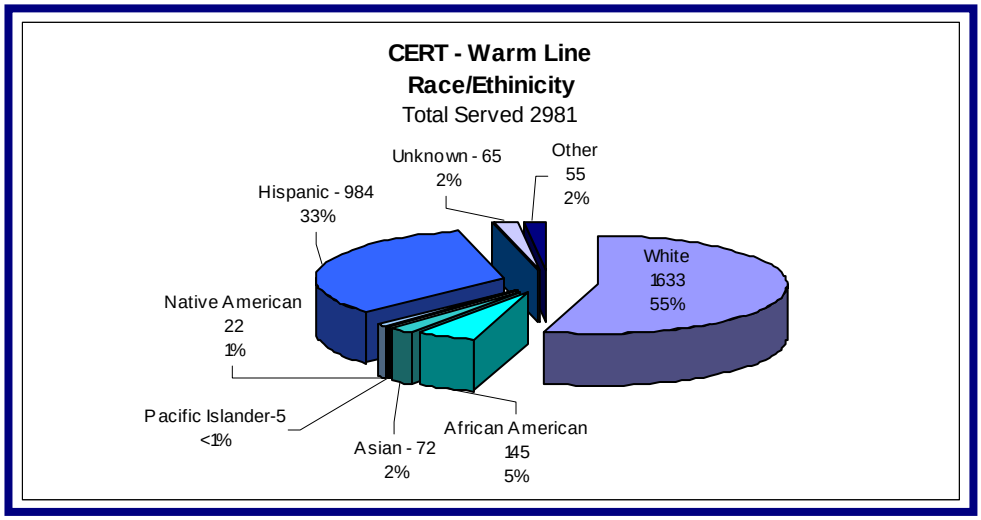
Warm Line is part of CERT that offers non-crisis services delivered by a team of individuals who are not treatment providers. Warm Line staff is a critical second point of contact, following assessment for crisis by clinical staff. Warm Line responds to incoming calls and as such, provides to many individuals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

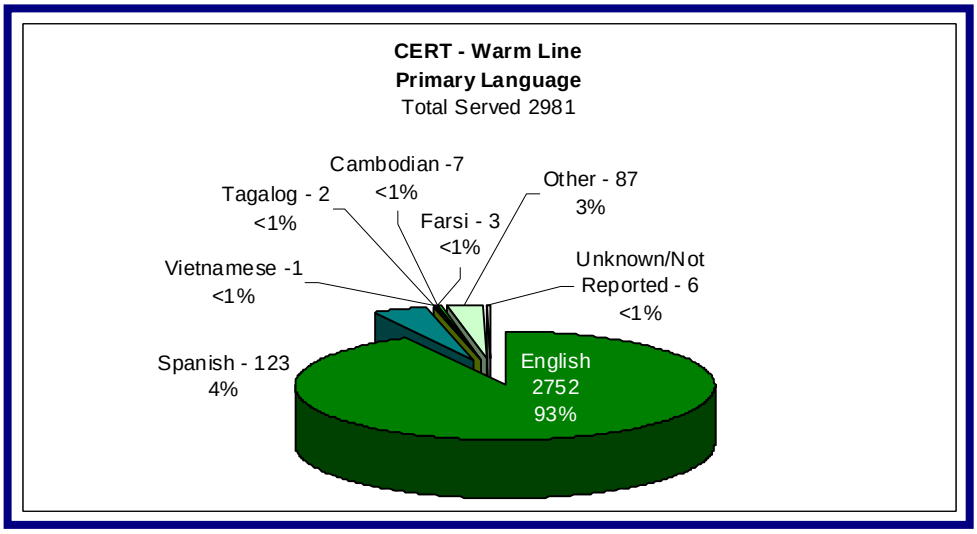
Each Warm Line team member has their own lived experience as a consumer of mental health services and/or a family member of a person with lived experience to draw upon in supporting others. They offer support from a place of “been there” and carry the message of hope that recovery is possible to every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

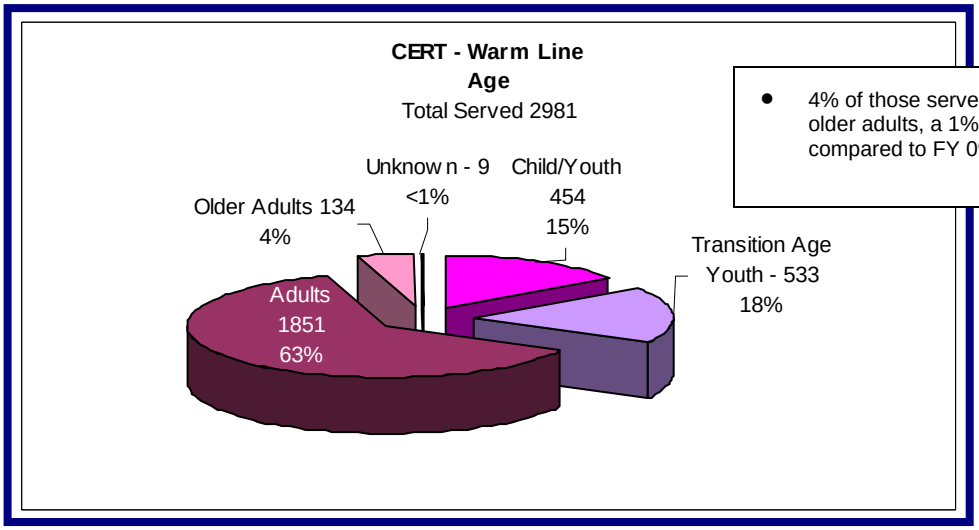
There are no proposed changes in the population to be served, service target or funding levels in FY12-13.

Estimated number of individuals projected to be served in FY12-13 is 3000.

Demographics







- 4% of those served were older adults, a 1% increase compared to FY 09/10.

Highlights

CERT/Warm Line is co-located in a community-based site, on a major bus route with a number of behavioral health services that work together collaboratively from the same location. These services located at the same site include: CERT/Warm Line, Modesto Recovery Services, Conservatorship Investigations, Integrated Forensic Team, all Telecare programs, NAMI offices and Consumer Coffee House. Clustering programs together enhances collaboration and integrated service experience for consumers and family members.

In FY10-11, CERT/Warm Line services continued to be focused on providing crisis intervention and peer support in this collaborative partnership of clinical staff and consumer/family members.

Target population is acute and sub-acute situations with individuals of all ages; children and youth with serious emotional disturbances (SED), Transition Age Young Adults (TAYA), adults, and older adults with serious mental illness (SMI). Overall emphasis continues to include outreach to culturally/ethnically diverse individuals.

Strategies and services continue to include engagement and support that bridges people to a recovery process and to crisis intervention with clinical professionals.

Mobile-CERT continues to be a very successful partnership between Behavioral Health and Recovery Services (BHRS) and Modesto Police Department. The clinical assessment staff of Community Emergency Response Team (CERT) and its Mobile component provided site-based as well as mobile crisis response in the community. In FY10-11, all CERT staff completed training to ride with patrol to expand capacity to respond in crisis situations.

In FY10-11, most Warm Line peer support calls were received after regular business hours of most mental health programs, between 4pm – 12 am.

Example of Program Results Shown in RBA Framework	
• 17,646 calls of all types answered by Warm Line in FY10-11 • 973 individuals utilized one or more peer support calls from Warm Line • 2169 individuals served by CERT/Warm Line in FY10-11	How Much?
• 31% of individuals served by CERT report they live outside Modesto • 41% of individuals served by CERT/Warm Line are from diverse racial groups	How Well?
• Warm Line participant commented "…Because of the information and support that you have given me, we are able to help my son. You gave me hope…Thank you"	Is Anyone Better Off?

CSS - Families Together (GSD-04)

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

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

Families Together provides a relaxing, tranquil space for parents and caregivers to read and socialize as a means of peer support when they bring their children in for services. Support groups are offered including a Men's group that has continued to grow. Outreach and collaborative partnership with Stanislaus County Department of Education Special Education's Local Plan Area (SELPA) in multiple locations continues to be successful. Outreach is extended through two additional committees: Stanislaus County E.D. Panel and School Review and Attendance Board (SARB). Through these partnerships mental health issues are identified in children and youth at risk for school failure. Referrals to the Family Partnership Center provide support and service needed to succeed and stay in school.

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

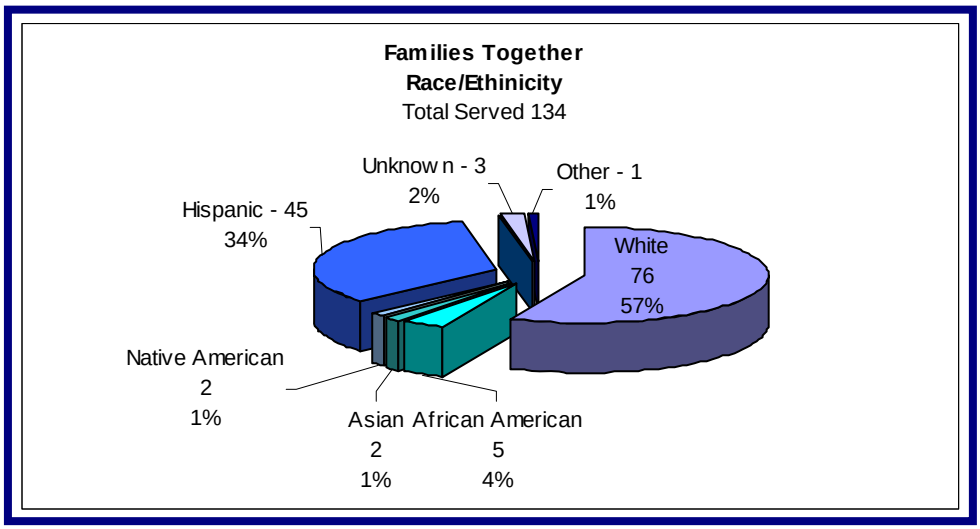
Parent Partnership Project promotes collaboration between parents and mental health service providers. Parent participation is encouraged and as they access services for their children and family they may contribute to policy development, program implementation methods, and refinement of services. Many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

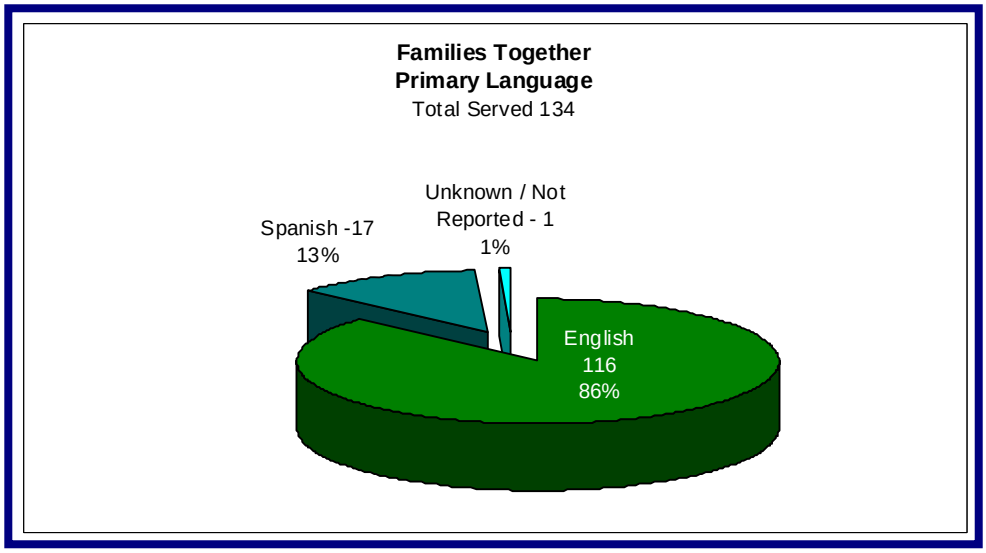
Kinship services are provided primarily by staff members who are Kinship caregivers. Kinship caregivers are often grandparents and other relatives who find they need to serve as parents for children whose own parents are unable to care for them. Sometimes, the arrangement is an informal, private arrangement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

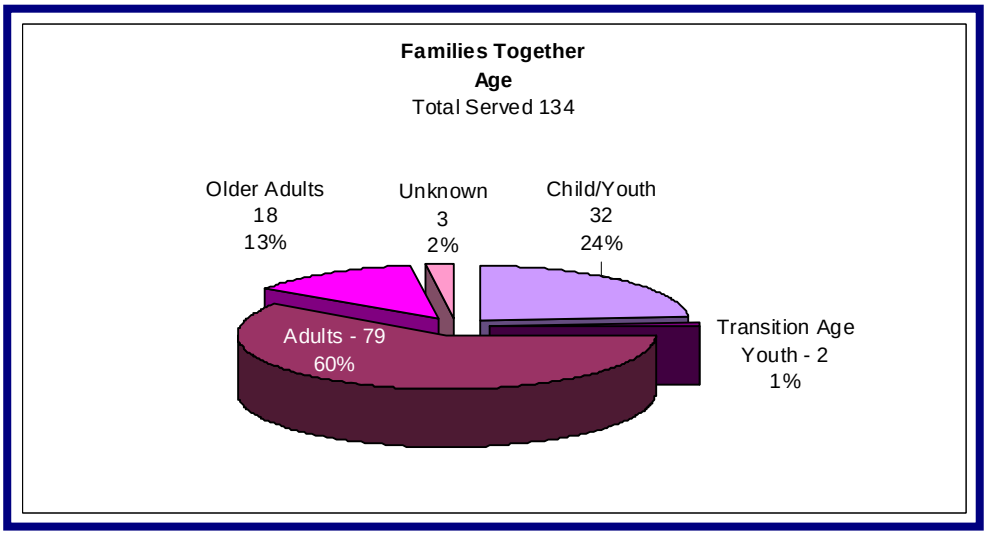
There are no proposed changes in the population to be served, service target or funding levels in FY12-13.

Estimated number of individuals projected to be served in FY12-13 is 80.

Demographics







Highlights

Families Together provides a relaxing, tranquil space for parents and caregivers to read, socialize and seek mutual support weekly as they bring their youth to the center for services and activities. The Beading Group has flourished; as an opportunity for relaxation and as a social connection point that expanded to include workshops designed to invite others to participate. The continued growth of the Men's group is an indication of its importance to male parents and caregivers seeking support in raising children with mental health and behavioral challenges. Many of the youth and families served are from underserved and/or unserved racially and ethnically diverse communities and families of all ethnicities who may not find peer support elsewhere. English and Spanish are the primary languages spoken at the center. Spanish is spoken by four staff and one volunteer.

Josie's Place Drop-In Center for Transition Age Young Adults serves 16-25 year old individuals and the Family Partnership Center/Families Together program also serves some individuals in the TAYA age group and their families. Youth and adults have opportunities to participate on the respective advisory committees, providing input, practice leadership skills, and giving feedback on everything from day-to-day services and activities as well as input on the center's processes and protocols.

Some family members, parents of youth with SED, and kinship caregivers (Parent Partners) are employed as staff and are involved in service provision, program leadership, and policy development. The addition of family advisory boards expands the consumer/family-driven philosophy of MHSA and has resulted in further enhancement through increased youth, parent, and family member volunteerism at the Family Partnership Center.

Example of Program Results Shown in RBA Framework	
• 134 individuals served in FY10-11 • 4 education-based committees provide linkage for families in need of mental health service and support	How Much?
• 13% of participants are Spanish Speaking only • 34% of participants are Hispanic • 4% of participants are African American	How Well?
• A single parent family with many issues received services that led to the parent attending college and a child returning to mainstream classrooms. • Parent comment; "I have a sense of ownership here, through volunteering, being part of FPC and helping others."	Is Anyone Better Off?

CSS - The Consumer Empowerment Center (GSD-05)

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

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

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

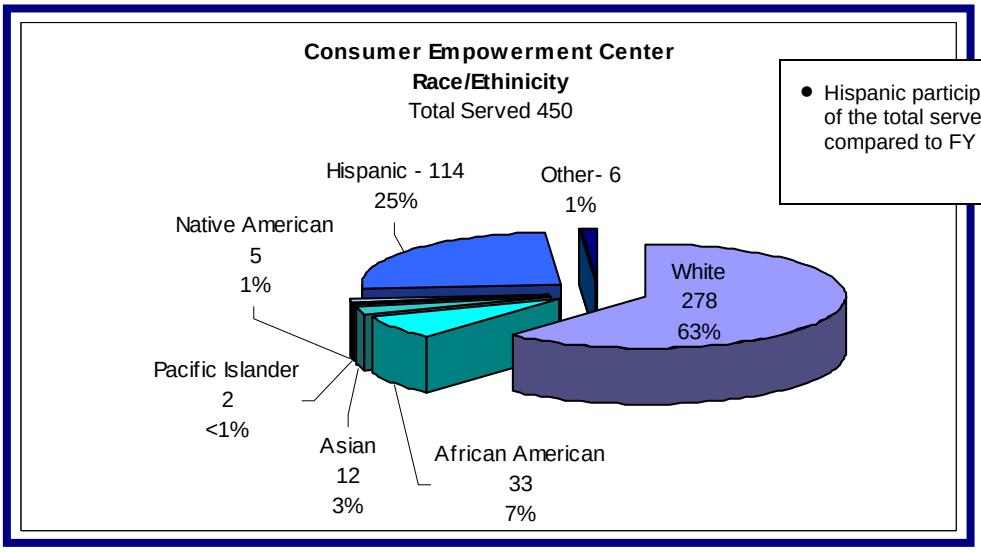
Steering Committee

The CEC Steering Committee meets monthly and provides support to enhance and transform existing services into a strong consumer and family focused program. This committee makes decisions with regard to the overall implementation of all aspects of CEC. Its focus is strongly related to peer recovery, family support, consumer education, training, employment, and advocacy. The steering committee is comprised of mental health consumers, community leaders, family advocates, stakeholders, volunteers, and members of various community groups.

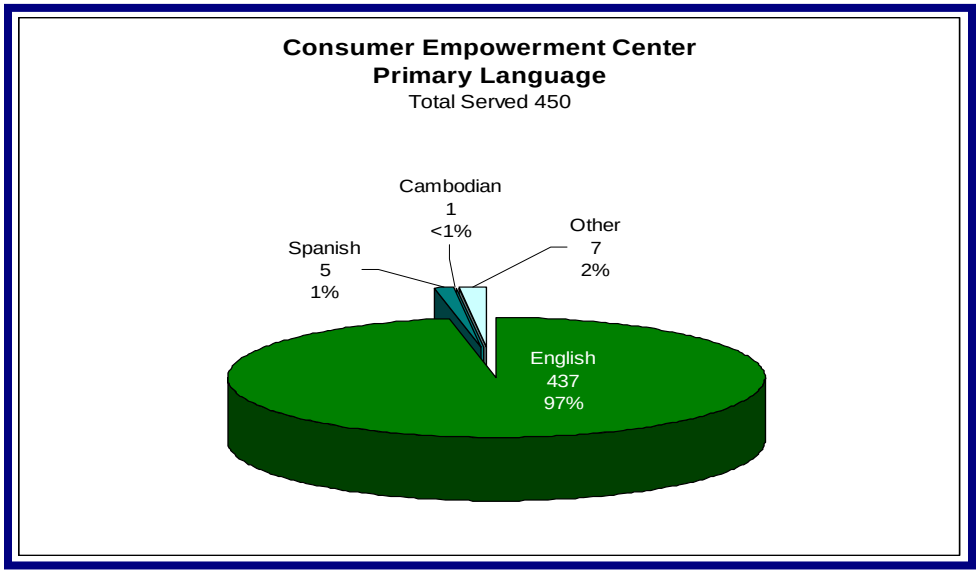
Advisory Committee

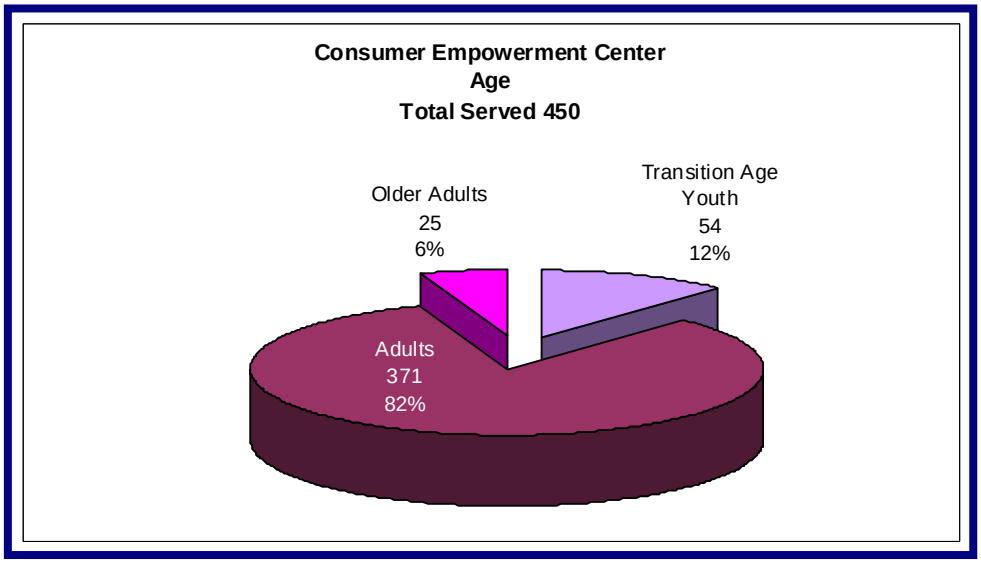
The CEC Advisory Committee reports monthly to the steering committee. The advisory committee is comprised of members of the CEC and their families. This committee meets once a month and discusses the direction of the center, making suggestions about activities and upcoming events. The advisory committee sought to further community linkage by using the social networking site Facebook in FY10-11. This has allowed the center to reach rural communities and invite users to participate in the program online. The CEC uses this site to show what is happening at the center as well as post news, events, and other great stuff that is happening in the community. The CEC can be found by using this link: http://www.facebook.com/pages/Empowerment-Center/99349197580

Demographics



- Hispanic participants make up 25% of the total served, a 5% increase compared to FY 09/10.





Highlights

In December 2009, the Consumer Empowerment Center was the first CSS program to begin a process to incorporate a measure of whether participants are better off as a result of participation in the program.

Process:
A committee was formed that included mental health consumers, Turning Point administrators, family advocates and family members, as well as Stanislaus County Mental Health Board members and members of BHRS Senior Leadership. This committee focused on identifying and refining indicators of well-being that are most important to knowing whether participants are better off and how to measure success of the identified indicators. How much service is provided and how well the service is delivered were also part of the discussion.

A facilitator-led discussion focused on development of new tools to track participation, feedback, and personal well-being. In brief, a plan was developed to learn how participants perceived their situation upon initial contact with the center, then how they were doing throughout their use of the center, and finally, how they were doing when they were ready to move on from the Center.

Data collection:
The tool developed to collect information from participants was strategically titled by the committee as "The Well-Being Survey". Piloted in early 2010, start up issues such as data entry methods to be used, database development, and refinement of survey questions were soon resolved. In January of 2011, the final version of the survey began to be distributed to all individuals in new member packets when they enrolled into the Consumer Empowerment Center. The survey is currently redistributed to enrolled members quarterly.

Lessons Learned, Early Results and Next Steps:

- From this process, we learned that we often lack data sources for the measures we most want to effect. In this case, the Consumer Empowerment Center has always been dedicated to supporting each participant's recovery and well-being.
- Through this process, agreement emerged that one determinant of program success could be based on participant's experience and perceptions of his or her own recovery and well-being as a result of participating in the program, and that tracking of this would allow assessment, by staff and others, of progress on this commitment.
- Participation in the Well-Being Survey is completely voluntary and some individuals decline to participate. However, overall participation in initial surveying and quarterly updates is good.
- As staff members continue to collect and reflect on this data, it will help them stay focused on the fundamental purpose of the center—to support each participant's recovery and well-being—and to make judgments about how to effectively evolve the programming at the center in response to participants' feedback and experience.

There are no proposed changes in the population to be served, service target or funding levels in FY12-13.

Estimated number of individuals projected to be served in FY12-13 is 500.

Example of Program Results Shown in RBA Framework	
• 450 individuals served • 34 groups and events offered • 16 agencies or programs are key collaborative partners with CEC	How Much?
• 100% staffed by consumers/family members • 66% of participants are consumers • 34% of participants are family members • 96% (31/32) of participants stated in annual satisfaction survey “Staff believed I could change”	How Well?
• Participants report they have found the Consumer Empowerment Center to be a safe, friendly, and fun place for them to be during the day • Participant report: “It lead to me getting healthier, a better outlook at life, a PG&E bill, and an apartment. I’m still doing what it takes to getting it done. I know I still have things to accomplish. If it wasn’t for the center and the staff and the interesting individuals, I would still be walking in the rain.” • 81% (27/33) of participants stated in annual satisfaction survey “I feel I belong in my community”	Is Anyone Better Off?

CSS - Community Outreach & Engagement (OE-01)

Operated through contract with
West Modesto King-Kennedy Neighborhood Collaborative and
El Concilio: Latino Behavioral Health Services

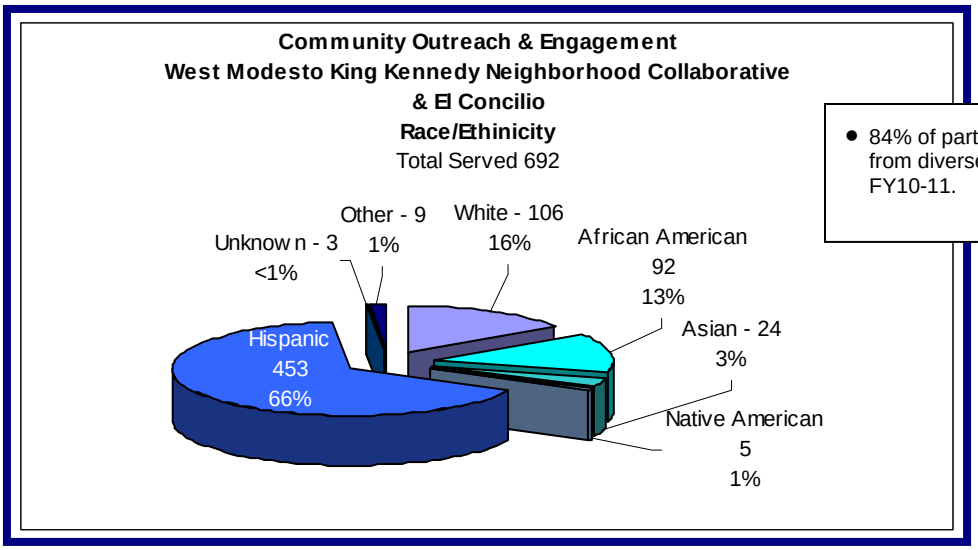
This community Outreach and Engagement (O&E) program was established in recognition of the special activities needed to reach diverse underserved communities that have high needs and are disproportionately unserved by traditional types of mental health services. This program's strategy is based on outreach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

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

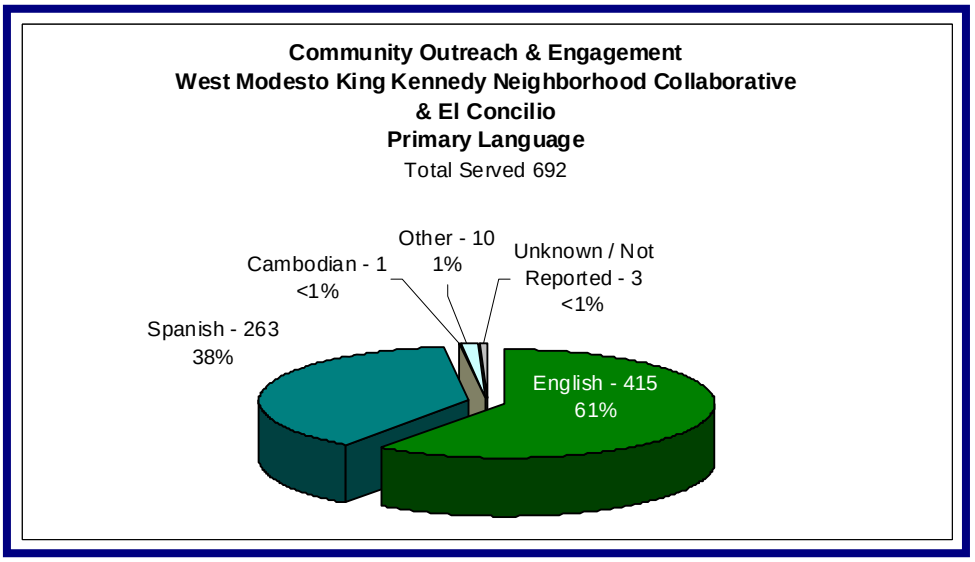
West Modesto King Kennedy Neighborhood Collaborative has focused on increasing outreach into neighborhood based supports that honor cultural practices by hiring individuals from the neighborhood. Several important objectives define the approach: 1) continuation of the community-based strategy for mental health outreach and engagement in West Modesto; 2) provide mental health depression screenings; 3) provide mental health referrals for West Modesto residents needing specialty services; 4) provide group peer support sessions for depression and substance abuse; 5) provide transportation services to residents in support of their mental health service needs; 6) continue operation of the mental health drop-in center in West Modesto; 7) continue to increase awareness and engage youth in the neighborhood regarding mental health issues and career opportunities in mental health.

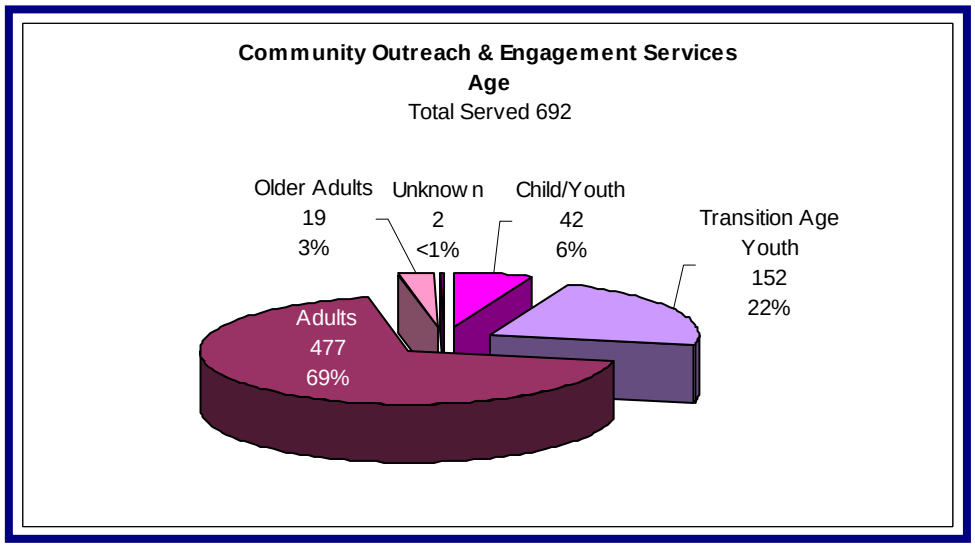
El Concilio: Latino Behavioral Health has focused on outreach to promote and educate the community on mental health and substance abuse recovery to the underserved/unserved populations in the outer geographical areas of Stanislaus County. As a founding member of the Central Valley Promotores Network Vision y Compromiso, El Concilio continues to work closely with Promotores to educate and outreach to Latino communities about health and behavioral health in a way that honors their culture and way of life.

Demographics



- 84% of participants served are from diverse race/ethnicities in FY10-11.





Highlights

A stakeholder process was convened in FY10-11 to accomplish revisions to the CSS plan that would increase fiscal sustainability in years to come. One outcome of the stakeholder process was to transfer the O&E-01 Program from the CSS plan to the PEI plan with the intent to, 1) preserve the outreach and community engagement already established, and 2) fold these organizations into the prevention efforts to build community capacity.

In doing so, BHRS and community stakeholders continue to be committed to stigma reduction and increasing well-being and recovery through community capacity building. These projects joined the prevention efforts outlined in the Community Capacity Building Project in January 2011. The program operated as a CSS funded program from June 2010 to December 2010 and those services are reported here.

Example of Program Results Shown in RBA Framework	
• 692 individuals served by Outreach & Engagement Program from 7/1/10-12/31/10 • WMKKNC held monthly neighborhood collaborative meetings for residents • El Concilio: Latino Behavioral Health & Recovery Services offered support groups in 8 locations throughout the county	How Much?
• Diverse staff members of West Modesto King Kennedy Neighborhood Collaborative are hired from the community they serve • Languages spoken by O&E program staff: Spanish, Cambodian, Choctaw & English • El Concilio works with Promotores in rural outreach with migrant families	How Well?
• Participant comments from WMKKNC: "I am writing this letter to express my thanks. The gifts that I have received are so hard for me to put into words but I will do my best. When I first arrived at the drop in I was a man lost homeless dieng (sic) from alcohol and drug addiction. Here at the drop in was a safe positive place for me to go on the weekends. I got sober here, my home group, real friends, God, my self. I now have 7 months clean. Life is happening for me I thank you and the king kennedy collaborative for saving a man like me. Love & Respect, (name withheld)"	Is Anyone Better Off?

CSS - Garden Gate Crisis Outreach (OE-02)

Operated through contract with Turning Point Community Programs

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

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

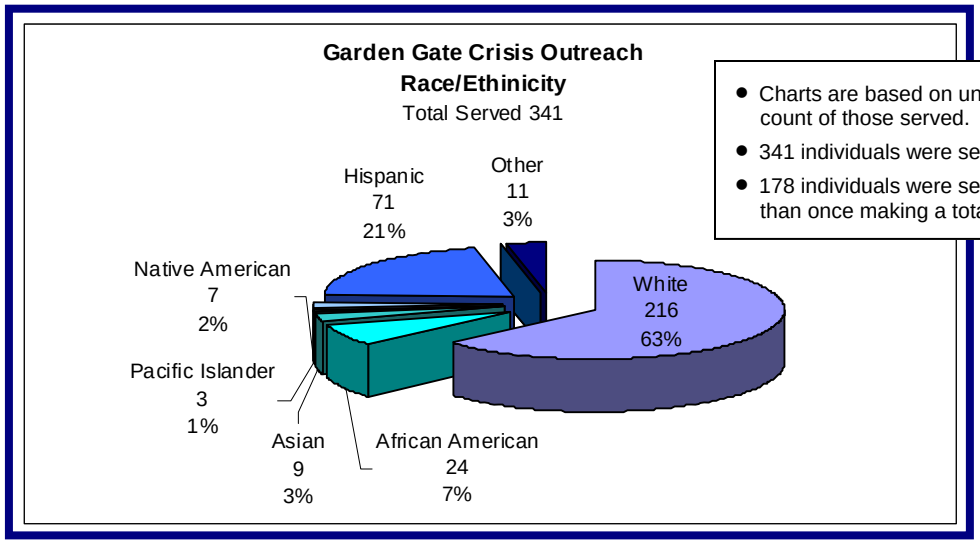
Not a treatment program, Garden Gate Respite Center serves as an engagement program that provides a safe haven with a philosophy of “moving toward wellness”. GGRC often is a first point of contact for individuals who need mental health treatment, access to medical care and other services. For some individuals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

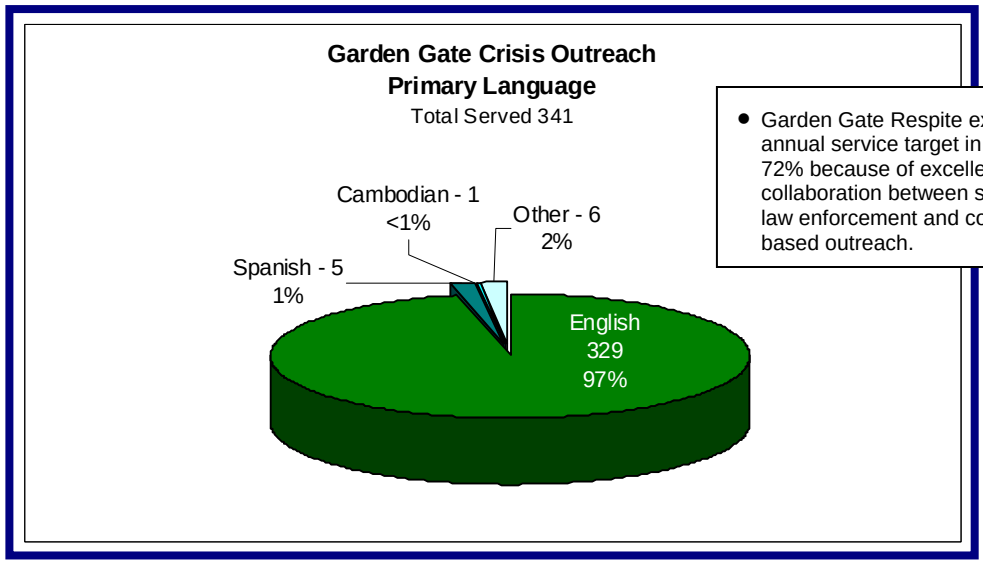
GGRC staff collaborate closely with the Telecare Stanislaus Homeless Outreach Program (SHOP) Team to coordinate referrals to needed resources that may include but not be limited to, medical care, options for longer term temporary or permanent supportive housing, culturally appropriate support services, supportive education at the Consumer Empowerment Center, client advocacy agencies for criminal justice issues, and ongoing outreach if individuals remain homeless after leaving respite housing. Collaborative relationships exist with many key agencies in Stanislaus County.

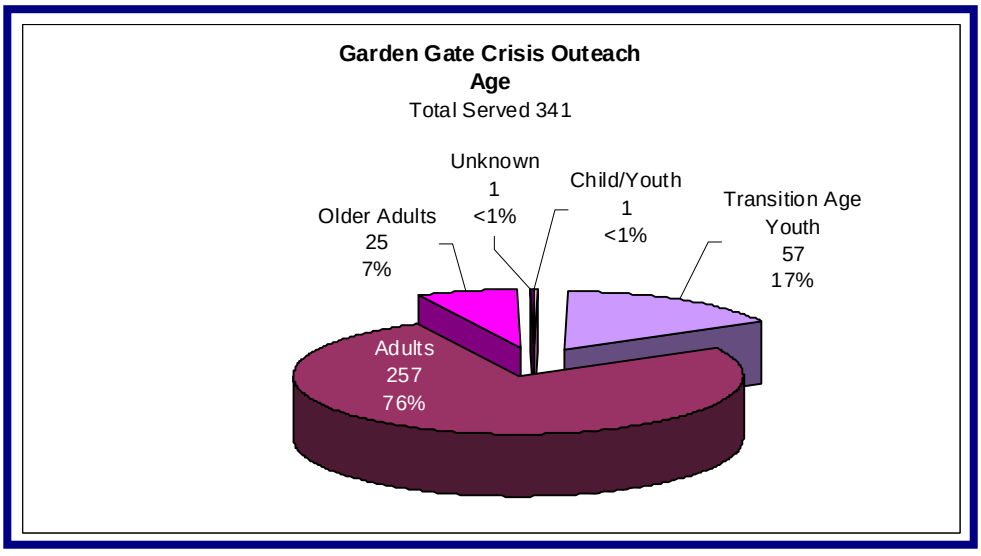
There are no proposed changes in the population to be served, service target or funding levels in FY12-13.

Estimated number of individuals projected to be served in FY12-13 is 97.

Demographics







Highlights

In FY10-11, two times during the year presentations were done with Modesto Police officers at shift briefings (2 consecutive days) to inform them about Garden Gate's role as an alternative to jail for individuals who are homeless and have mental illness. This process is an important service and worked effectively to engage a collaborative relationship with law enforcement. Feedback from law enforcement is overwhelmingly positive and it is anticipated that these presentations at shift briefings will continue in the future.

Garden Gate Respite staff participated in Crisis Intervention Training (CIT) offered bi-annually to law enforcement by BHRS. GGR staff provide transportation to CIT participants as they tour various programs. The drive time provides an excellent opportunity for informal discussion between the officers and GGR staff.

The Community Activities & Rehabilitation Transportation (CART), a Turning Point program, provided non-traditional transportation to consumer and family members. Specifically targeting individuals who live in more remote areas of the county, CART offered transportation to community activities and other appointments including to work. Transportation is available outside traditional business hours and when public transportation is not available. In FY10-11, CART provided 1598 rides to activities.

Example of Program Results Shown in RBA Framework	
• 50% (172/341) individuals served were Police referred • 41% (139/341) individuals served completed voluntary participant feedback forms • 616 bed days were provided (within 6 months) to individuals at risk for psychiatric admission, arrest and homelessness	How Much?
• Police feedback surveys (88 surveys completed) expressed 100% satisfied or very satisfied with Respite Center Service • Client surveys (139 surveys completed) expressed 99% satisfied or very satisfied with services they received.	How Well?
• Officer feedback comment: "I have been using respite…since it opened…it is one of the biggest blessings of this community. I can't speak enough about how much I appreciate the work they do." • Participant comment: "This place is an absolute miracle that I wound up here. I have felt safe, calm and for the first time in a very long time, Happy for a change. Life on the streets is brutal, violent, and leaves a person feeling very alone, isolated and hopeless. I have experienced nothing but frustration being homeless, until I came to Garden Gate. Here I feel like a human again…"	Is Anyone Better Off?

Long Term Supported Housing (CSS-Housing)

MHSA CSS Housing Program applications are considered updates to the CSS Plan. Long term supported housing must be designed with the goal of establishing and/or strengthening partnerships that result in development of housing that reflects local priorities and expands safe, affordable housing options for individuals of all ages with serious mental illness or youth with serious emotional disturbance and their families.

Background:
Long term supported housing funds are a one-time amount of funding, appropriated from CSS funds in FY07-08. In 2008, Stanislaus County assigned $4.8 million for CalHFA to hold in a sub-account for Stanislaus. These funds may only be used for long term supported housing which is separate from but complimentary to, CSS program funds that provide emergency and transitional housing for the homeless and mentally ill residents of Stanislaus County. Counties were required to assign CSS housing funds to the California Housing Finance Agency (CalHFA) prior to developing housing projects. To complete a project, MHSA funds must be leveraged with other forms of financing (e.g. HUD).

Behavioral Health and Recovery Services has a proven history of successful collaboration with key community partners that produced results and developed supported housing projects for individuals who have mental illness. Despite that history, development of MHSA-funded housing projects has been challenging. Factors contributing to the challenge are: the program began during an economic recession, State Housing Community Development funding significantly decreased during this period, tax exempt bond funding became limited, local funding sources were being redirected or eliminated such as predevelopment funds, and sources of operating subsidies and services funding have diminished.

Across California, medium and smaller counties have additional challenges. These funds have strict program rules and limited flexibility that cause barriers to a local environment that does not have the housing development resources than larger counties; and restrictions on the use of these funds for rental subsidies are prohibitive when new construction is not a realistic or cost-effective option.

In FY10-11, BHRS had two projects that were submitted to CalHFA: Lincoln Avenue, also known as “Bennett Place,” and Coolidge Avenue, known as “Meadow Glen.”

Bennett Place Update: This project was originally intended to be an older adult housing project. It is anticipated this project will progress in FY11-12 and beyond.

Meadow Glen Update: Following submission to CalHFA for approval as an MHSA-funded project, local issues arose that resulted in consideration of transfer to Stanislaus County Housing Authority. This transfer would not include MHSA funds and BHRS would have access to housing units for transition aged youth when the project is complete. This transfer is anticipated to occur in FY11-12.

Discussions are ongoing with local partners to continuously investigate opportunities for funding and suitable properties for development into supported housing sites. This history of collaboration combined with stakeholder input, obtained during initial CSS Community Planning Process that addressed unmet housing need for all age groups, will be utilized in developing permanent supportive housing through the MHSA Housing Program in FY11-12 and beyond.

Workforce Education and Training (WE&T)

WE&T was the second component of MHSA to be planned and implemented beginning in FY06-07. It is the MHSA component that provides funding to address shortages in the workforce, train the existing workforce to incorporate MHSA values into practice, identify hard to fill positions, and develop career pathways for diverse populations and individuals with lived experience. Unlike many of the MHSA programs, Workforce Education and Training (WE&T) programs do not provide direct services. The overarching goal of WE&T is to develop a diverse and well-trained mental heath workforce skilled in providing services to consumers and the community, and that understand the recovery and wellness philosophy.

Stanislaus County had seven WE&T programs operating during FY10-11 including two Training and Technical Assistance; two Mental Health Career Pathways; one Residency; one Internship Program; and one Financial Incentives Program. One action also provided for a WE&T Manager and support staff to implement the plan. Each program has a unique approach that incorporates MHSA values of cultural competency, community collaboration, wellness, recovery/resiliency, client/family driven services, and an integrated service experience for clients and their families.

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Overall progress includes delivery of training, establishment of stipend and fiscal incentive programs to support career pathways, and establishment of volunteer training as well as maintaining administrative structures that are in place to support management of long-term workforce development. WE&T programs are actively outreaching to support career pathways at several levels of secondary and post-secondary education.

The Workforce Development Council members are active implementation partners from community-based organizations, consumers and family members, BHRS Training Coordinator and BHRS Human Resources Director. The council is facilitated by the WE&T Manager. In FY10-11, the Workforce Development Council engaged in a process to consider a fiscal sustainability approach for WE&T programs as it is tied to statute. The discussion included a review of statute that states the funds are appropriated for a one-time, initial allocation to be used for Workforce Development. When the initial allocation is exhausted, funds for ongoing workforce development may come from Community Services and Supports – an MHSA component that is continuously appropriated. The discussion of fiscal sustainability included WE&T actions and objectives in the approved plan including budgets and expenditures. Data and outcomes were considered as a way to prioritize which actions are producing desired results allowing for some WE&T priorities to be modified a bit to ensure initial WE&T funding will continue through June 2014. Efforts to collect data that shows trends for participants and overall WE&T program effectiveness using Results Based Accountability Framework are being considered.

Project Budget & Expenditures	
FY 10/11 Total Requested MHSA Funds	**FY 10/11 MHSA Funds Expended**
$ 535,616	**$341,449***

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

WE&T - Consumer Family Member Training & Support

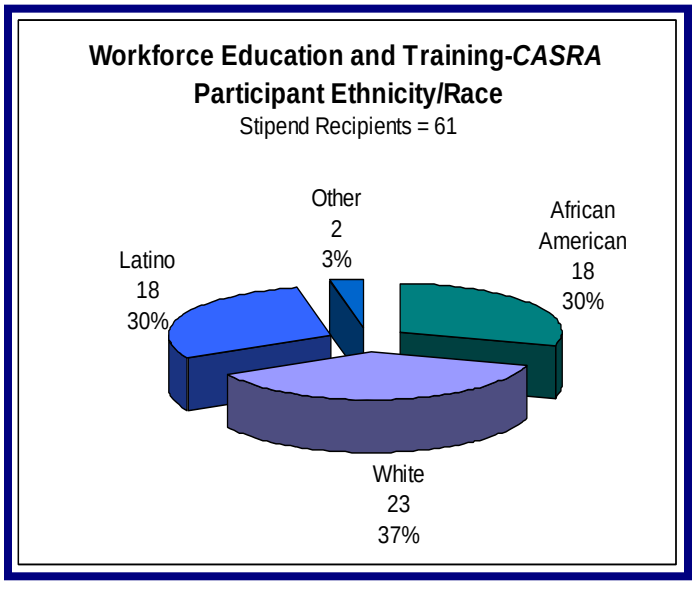
Operated in Human Resources and Training Division of Behavioral Health and Recovery Services in partnership with community-based organizations and Modesto Junior College

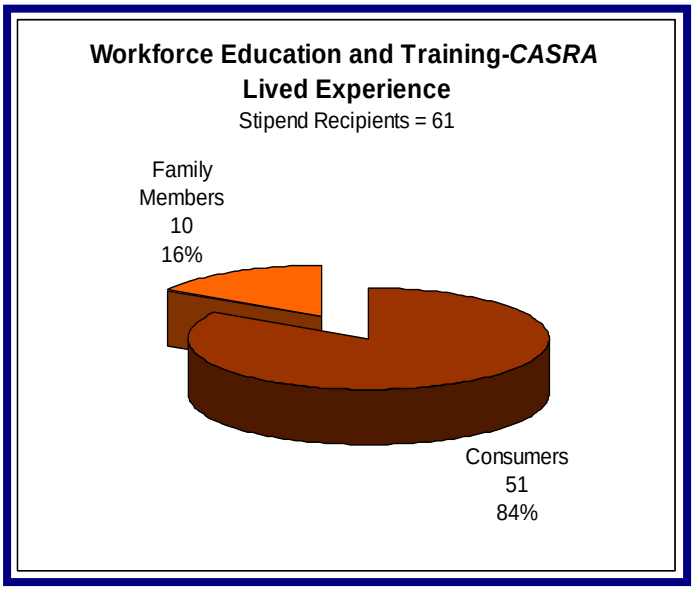
The initial community planning process and workforce needs assessment identified gaps and barriers in the employment of consumers and family members, despite a decade long history of recruiting and hiring consumers and family members. In order to bridge this gap, the Consumer and Family Member Training and Support program was established. Initially, it was developed to prepare consumer and family members in the basics of becoming employed in the public mental health system. Subsequently, it has evolved to include a priority to impact the work environment to be welcoming and incorporate the perspective of lived experience.

In FY10-11, training was offered to reduce stigma of mental illness in the workplace. The training entitled "Creating a Welcoming Workplace for Staff with Lived Experience" supports inclusion of the diverse perspectives and the need for consumer and family members to contribute their perspective in the workforce.

The California Association of Social Rehabilitation Agency (CASRA) course at Modesto Junior College provides a structure to integrate academic learning to real life field experience in the adult public mental health system. Sixty-one (61) students were recipients of the CASRA stipend. Other features of this program are a textbook loan program, bus passes, and ongoing peer support for CASRA students. This program was very successful in FY10-11.

Demographics





Highlights

The WE&T Manager attended the following community events in FY10-11 to promote WE&T programs:

- Schizophrenia Awareness Day - attended by 50 consumers/family members
- Day of Hope – attended by 80 consumers, family members, providers
- 2 college job fairs- MJC & CSU, Stanislaus – attended by 90 students
- 3 high school job fairs- Central Catholic High School, Occupational Olympics sponsored by Stanislaus County Office of Education – attended by 130 students

Community events offer a unique perspective that has shown that many individuals are students already studying for a career or have a budding interest in behavioral health. Personal conversations with individuals at job fairs can include a number of items such as types of occupations, pay scale, and qualifications required. This information is useful as individuals consider and plan their choices.

Example of Program Results Shown in RBA Framework	
• 61 CASRA students received education stipends in FY10-11 • 10 CASRA students were placed in field placement • 7 community events attended by WE&T staff • 350 individuals contacted through community events	How Much?
• 100% of CASRA stipend recipients have lived experience as consumers or are from diverse cultural backgrounds • The Welcoming Workplace for Staff with Lived Experience training included perspectives shared by consumer and family member staff	How Well?
• CASRA student comment: “Like in many Latino families, there is a stigma having depression. It was a weakness. I truly understand that depression is a treatable condition, not a failure for a person.” • Participant comment from Welcoming Workplace for Staff with Lived Experience: “Excellent training, the whole department would benefit!! For everyone to take this would help with unity and to break stigma!”	Is Anyone Better Off?

WE&T – Workforce Development

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

The overarching goal of training is to further MHSA essential elements throughout the existing workforce and expand capacity to implement additional components of MHSA. Training addresses a variety of key content areas that were identified during the planning process including but not limited to community collaboration skills, resiliency and recovery, treatment of co-occurring disorders, welcoming to the workplace consumers and family members perspective as a way to ensure an integrated service experience, and how to work with people from diverse cultures to ensure a culturally competent service experience. Training is designed with consumer and family member input and use consumer and family member trainers. Training is offered to BHRS and organizational provider staff as well as allied professions (e.g., educators and primary care providers) to enhance knowledge and skills, especially in the areas of recovery and resilience.

The following trainings were conducted in FY2010-2011:
a) Evidence based practice for youth with a first episode of mental illness
b) Suicide prevention and intervention for older adults
c) Solution focused brief treatment for individuals and families
d) Best Practice with youth with co-occurring AOD and mental illness: series of 3
e) Effective strategies for integrating peer staff in behavioral health for supervisors

Due to a limited budget for outside trainers, experienced and knowledgeable staff is relied upon to deliver and facilitate trainings. Participant evaluations of trainings are generally very good. In that spirit, BHRS and Center for Human Services became certified trainers in the California Brief Multicultural Competency Training curriculum and plan offered the first series of training in August of 2011.

Highlights

The Workforce Development Council and the BHRS Training Committee met on April 20, 2011, and on May 18, 2011, to review the BHRS strategic training plan to revise the WE&T 3 year training plan. The 3 year training plan was jointly developed by the Workforce Development Council & the BHRS Training Committee in 2009. Initially, the committee identified up to 5 trainings per year that focused on a system of care population, children and families, transitional age youth, adult, and older adult.

The training committee decided to postpone offering any additional culturally specific strategies training until all staff is trained in the California Brief Multicultural Competency Training (CBMCS). Training on community referral resources in Stanislaus County was also delayed in order to allow for development of Prevention Early Intervention (PEI) plan to be further implemented. The PEI plan includes a well-being promotion program called “Friends are Good Medicine” that includes a website that is a resource of self help groups in the community.

In FY10-11, BHRS embarked on a strategic and organizational long term transformation with four dimensions: community capacity building, results based accountability, fiscal sustainability and leadership. The Workforce Development Council revised the focus of the WE&T training plan to include

6 trainings that would support this transformation: 1) Community Capacity Building, 2) Results Based Accountability, 3) Fiscal Sustainability, 4) Leadership Development, 5) Resources in Stanislaus County, and 6) Effective Strategies for Integration of Staff with Lived Experience into Mental Health. These trainings will be offered to all BHRS staff, contract agency staff, and other interested community agencies and members in FY11-12 and beyond.

Example of Program Results Shown in RBA Framework	
• 7 trainings provided in FY10-11 • 177 BHRS and contractor staff attended	How Much?
• 68% of participants completed evaluations of training • 96% of participants reported improved understanding of the subject • 97% of participants reported improved skills • 95% of participants agreed training content included family/consumer perspectives	How Well?
• Comments from participants at trainings, "This training was so informative for me and has given me a better understanding when working with consumers." "This training has extended my understanding of the subject…" • "Great training and very helpful! Great focus on teens."	Is Anyone Better Off?

WE&T - Consumer and Family Volunteerism

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

This program specifically addresses the needs of consumers, family members, and diverse community members who wish to volunteer in the public mental health workforce. Efforts to creatively maintain a program that recruits, trains, and supports volunteers of all ages are ongoing.

In FY10-11, volunteer opportunities continued for fifteen California Association of Social Rehabilitation Agencies (CASRA) students from Modesto Junior College, referred to as 'field placements.' The placements were located in BHRS programs as well as community-based organizations. To support students' success, WE&T has volunteers who work under the direct supervision of the WE&T Manager. The volunteers offer a focus to students on how they can be organized to succeed in their studies, how being an effective student is preparation for future employment as well as practical hands-on support with enrollment and registration processes. These efforts can be critical for consumers and family members who are re-entry or first time college students. The volunteers distribute an orientation/welcome packet for new students, organize distribution of the WE&T loan program information, and maintain weekly drop-in hours in the WE&T volunteer office.

In FY10-11, Stanislaus County ended the contract with United Way of Stanislaus County. United Way was administratively responsible for registration, deployment, and record keeping for all volunteerism within all county departments including Behavioral Health and Recovery Services. In the transition, the WE&T manager became the coordinator of all BHRS volunteerism which necessitated that BHRS establish a way to comply with newly established volunteerism processes and procedures.

Highlights

To address these changes, a volunteer workgroup was developed to focus on policies and processes that would support successful implementation of the WE&T/BHRS volunteer program. An important aspect of the workgroup was to develop a 'decision tree process' to assist with identifying the type of volunteerism sought. Additional features of the 'decision tree' include location and type of volunteer e.g., community volunteer, field placements or internships. An online volunteer match page with Stanislaus County's webpage will streamline efforts and comply with County policy. Additionally, the need to have a Volunteer Liaison was emphasized and a plan developed to identify the specific type of role in the next fiscal year. The Volunteer Liaison has a key role in ensuring BHRS volunteer processes run smoothly for tasks such as registration of volunteers and technical support to processes related to volunteerism in the behavioral health system. In FY11-12, as volunteerism increases, further development of the role of a Volunteer Liaison will occur.

During the transition period from United Way to Stanislaus County of overseeing the Volunteerism Program, BHRS was still able to place 71 individuals in 10 different BHRS programs for a total of 4,002 hours.

Example of Program Results Shown in RBA Framework	
• 71 individuals in volunteer positions in 10 different BHRS programs • 5 volunteers placed in BHRS program sites • 10 CASRA student field placements	How Much?
• 100% of CASRA students completed field placement • 100% of 10 students in field placement have lived experience perspective to contribute	How Well?
• Volunteer comment: “Volunteering helped me learn to get my skills back. I was suicidal and homicidal when I was depressed. Now, I want to help others who were sick like me bounce back.” • Volunteer comment: “I am not just learning as a volunteer, I am also helping others. You just can’t lose when you are learning and giving.”	Is Anyone Better Off?

WE&T - Outreach and Career Academies

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

This action was established during initial community planning for WE&T in response to strong input regarding the need to acquaint students from diverse populations with career paths in mental/behavioral health. Two approaches continued to be implemented in FY10-11: Davis High School Health Career Academy and The Wellness Project, a junior high program offering interested students ways to experience mental health career introductions.

Davis High School Health Academy

The high school academy was very successful in FY10-11. Since the onset of the contract with Davis High School, six (6) scholarships have been available for students interested in pursuing psychology or behavioral health. The scholarship opportunity is available in the junior year when students may do a volunteer/field placement at a mental health site. Each year, one student has pursued the scholarship.

For the first time, Josie's Place (an MHSA-funded drop-in center for transition aged young adults) was selected as the mental health practicum site for the Health Academy students. The practicum session included a discussion panel of young adults who openly shared their lived experience as consumers. The academy students were deeply affected by hearing intimate and personal accounts from individuals of the same age. All of the practicum students reported their experience was an excellent learning experience.

Westside King Kennedy Neighborhood Collaborative Wellness Project

Mark Twain Junior High School participates in this project to provide junior high students with introductions to mental health careers. In FY10-11, six (6) junior high students (Asian and African American) volunteered to do an information table at an annual mental health recovery celebration called "The Day of Hope". At the celebration, the students used the information table as a method for outreaching to other students, family members, and others who were attending the community event. The learning experience for students is to celebrate recovery/wellness, reduce stigma about mental illness, and expand interest in a career in mental health.

Highlights

In FY10-11, the Academy Director of 20 years retired from Davis High School which created issues of continuity in this newly established partnership. The incoming Academy Director worked to make the transition and continued the planned classroom presentations and the practicum at a mental health program. Ongoing challenges include development of the mental health curriculum, maintaining ongoing communication and collaborative relationships with academy teachers, and encouraging freshmen and sophomores to consider behavioral health careers.

Example of Program Results Shown in RBA Framework	
• 1 BHRS program hosted 10 Health Academy students in their practicum rotation sites • 2 classroom presentations to Davis Health Academy psychology class by the WE&T Manager • 6 Junior High youth volunteered for the annual Day of Hope event at King Kennedy Memorial Center • One high school academy senior completed 40 hours of volunteerism at Josie's Place	How Much?
• 100% of academy students provided outstanding evaluations of their practicum experience at Josie's Place • For the first time, a mental health program was selected as a volunteer site by an academy student • 100% of six Junior High students were from diverse backgrounds	How Well?
• An academy student comment: "Highly informative, opened new doors and broadened my knowledge of mental health". • An African American student declared her intention to pursue psychology because the academy included a behavioral health component.	Is Anyone Better Off?

WE&T - Expanded Internship and Supervision Program

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

The community planning process identified challenges that need to be addressed by this action and acknowledged that the challenges are related to longstanding workforce shortages. Internships at all levels of educational experience are needed (high school, community college, baccalaureate and graduate levels). The barriers identified to adequate staffing for internship programs were similarly identified as barriers to ongoing supervision for professional development of pre and post-licensed staff.

In FY10-11, objectives of this action to expand internships and provide supervision were met through partnership with community organizations and academic institutions in the following ways:

- MSW/MA student's internships in public mental health system
- Clinical Supervisor Training Workshop on the MHSA essential core competencies for supervisors and staff to educate them about the MHSA elements
- Contracts with non-profit agencies (Sierra Vista Child and Family Services, Center for Human Services, Telecare, and Aspira Net) to provide clinical supervision to pre and post-licensed staff in their clinical settings
- Ongoing clinical supervision for MJC CASRA/ Human Services students in public mental health
- Providing practicum placement in public mental health for undergraduate nursing and LVN students from MJC and CSU, Stanislaus

Additionally, progress was achieved by developing a contract with CSU, Fresno that will offer preceptorships (a placement opportunity for specialty training in nursing) for primary care nurse practitioners interested in obtaining a certification in psychiatry. One nurse practitioner received a preceptorship with BHRS.

Highlights

Two key successes in FY10-11 to highlight:

1) The creation of a contract with CSU, Fresno for preceptorships for nurse practitioners. Stanislaus County can build on this success and potentially become a "magnet" for nurse practitioners who want to be certified in mental health. With the potential for future employment in our County, this accomplishment addresses a hard to fill position.

2) The Clinical Supervisor Training Workshop addresses inclusion of MHSA core essential competencies and establishes a systematized way to incorporate MHSA values into practice and agency culture. A significant dimension of this movement will be carried out by clinical supervisors who also hold management positions in their organizations. This training will support efforts to expand supervision knowledge about MHSA for professional development of pre and post-licensed staff throughout the mental health workforce.

Example of Program Results Shown in RBA Framework	
• 14 master's level MS/MSW students were placed in internships for clinical supervision • 1 Clinical Supervisor Workshop provided on the MHSA core essential competencies • 1 contract signed with CSU, Fresno to offer preceptorship for nurse practitioners to gain psychiatric certification	How Much?
• 140% of goal to place 10 master's level MS/MSW internship students was achieved when 4 additional students were placed • 56% (9/16) of participants in clinical supervisor training are managers/leaders in their organizations position • Nurse practitioner (African American) received preceptorship	How Well?
• Nurse practitioner commented that her perceptorship has both met her needs and has been extremely satisfying. She felt her supervision has been excellent and rotating with other psychiatrists has also been great. • Clinical Supervisor Workshop participants comments: – "Challenging (in a good way) our thinking about recovery." – "Issues were facilitated well."	Is Anyone Better Off?

WE&T - Targeted Financial Incentives to Increase Workforce Diversity

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

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

This Action proposes that financial incentives include educational scholarships and tuition and book reimbursement for BHRS and organizational provider staff working on Associate or Baccalaureate degrees as well as educational stipends for graduate masters level MS/MSW education. Stipends are provided for potential graduate level recruits who meet established criteria based on the assessment of 'hard to fill or retain' positions.

The MS and MSW stipends continued in this fiscal year through our existing contract with CSU, Stanislaus. BHRS awarded eight (8) stipends this year and seven (7) of the eight (8) recipients met desirable classifications for hard-to-fill positions identified in the WE&T plan workforce needs assessment.

BHRS assisted in submission of 24 loan repayment applications to the Statewide Loan Repayment Program. Ten (10) were awarded in Stanislaus.

Highlights

Through the MSW stipend and clinical supervision afforded by this WE&T program, one individual successfully gained employment as a mental health clinician. Job placement of this graduate into the mental health workforce validates not only the individual mastery of skill but also the intent of this and other WE&T programs.

The downturn in the economy continues to be a challenge in a key area of workforce development - there have not been many new job opportunities in the mental health workforce in FY10-11. In today's economy the WE&T plan includes more master's level stipends that are needed to match the number of opportunities available. As a result, the Workforce Development Council recommended a reduction in stipends for master's level students to mirror the current workforce outlook in mental health.

Significant progress in development of guidelines for Baccalaureate Degrees stipends was made in FY10-11. A number of meetings were conducted with the California State University Stanislaus and BHRS as well as a workgroup with the Workforce Development Council. Issues related to these stipends were discussed such as, how to structure stipends for full time staff and how to achieve paybacks. We hope Baccalaureate Degree stipends will be available in fall 2012.

Example of Program Results Shown in RBA Framework	
• Awarded 8 stipends: 4 MSW and 4 MS stipends, each to graduate students at CSU, Stanislaus • Stipend awards equal a total of $74,000	How Much?
• 100% of field placement students did an outstanding job and were successful in completing their field placement. • 87% of stipend recipients are from diverse populations: 3 bilingual Spanish, 2 African American, 2 with lived experience as consumer or family member.	How Well?
• 1 MSW/MS stipend recipient was hired as a full-time mental health clinician at Center for Human Services	Is Anyone Better Off?

Prevention & Early Intervention (PEI)

PEI was the third component of MHSA to be approved and funded in FY09-10. Extensive community planning that was built on lessons learned from earlier processes involved over 500 people, many of whom had not previously participated in MHSA stakeholder processes.

The presence of prevention and early intervention as a separate component of the Mental Health Service Act represents the biggest change in mental health planning and funding that had occurred in twenty years. Sometimes services may not look like conventional mental health services due to their emphasis on prevention and informal networks support. However, this component of MHSA has the greatest potential to reduce other costs such as costly and longer term mental health treatment, special education, welfare supports, and criminal justice costs as well as decrease the disparities in accessing services for unserved and underserved populations.

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

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

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

PEI Component Budget & Expenditures	
FY 10/11 Total Requested MHSA Budget	**FY 10/11 MHSA Funds Expended**
$ 5,396,828	**$3,251,500***

*Unexpended funds in the fiscal year are due to operating reserve, salary savings, and delays in program implementations.

PEI - The Community Capacity Building Project

Operated by Behavioral Health and Recovery Services in partnership with Stanislaus County Public Health Department, Aspiranet, Center for Human Services, Hughson Family Resource Center, Oak Valley Hospital District, Riverbank Unified School District, Sierra Vista Child and Family Services, West Modesto King Kennedy Neighborhood Collaborative and El Concilio.

Unique to the BHRS PEI Plan is the Result Based Accountability (RBA) framework that is the evaluation framework for every program. FY10-11 was the first full year of PEI program implementation and BHRS staff and staff from contracted programs participated in a series of trainings, community learning events, and 1-1 technical assistance consultations to begin mastering the core concepts of RBA and beginning to apply these concepts to their programs. It is anticipated that in FY11-12 and FY12-13 programs will begin to have RBA program performance measures with data to report, trends to follow, and real outcomes to show that people are better off.

The Community Capacity Building (CCB) Project activities were offered throughout the county in a place-based approach that includes community anchored, diverse settings, (e.g., schools, parks, community centers, family resource centers, community collaboratives, places of worship, etc.). Targeted communities are underserved cultural communities (Hispanic, Asian, African-American and LGBTQ) as well as communities that are geographically isolated due to transportation and other barriers. The project includes strategies to increase targeted communities' behavioral health capacity in the areas of (1) leadership development, (2) organizational capacity, and (3) community capacity. A primary focus of this project involves expansion of existing Asset-Based Community Development (ABCD) efforts and Promotores de Salud/Community Health Workers (P/CHW) programs. Typically these programs involve volunteer community members and paid frontline public health workers who are trusted members of and/or have an unusually close understanding of the community served.

Programs:

- **Asset-Based Community Development (ABCD):** Through this project, Behavioral Health and Recovery Services (BHRS) helps local communities develop and implement community-driven plans to improve and sustain the behavioral and emotional wellbeing of their members. To support these community-driven efforts, BHRS provides facilitation, planning, and data support to help communities track progress on their priority results over time, and some small, time-limited funding support to help jump start the community's actions.

- **Promotores and Community Health Workers (P/CHW):** Through this project, Behavioral Health and Recovery Services (BHRS) helps Promotores and Community Health workers play a critical role in promoting community-based health education and prevention, particularly in diverse, primarily Hispanic, communities underserved by the healthcare system across the United States. Promotores and Community Health Workers in all cultures represent a rich spectrum of characteristics that make them a natural bridge between healthcare institutions, professional providers, and community residents who are in need of healthcare services. As a result, they are able to provide culturally sensitive service, establish trust in the community, and receive feedback from communities.

Highlights

At the center of CCB is the idea that communities have both the capacity and will to act on their own behalf to improve behavioral health outcomes for their communities. BHRS launched this initiative by convening leaders and residents from multiple communities from throughout Stanislaus County and engaging in a dialogue about how communities can improve behavioral health in their communities.

Promotores/Community Health Worker (P/CHW)
BHRS fully funded nine communities to implement the Promotores/community health worker program providing support and technical assistance to first develop a scope of work based on individuals that had years of experience working within culturally diverse and ethnic communities. The nine Promotores/community health workers convened multiple times over the fiscal year to develop a plan and scope of work based on their years of experience working within the specific communities. In addition, the Promotores/community health workers convened residents within their community and developed multiple projects that focused on improving behavioral health and well-being for their communities. Projects included, lead support groups, community behavioral health event, mental health training, dance therapy groups, and many other community led efforts and events. The nine Promotores/community health workers were also trained by the California Institute of Mental Health (CIMH) in the Mental Health 101 and Promotora 101 training curriculum.

Asset-Based Community Development
BHRS launched the ABCD program by convening multiple leaders from throughout Stanislaus County to engage in a dialogue and conversation on how communities can act together to improve their well-being. BHRS hired a full-time behavioral health advocate to convene multiple meetings and to provide education and engage in a dialogue regarding the specifics of community-based well-being efforts. The ABCD program convened over 60 community meetings with over 700 people in attendance providing training on the ABCD program and the specific resources, and in addition, the commitments from community leaders and residents needed to initiate a project.

In addition, BHRS convened and started two new community collaboratives focused on improving behavioral health and well-being in the Grayson and South Modesto communities. Both communities did not have an existing community collaborative and were identified as geographic regions where behavioral health outcomes have not been addressed in recent years. South Modesto was selected in partnership with local law enforcement and education partners as a prime location due to a gang injunction designation recently made by local enforcement.

The Grayson community collaborative has experienced early success in convening community meetings with well over 60 people participating. Residents have stated this is the first time in their recollection that these many people have been engaged in community work and conversations. In addition, South Modesto residents have begun to lead community improvement efforts focused on shifting the perception of their community from one of gangs and drugs to individuals that really care about their neighborhood. This community recently partnered with an international organization called "Run for Peace" to sponsor a 5 kilometer “fun run” through their neighborhood.

South Modesto and Grayson community members have begun to organize themselves to respond to future funding opportunities to improve behavioral health in their communities.

BHRS provided potential contractor outreach workshops and engaged leaders throughout these communities prior to initiating a request for proposal process offering opportunity for community collaboratives to develop and implement small community projects, based on Asset-Based Community Development model, to improve behavioral health and well-being within their communities. BHRS felt it was of utmost importance to provide training and to create a dialogue with community leaders on how best to implement this community-based strategy.

In FY11-12, BHRS will provide training and funding for communities to develop plans to improve behavioral health and well-being within their geographic area. The funding strategy is based on the ABCD model where small amounts of contract funding are allocated for multiple projects within a geographic area. After key training and collaborative development support, BHRS expects to support these regions in developing community driven plans and find multiple small well-being projects Individuals from four geographic areas made commitments to lead community capacity building efforts in their communities (West Modesto, Hughson/South East Stanislaus County/Grayson and Wesley/South Modesto).

Example of Program Results Shown in RBA Framework	
• 502 individuals served through well-being groups by P/CHW • 400 agencies/community supports contacted in an asset mapping process • 9 Spanish-speaking support groups added to the Friends are Good Medicine Directory • Approximately 230 community members recruited • 359 community residents and leaders from throughout the County received training and education on ABCD model • 58 community meetings in nine geographic regions in the County convened by ABCD • 2 new community collaboratives in South Modesto and Grayson started by ABCD • ABCD has commitments from leaders and initiated planning process within four communities • 63 BHRS/partner agency staff trained in CCB models and practice • 25 Individuals trained in Results Based Accountability Model • 21 community, BHRS, and agency staff trained as RBA Trainers	How Much?
• BHRS developed ABCD program training materials • 50% (4/8) communities agreed and made commitments to ABCD partnership • P/CHW developed Contract Scope of Work and Workplan for 2011/2012 • 9 P/CHW trained through CIMH Core Mental Health training (32 Hours) • 9 P/CHW trained in Asset-Based Community Development & Results-Based Accountability	How Well?
• **“**This project has awakened the leadership of these young people. They’re forging their way into adulthood and they’re integrating themselves in the city, helping keep up the streets, supporting the wellness of each other, and completing group tasks together. They’re blossoming into responsible young men and women, and I’m so proud of each one of them.” - Oakdale Promotora • “This project has given me a group of women as friends. As we were putting together the Women’s Day Celebration, I thought, after this I’m out… but then, I realized that there are so many women who have nowhere else to turn, and I found	Is Anyone Better Off?

myself saying… I don't want to stop, I can't stop – there are many other women and mothers like I was before, and I want to be there for them as we were here for each other." -Patterson Promotora

- **"**Coming to the dance therapy gives me the strength to continue my day, I get out of here with so much energy and a smile in my face." - Ceres Promotora

PEI - Emotional Wellness Education/Community Support

Operated by Behavioral Health and Recovery Services and on contract to Imagen, LLC

Programs

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

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

Highlights

The Mental Health Promotion Campaign (MHPC):
In FY10-11, Stanislaus County Behavioral Health and Recovery Services released an RFP to seek partnership with a public relations and marketing firm that resulted in a contract with Imagen, LLC, a locally based firm to implement this three year mental health promotion campaign.

Implementation began with seeking guidance from a group of local stakeholders in various types of community leadership roles. The intent was to consider best strategies to engage broad community interest in emotional health and well-being from their unique leadership perspective. This unique stakeholder group was drawn from community leaders, business leaders, and local elected officials. The group met four times over two months with Imagen consultants and the PEI Manager to provide leadership insights on how to engage the community interest in mental health promotion and developed themes for the campaign slogan. Following this process, additional stakeholder input was sought through 60 Key Informant Surveys with a broader group of community stakeholders such as, faith-based leadership, additional business leaders, and other key community representatives.

Imagen, LLC consultants conducted a variety of technical assistance workshops with 16 PEI program representatives. These workshops were valuable in providing baseline information on the marketing needs and service strategies offered by PEI programs. Imagen, LLC consultants worked with BHRS PEI programs to create several collateral pieces of marketing and promotion information for PEI programs, including 8 new advertisements for Area Agency on Aging implementer of PEI programs for older adults, 2 BHRS-PEI newsletters, 8 logo designs for the Friends Are Good Medicine program and a variety of invitation design pieces for the stakeholder process. All the processes conducted produced information that contributed to the overall marketing and communications plan.

Friends are Good Medicine Program (FGM):
In FY10-11, this program was operational for half of the fiscal year with one part-time staff assigned and accountable to the PEI Manager. In this time, efforts were focused on mapping existing peer support groups throughout Stanislaus County. Outreach to over 150 peer support groups was accomplished and features of the groups such as hours and locations as well as detailed explanations of the type of support group offered were confirmed and documented for the database.

Next phase of implementation involved development of a website with a search feature for the entire database of support groups. Searches may be conducted based on location of the group e.g. which town, issue addressed e.g. faith/spirituality, and languages spoken e.g. Spanish groups.

Peer support group facilitator training and consultant activities began in FY10-11. The training is offered monthly in day and evening times for accessibility. Consultation and support is available for individuals who want to start a peer support group. FGM staff worked in collaboration with other PEI programs to update the directory with Spanish-speaking and faith/spiritual based or support groups.

Example of Program Results Shown in RBA Framework	
• 35 community stakeholders convened for promotion campaign • 60 Key Informant Interviews with key community leaders members • 8 Area Agency on Aging ads created • 8 draft logo redesigns for Friends are Good Medicine • 16 PEI programs provided with marketing and outreach consultation • 43 people trained as peer support group facilitators • 150 peer support groups confirmed and mapped in Stanislaus County • 32 page Support Group Directory was developed • 1 Friends are Good Medicine website was developed • 45 individuals were trained in Mental Health First Aid	How Much?
• 95% (36/38) of participants in Friends are Good Medicine group facilitator training responded favorably to “My understanding has improved as a result of the training” • MHPC stakeholders included diverse communities and family members and consumers of mental health services.	How Well?
• Comment from Friends are Good Medicine group facilitator training: “I am glad to have a lot more knowledge of this subject and feel more confident about co-leading a group.” • 92% (35/38) participants in Friends are Good Medicine group facilitator training responded favorably to “My skills have improved as a result of the training”	Is Anyone Better Off?

PEI - Adverse Childhood Experience Interventions

Operated by Behavioral Health and Recovery Services and on contract to Parents United/Child Sexual Abuse Treatment Team, Sierra Vista Child and Family Programs and Center for Human Services

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

Programs:

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

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

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

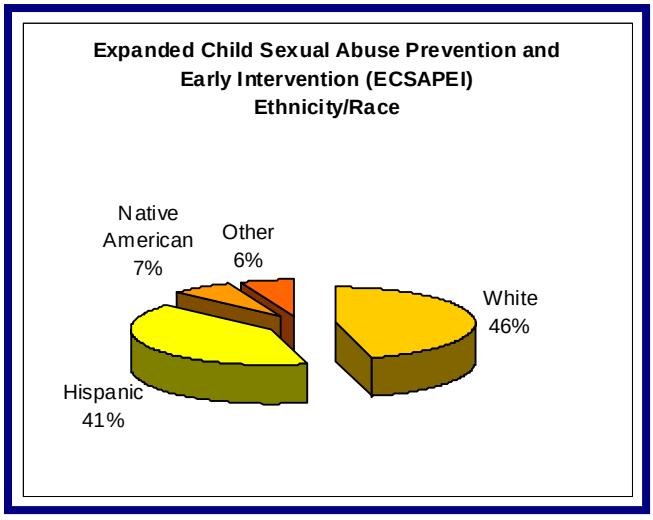
Highlights

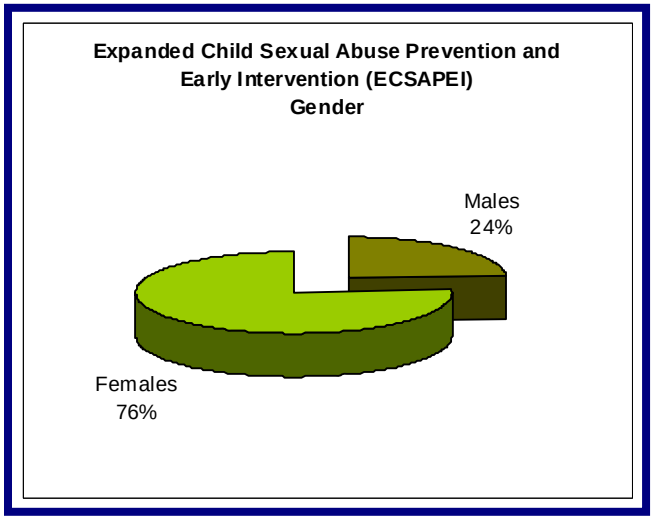
Aggression Replacement Training (ART)
Initially, implementation of this program focused on a community-based approach that would teach and strengthen the capacity of community partners to provide ART groups in their communities and leverage existing assets and resources. BHRS PEI staff provided training and support for implementation to approximately 99 community-based facilitators in the ART model. Through these partnerships, BHRS co-facilitated services to approximately 125 youth. As implementation progressed issues arose related to sustaining the groups and adhering to the fidelity of this evidence-based model. Though all partners worked diligently to the build skills and knowledge necessary, ultimately it was clear that fidelity to the model was a barrier to community-based implementation. The program was re-focused and is to be based as an extension of the MHSA Juvenile Justice program serving youth on informal probation. In FY11- 12, ART program will be expanded to provide groups in alternative education school sites in addition to County's Juvenile Hall facility with an additional feature of a peer support model. The intent is to include a focus on building youth leadership skills.

In June 2011, a youth leadership summit was held with over 250 youth participating. Youth leaders highlighted their efforts within communities as viable options for interventions for youth at risk for juvenile justice involvement and other behavioral health issues. In addition, BHRS has partnered with school districts and the Gallo Center for the Arts to provide preventative education using the dramatic arts as a medium to reach over 8000 students with messages on suicide prevention and stigma reduction.

Expanded Child Sexual Abuse Prevention and Early Intervention (ECSAPEI)
In FY10-11, ECSAPEI continued to provide a 24-hour, 7 days a week hotline and outreach services to offer support for victims of sexual abuse with the additional capacity of Spanish language call takers.

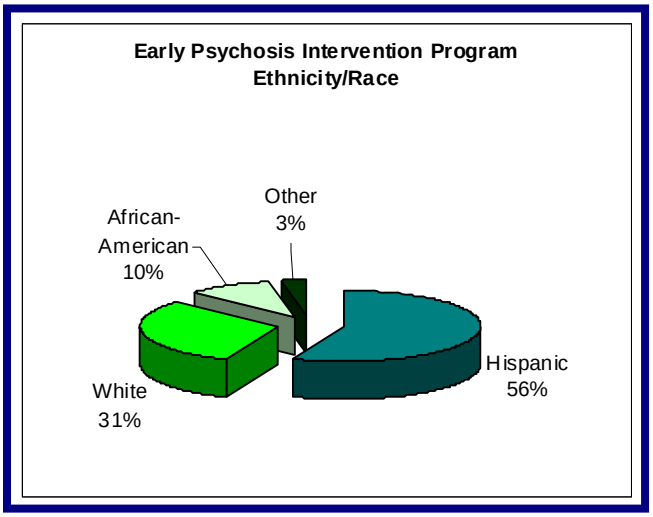
Parents United provided education on how to identify signs and symptoms of child sexual abuse and how to prevent and protect children to approximately 1000 individuals. In addition, the program continues to provide treatment and support groups targeting individuals within the Spanish-speaking community.

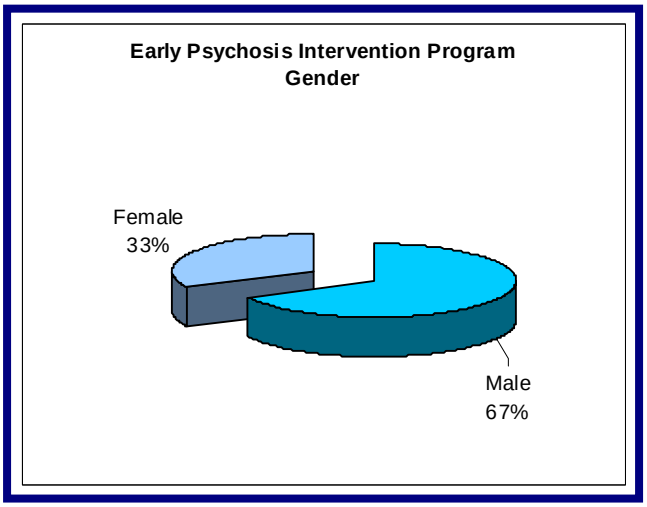




Early Psychosis Intervention: LIFE Path

In the second half of FY10-11, Early Psychosis Intervention Program began to offer services. The first six (6) months of implementation involved identifying qualified clinical staff. To properly implement this highly sophisticated clinical service program, the treatment team received several intense trainings provided by the Early Assessment and Screen Team based out of Portland, Oregon. As initial training occurred, this early intervention team began to conduct community outreach to educate and promote understanding of the program. Towards the end of FY10-11, the program began serving young adults through the initial screening process. Twenty-five (25) youth were screened, four (4) entered into initial early intervention/treatment services.

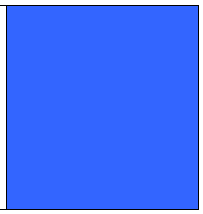




Example of Program Results Shown in RBA Framework	
• 99 group facilitators trained in the ART model • 138 youth serving providers trained in Resiliency Models • 128 ART youth groups conducted in community and juvenile justice settings • 8,000 students attended 'Ophelia Lives' a theatrical presentation with suicide prevention and stigma reduction messages • 40 youth planned first Behavioral Health Youth Summit focused on youth educating the community and leaders on best practice approaches in reaching youth at-risk for juvenile justice involvement and behavioral health issues • 250 youth attended the Behavioral Health Youth Summit held in West Modesto • 1,000 people received education from ECSAPEI on prevention of and signs of sexual abuse • 25 youth assessed for early psychosis intervention services	How Much?
• 56% of participants in LIFE Path are Hispanic • 41% of service recipients are Hispanic in ECSAPEI	How Well?
• Comments from Life Path participants: • "I really enjoyed the club and working with other students. I would like to keep participating in this club because it helps us in many ways and gives us ideas about our future." • "I liked this program. It helped with things and it's just a cool place to get to know people. I believe Life Path helped a lot with things I didn't know about; jobs and such."	Is Anyone Better Off?

- Comment from ART Participant:

“Having the opportunity to be involved in a youth leadership program like this has helped me to become so much more outspoken and it has helped me make so many new friends that have the same goal as me; to help the community become a better place for everyone ----“A” 17 years old



PEI - Child and Youth Resiliency and Development

Operated on contract to
Sierra Vista Child & Family Services, The Bridge Community Center, Hughson Family Resource Center - Youth Connection, Center for Human Services - Patterson Teen Center, West Modesto Leadership for the Future - Project Uplift

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

Programs:

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

    - Sierra Vista Child and Family Services- The Bridge Community Center
    - Hughson Family Resource Center - Youth Connection
    - Center for Human Services - Patterson Teen Center
    - West Modesto Leadership for the Future - Project Uplift

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

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

Highlights

Leadership and Resiliency Program (LRP)
In FY10-11, BHRS funded four youth leadership programs reaching out to diverse and cultural communities. The programs are primarily targeting youth in the African-American community, Southeast Asian community, and outlying rural communities of Patterson and Hughson where access to youth services is minimal. The youth leadership programs provided mentorship opportunities, meaningful opportunities to serve in the community; career planning, academic support and exposure to cultural arts and music intended to increase resiliency, and protective factors within the lives of

program participants. These new and exciting programs focused on recruiting and training a base of youth leaders and building the administrative and supportive infrastructures for thriving programs.

In FY11-12, the programs are expected to continue to grow and increase the number of individuals served and creating the necessary key partners to reach and serve the target population.

Children are People Program (CAP)
In FY10-11, CAP began implementation by seeking partnership with two elementary schools that have Healthy Start programs onsite; Orville Wright and Fairview. The CAP curriculum was implemented as originally designed as a psycho-educational, problem-solving program designed to address in a small group setting, the problems of children in third through fifth grades who are exposed to family substance abuse. Eight to ten (8-10) weeks of sessions include opening and closing exercises and a topic for learning/discussion that addresses a specific psychosocial concern children may encounter.

Early on, feedback from school partners and parents suggested that the curriculum needed to be revised and broadened to achieve a universal prevention approach to child resiliency. The program was adjusted to include 40 Developmental Assets education, classroom-based activities focused on strengthening assets and protective factors and away from a specific family substance abuse/addiction focus. The process now includes providing education on assets and strengths children inherently have and leading them through a planning process focused on improving that behavioral health and well-being of their classroom or community. Subsequently, teachers and parents have praised the program and have communicated noticeable outcomes in the lives of their children. This success is a result of the partnership sought by program staff with the initial challenges. By seeking input from schools, parents, and kids to revise the approach, an improved working relationship, trust, and sense of community was achieved.

Example of Program Results Shown in RBA Framework	
• 97 youth served by LRP • 207 children participated in CAP group and individual services • 35 parents participated in CAP group and individual services	How Much?
• 25% of services serving South Asian Youth • 25% of service serving African American Youth	How Well?
Youth Leadership and Resiliency participant's comments: • "Being a part of the Bridge Youth Builders helped me get a job with the county as a Youth Leadership Specialist." – Youth participant from The Bridge • "Hughson Youth Connection (HYC) is more accepting of diversity, more accepting of people in general and promotes tolerance and builds self-confidence." Youth participant in Hughson Youth Leadership Focus Group • "Being in a program like this has helped me become so much more outspoken and it has helped me make so many new friends that have the same goals as me, to help the community become better for everyone." – Youth participant at The Bridge • "My class began sharing their feelings and opening up more." – Teacher comment following CAP classroom presentations	Is Anyone Better Off?

PEI - Adult Resiliency and Social Connectedness

Operated by Behavioral Health and Recovery Services in partnership with community-based organizations and on contract to National Alliance on Mental Illness (NAMI)

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

Programs:

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

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

- **Adult Arts Resiliency & Social Connectedness:** This program is intended to support community members, especially those with a mental illness or co-occurring disorders, in developing their artistic craft and finding an outlet for their creative abilities through art in all forms. These activities will raise public awareness and acceptance of the creative talents of people living with mental illness or co-occurring disorders who are involved in the arts (e.g., painting, film, photography, sculpture, music, literature, and drama). These artists will engage other adults in the community to organize creative workshops and other activities that promote resiliency and social connectedness. Stakeholders' interest in providing these opportunities suggests that family members and adults who receive services and others will benefit in sharing their interests and mutual support based on creative interests. Activities may include operating a drop-in art studio that holds exhibitions, writing workshops, performance rehearsals, and other artistic activities.

Highlights

In Our Own Voice (IOOV)

In FY10-11, the local NAMI chapter continued to effectively implement the In Our Own Voice program. The highlight of this year was the recruitment and training of four Spanish-speaking presenters that started to work immediately in the Patterson and Westside of the County. The program continues to enjoy increase access and new volunteers willing to help spread the anti-stigma messages of the IOOV

program. Most recently, IOOV has partnered with the Promotores/Community Health Worker to provide presentations in private residences for Spanish-speaking individuals. These presentations have resulted in individuals from the Spanish-speaking community sharing their stories of their struggles with mental illness and now trained to share their story of recovery with others in their community.

Faith/Spirituality-Based Resiliency and Social Connectedness (F/SRC)
In 2010/2011, the F/SRSC program was partially funded with one staff assigned part-time to begin developing a strategy on how to effectively implement the program. In this time, BHRS partnered with faith-based community leaders to convene a collaborative focused on increasing and improving faith-based supports for people struggling with behavioral health issues. Originally called the Stanislaus County Faith-Based Behavioral Health initiative, the group has since taken on its own identity as Recovery Modesto. The collaborative represents over 40 different faith-based efforts that serve an estimated 1,600 people on a monthly basis through various recovery and support groups.

Also in 2010, the group mapped all of the faith-based recovery supports in Stanislaus County and uploaded them to the Friends are Good Medicine online directory. In addition, the group organized Mental Health First Aid training for their program staff. Self-help group facilitators were trained to provide faith-based recovery support group at the county's alcohol and other drug treatment residential center as well as various community settings throughout the County. In 2011/2012, the program's staff time will be expanded to continue support for efforts such as Recovery Modesto and initiating new efforts in other faith-based and spiritual tradition communities.

Adult Arts Resiliency & Social Connectedness
In 2010, BHRS sought potential contractors to implement this program by releasing a Request for Proposal (RFP). At the end of the process - no proposals were received.

Feedback from local agency partners and community arts organizations was helpful in deciding next steps. Additionally, BHRS had numerous other PEI programs in early stages of implementation in 2010. Considering these variables, the RFP was not immediately re-released and an approach was developed; wait for 6-12 months, do some outreach education designed to engage the potential contractors in the community, re-release same or revised RFP in FY11-12.

Example of Program Results Shown in RBA Framework	
• 1302 individuals served by IOOV • 1 Faith-Based Recovery Group started at Stanislaus Recovery Center • 26 faith/spirituality peer supports groups added to Friends are Good Medicine Website	How Much?
• 5 Spanish-speaking trainers with lived experience recruited and trained by IOOV	How Well?
• Comment from a leader in faith based community: "Most of the problems we face as a community have their origins in addiction. The Faith based recovery initiative provides a collaborative opportunity for people to serve and change lives. It is a living testimony to the fact that government and the faith community can partner and truly make a difference."	Is Anyone Better Off?

PEI - Older Adult Resiliency and Social Connectedness

Operated on contract to Stanislaus County Area Agency on Aging and Veteran's Affairs

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

Programs:

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

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

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

Highlights

Implementation began in July 2010 with training, establishment of data collection methods, marketing and outreach efforts, and start of service delivery.

Training is critical to successful implementation of these programs for all sub-contracting agencies, and clinical support staff including a psychiatrist and a licensed Marriage, Family Therapist. Community-based agency partners attended the PEARLS training from the University of Washington where PEARLS was originally developed. Training for Senior Peer Counseling was addressed by seeking guidance from the statewide Senior Peer Counseling organization and San Joaquin County where a well developed program exists. Through this technical assistance and training, an effective training model was adopted and the first classes for volunteer peer counselors were conducted in September 2010 and May 2011.

Senior Center With out Walls (SCWW) of Northern California was helpful with training and the establishment of the local program. The ability to utilize their toll-free number and programming facilitate a smooth start-up and training of Senior Info Line staff that would assist with registration and encourage seniors to use the call line for phone-based social support and interaction.

Marketing and scheduling of community presentations were critical to early implementation activities. This effort began by scheduling presentations to announce the start of new PEI programs to professional groups serving older adults. The fact that the new programs would be free to seniors and provided in the comfort of their own homes was very well received.

New marketing materials for PEARLS and "Peer 2 Peer" were developed as well as a "Project Hope" tri-fold brochure that included brief information about all the PEI programs and the Friendly Visitor volunteer social visits available to adults 60 or older. The PEARLS and Project Hope Brochures were translated into Spanish. Area Agency on Aging Agency's well established Information & Assistance "Senior Info Line" provides bilingual staff and was included in all materials. For general community information and promotion of the programs, The Modesto Bee printed two articles about the PEI programs for older adults in FY10-11; December 24, 2010 "Seniors Gain Listening ear of a peer" was featured. Subsequently, on January 2, 2011 Modest Bee published a brief follow-up article entitled "Programs to Assist Seniors Launched".

A challenge in implementation became apparent early on when home-bound seniors did not engage in seeking social support through the SCWW program. Feedback from potential participants lead to a simple revision in approach that includes: pairing enrollment with an already successful approach called "Friendly Visitor Program", working to localize the "feel" of the program as well as developing SCWW as a collateral support program for PEARLS, Senior Peer Counseling and Friendly Visitor program participants.

Example of Program Results Shown in RBA Framework	
• 30 community presentations were conducted in FY10-11 • 92 older adults assessed by PEARLS • 44 older adults enrolled in PEARLS services • 19 new peer counselors provided peer support • 23 older adults received support from senior peer counselors	How Much?
• 48% (44/92) of older adults assessed were enrolled in services • 86% (18/21) of senior peer counselors completed training • 67% (12/18) senior peer counselors who completed training volunteered for at least one year	How Well?
• PEARLS participant comment: "She (PEARLS staff) helped me think of ways to meet daily challenges rather than feel sorry for current situation or dwell on the "negative", but rather on potential "positive". • PEARLS participant comment: "Before the program, I had contemplated taking my life several times but meeting and changing things a little bit at a time I could see things can get better and I had hope again"	Is Anyone Better Off?

PEI – Health/Behavioral Health Integration

Operated on contract to Stanislaus County Health Services and Golden Valley Health Clinics

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

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

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

Highlights

In FY10-11, two implementing partners were identified through a county-wide Request for Proposal process; Golden Valley Health Clinics (GVHC) and Stanislaus County Health Services Agency (H.S.A). Both organizations had established behavioral health programs with years of experience providing mental health treatment services in primary care health clinics.

The intention of this project is to expand these services and increase access to early intervention services to under/unserved populations in primary care settings where people access their healthcare services. Both contractors expanded their programs to provide these behavioral services to include depression screening for patients and brief intervention services (low intensity and short duration).

In seeking potential partners for this project, BHRS specifically looked for providers that could service the West County and East County regions as BHRS has reduced mental health treatment service sites in these areas in the past few years. In response to this identified need, GVHC is implementing the program in clinics located in Turlock, Patterson (serving the West County) and Modesto. H.S.A. is implementing the program in clinics located in Hughson (serving the Southeast County region) and Ceres.

Both partners are employing behavioral health clinicians who have mental health and substance abuse competency and knowledge of evidence-based behavioral assessments and interventions relevant to medical conditions (e.g., disease management, treatment adherence, and lifestyle change) as well as consultation liaison skills.

Example of Program Results Shown in RBA Framework	
• Approximately 3000 Stanislaus County residents received behavioral health services in a primary care setting through this project • 6 clinics are part of this project	How Much?
• 70% of patients who received behavioral health services through the PEI behavioral health integration project did not have any previous contact with Stanislaus BHRS • 100% (9/9) medical providers responded favorably to the survey question “How helpful would you rate the consultation process between you and behavioral health providers?” (extremely helpful (4 responses) – pretty helpful (5 responses)	How Well?
• 60% of patients with a depressive disorder who received treatment improved! • Medical Provider comment in survey: “The most important aspect of our clinic's integrated behavioral health programs is that we are attempting to meet the medical/behavioral needs of our patients. Working together with the medical staff, maintaining communication about our patients treatment plans, increases our ability to better meet the needs of our patients.	Is Anyone Better Off?

PEI - School-Behavioral Health Integration

Operated on contract to Center for Human Services, Sierra Vista Child and Family Services and National Alliance on Mental Illness (NAMI)

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

Programs:

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

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

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

Highlights

In FY10-11, BHRS funded this project in December of 2010 and subsequently programs primarily focused on start up activities. Two community partners are funded to implement two different approaches to Student Assistance and School-based Consultation Program. One partner, NAMI, is implementing Parents and Teachers as Allies at multiple academic sites in secondary and post secondary education.

The Nurtured Heart Program (NHA)
The Nurtured Heart Program, a Center for Human Services contract program, is being offered at Las Palmas and Apricot Valley elementary schools within the Patterson Unified School District.

Early implementation involved hiring and training of lead teachers, lead parents, school administrators, and Center for Human Services staff. The Nurtured Heart Approach (NHA) training is a two-day intensive, followed by multiple education sessions for others provided by school staff, parents, and program staff on the NHA model. Everyone within the school and within the parent community, are trained in the Three NHA Components; 1) Refusing to energize negativity, 2) Super-energizing success, 3) establishing and implementing clear limits and consequences. Teachers and program staff begin to work together to implement the model within classrooms. In addition, mental health clinicians begin to provide screening and early intervention services for students whose behavioral health needs arose beyond the interventions of the NHA. Teachers made adaptations to their classroom involving supplanting practices and positive recognition. Almost all staff implemented praising their classrooms and found it surprising how enthusiastically the students responded.

Creating Lasting Student Success (CLaSS)
The CLaSS Program, a Sierra Vista Child and Family Services contracted program, offered at Modesto City Schools sites; Robertson Road, Harriet Kirschen, and Luther Burbank elementary schools. Of the two school behavioral integration programs, the CLaSS program has a less “prescriptive” approach to school behavioral health integration.

The CLaSS approach began by providing education to program and school staff on the model that strives to see students succeed in the home, at school, and in the community. It is built upon strength-based and evidenced-based practices that have proven results. It was important to ensure that all the partners understood the difference between behavioral health consultative approaches and direct provision of mental health services for children in school settings. Assessments, screenings, and interventions for children experiencing very serious mental health issues were immediately available from CLaSS program staff. Simultaneously, CLaSS staff began to provide consultation to school staff that included behavioral health interventions on the schoolyard and assistance in learning to provide supportive environments within the classroom for children who have serious emotional disturbances.

Parents and Teachers as Allies (PTA)
Parents and Teachers as Allies was fully funded for the 2010/2011 fiscal year. Challenges were present due to budget cuts and limited staff availability, school administrator’s reluctance to take teachers away from the classroom or to allow time for non-curriculum focused presentations. As a result, the program has been challenged to schedule one hour sessions for school staff. After working diligently to network throughout the many school districts in Stanisluas County, build appropriate partnerships with school administrators, and revise the PTA presentation to 45 minutes, the program was able make some in-roads and begin to provide education for 109 educators at three locations. PTA will continue in FY11-12 and is expected to increase the number of presentations and school sites they serve.

Example of Program Results Shown in RBA Framework	
• 60 students received services from NHP • 485 participants (147 adults, 20 children ages 0-5, 318 children ages 6-17) received services from CLaSS • 109 individuals received training from PTA • 4 trainers recruited and trained by PTA	How Much?
• Baseline indicators for evaluation of NHA program established through surveys from 1,029 students, parents, and staff • 100% of PTA trainers have lived experience as consumer or family member	How Well?
• "…witnessed a wonderful transformation in one of my most challenging students" --- Comment from 1st grade teacher at Apricot Valley. • "…implementing the nurtured heart approach has been refreshing and energizing. My class and I are embracing (the practice of) catching what is going right!" -- Comment from 5th grade teacher. • Comment from School Principal participating in CLaSS: "I'm very thankful for Sierra Vista Child and Family Services and their positive impact it has had in our local communities and at Robertson Road Elementary. The students and families of our school face many challenges due to a variety of circumstances, yet the have benefited greatly from the consistent on-site support this year through Sierra Vista. It is imperative that our schools continue to collaborate with local agencies to provide on-going support to the children and families in need of assistance."	Is Anyone Better Off?

Technological Needs Projects (TN)

Initially, stakeholder input was obtained for use of Capital Facilities/Technological Needs (CFTN) funds and the decision was made to devote all CFTN funds to technological needs. As a result, there are no Capital Facilities projects to report on in this or subsequent annual reports.

The overarching goal of technological needs projects is to support modernization of information systems and increase consumer/family empowerment by providing the tools for secure access to health and wellness information. These projects will result in improvements in quality of care, operational efficiency, coordination of care, and cost effectiveness. In FY10-11, Stanislaus had two projects in early implementation, 1) Electronic Health Record and 2) Consumer Family Access to Computing Resources. Service recipients, family members, and contract organizations were and continue to be involved in ongoing processes related to development, planning, and implementation of projects.

Electronic Health Record System implementation is a massive endeavor that reaches to every part of BHRS' service system. All support areas (such as billing) are affected and all face-to-face contacts between service recipients and providers are touched by this new method of keeping health records confidential and accessible. Key phases of early implementation were completed in FY10-11 or significantly started. For example, documentation of all workflow processes is complete, lead staff or "super user" training began, data conversion phases were piloted.

Consumer Family Access to Computing Resources Project is providing computers, printers, and access to internet for service recipients in service locations throughout the county since December 2010. Plans to hire two (2) Technical Support Technicians who will provide support and training to users at service sites were in development. Additional computers at more service sites are scheduled to be deployed.

In FY2010-11, the Youth Advisory Council at Josie's Place gave input on how to expand this project to focus on transition age youth and their unique uses of social connectivity for recovery and wellness support.

Project Budget & Expenditures	
FY 10/11 Total Requested MHSA Funds	**FY 10/11 MHSA Funds Expended**
$ 2,453,442	**$1,035,267***

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

Highlights

Electronic Health Record System - as anticipated, the new system "went live" on January 1, 2012.

Planning for two (2) additional projects; Electronic Health Data Warehousing Project and Document Imaging Projects began in 2011. Since they did not exist in FY10-11, there is no progress to report in this update.

Example of Program Results Shown in RBA Framework	
• 2 Technological Needs projects are underway • 1 Electronic Health Record Readiness Survey completed with BHRS staff • All clinical assessment forms were reviewed and revised to accommodate the new E.H.R. system • 10 computers, 2 printers, 2 internet connections set up in 4 service sites for consumer/family member access	How Much?
• All quarterly progress reports to State DMH were submitted • Both projects are within budget and on schedule • Quarterly newsletter published to communicate E.H.R. updates to staff • Job descriptions for Technical Support Technician in development • Network of Care website configured on all computers to support service recipient access to wellness information	How Well?
• Youth comment from stakeholder meeting: "Everyone had an opportunity to give their input" • Youth comment from stakeholder meeting: "There are many resources out there."	Is Anyone Better Off?

Some parts of our system have MHSA-funded projects such as Technology Needs that do not regularly collect or have formal sources of data to answer the question, "Is anyone better off?" There are exiting data sources available about their work that demonstrate "how much?" and even "how well?" they are doing.

We can cite examples of ways that service providers and recipients will be better off with an electronic medical record system such as, eliminating the wait for a paper medical record during an unplanned or emergency service situation.

When these BHRS programs begin to implement Results-based Accountability, we will need to develop data sources to effectively assess and tell the story of the impacts. This is the data development stage, and such work is typically a first step all programs take to integrate a focus on results into their daily operations.

Innovation (INN)

Innovation funding is unique and intended for projects that will seek to demonstrate ways to increase access to underserved groups, increase the quality of services including better outcomes, promote interagency collaboration, and increase access to services. The primary focus of innovation projects is learning and contributing to practice – not service delivery. Services may be delivered as a means to achieve the learning object proposed but Innovation funds may not be used to sustain the service after the learning project is completed. Innovation projects are expected to contribute to learning in the mental health field by introducing new approaches, making a change to an existing mental health practice or introducing a new application of a promising community-driven approach that has been successful in a non-mental health context.

Innovation projects are developed through input from community planning processes that are inclusive and representative of diverse community members. Stanislaus County's first innovation project: Evolving a Community-Owned Behavioral Health System of Supports and Services was approved in September 2010.

Evolving a Community-Owned Behavioral Health System of Supports and Services is an innovation project designed to develop and learn from stakeholder processes that are designed to enable community and county partners to join BHRS leaders in developing an integrated, financially sustainable behavioral health system committed to results.

Focused on promoting interagency (and community) collaboration, this 3 year project was designed to explore new approaches to stakeholder processes that would impact the following areas:

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

Implementation began in FY10-11 with a significant amount of preparation prior to starting stakeholder meetings. Part of the learning objective involved developing effective ways to inform stakeholders of the complexities of numerous funding streams at BHRS, regulations for use of categorical funds, flexible funds, and contingency planning required in public agencies. The initial phase of the project addressed preparation for and design of stakeholder processes to achieve essential revisions to the Community Services and Supports (CSS) plan and to FY2011-12 AOD budgets.

CSS Budget Process: Initially, the project began with discussion about CSS funding due to the need for reductions in the CSS plan that would achieve sustainable expenditure levels. An approach was taken to deepen the understanding of BHRS funding streams and CSS budget issues as they had not previously been discussed in stakeholder meetings. A key aspect involved how reductions, eliminations, and consolidations would affect sustainability in the coming years.

A 'Key Informant Process' was convened that included members of a variety of key stakeholder groups including members of the Representative Stakeholder Steering Committee, Mental Health Board members, NAMI, service recipients, representatives of diverse communities, BHRS Senior Leadership Team (SLT), and BHRS accountants. Two meetings were convened, August 31, 2010

and September 14, 2010. The BHRS Senior Leadership Team and accountants developed a detailed presentation that contained information designed to educate key informants on BHRS MHSA budget streams, structures, and planning. Information included a review of current budget challenges in public mental health funding, key aspects of a sustainable level of funding BHRS had committed to in the coming years, recommendations for CSS program consolidations, elimination and other administrative efficiencies. The meetings involved a rich discussion that resulted in more shared understanding of two key issues: 1) the adaptive dilemma we face in public mental health funding and 2) stakeholder input on program reductions that would go forward.

AOD Budget Process: The next part of phase included inviting stakeholder groups that had not participated in planning processes in the past as well as those who were very familiar with MHSA stakeholder processes. Participants included people in recovery, family members, community leaders, faith-based leaders, non-profit providers, private sector service providers; BHRS staff members, union members, BHRS Senior Leadership Team members, senior leaders from other county agencies, representatives from the County CEO's office, representatives from the Advisory Board on Substance Abuse Programs (ABSAP) and the Mental Health Board, and others. Each stakeholder group selected delegates and alternates to represent them in this process.

Eight (8) meetings were held between November 30, 2010 and March 2, 2011. Average attendance at these sessions was well over 60 people including delegates, alternates, and observers. In the early stages of the process, participants worked to understand the details of the AOD budget, the reasons for the projected shortfall, the diversity of services and supports available across the county to people who struggle with alcohol and other drug issues, the scope and focus of the BHRS-funded services most impacted by the budget reductions, and the available data about numbers of people served and the quality of the services provided by BHRS staff members and others.

Participants worked to develop principles to guide deliberations. They then reviewed cost and service level scenarios for various programs and worked through small and large group processes to develop multiple iterations of their recommendations. After several rounds of deliberations, delegates engaged in a series of conversations to understand where they had agreement and where they had divergence. Ultimately, delegates approved by consensus the set of recommendations that would be sent to BHRS leadership for consideration.

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

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

Early Lessons Learned: These first efforts allowed us to test various process designs aimed at educating community members and stakeholders about budget and program design issues within the realities of regulatory requirements and revenue constraints. A first year lessons learned document will be produced in early FY11-12.

At the end of the first phase of the project, BHRS leadership team had learned that three key elements of this project needed to be addressed before the process could move productively into the broader scope of all including all BHRS budgets; 1) more internal work with staff needed to happen in order to better support the next iteration of the process, 2) changes at the state budget process would need to be resolved and 3) statewide changes in MHSA statute/guidelines would need to be resolved. At the end of FY10-11, the project was "paused" in order to assess the process, make revisions, and prepare for the next year.

INN Budget & Expenditures	
FY 10/11 Total Request MHSA Funds	**FY 10/11 MHSA Funds Expended**
$ 534,860	**$231,624***

*Unexpended funds in the fiscal year are due to operating reserve, salary and other cost savings, and delays in implementation of RFP processes for community based projects.

Highlights

Planning for Innovation in FY10-11:
The BHRS leadership team has the intention to fulfill the opportunity and bring out ideas for projects in behavioral health that are unique to efforts in our county. To begin the process, stakeholder input was sought prior to innovative project development or release of requests for project proposals. In the spring of 2010, stakeholder input was solicited to begin to identify areas that could significantly move forward our learning. By identifying these areas named "learning edges" a refinement of the focus of innovation in Stanislaus County was achieved.

Subsequently, community program planning included county-wide outreach workshops to share, discuss, receive input, and assist stakeholders who may opt to propose project ideas in the next phase of Innovation planning. With the goal of assisting more stakeholders to participate fully, BHRS conducted six (6) orientation workshops in five (5) locations around Stanislaus County: Modesto, Riverbank, Ceres, Patterson and Turlock with the intention to deepen community understanding of the uniqueness of potential innovation projects, the learning edges proposed, and the upcoming Request for Proposal (RFP) process that would lead to the selection of projects to be implemented. In the fall of 2010, sixty-eight (68) stakeholders participated in these workshops. Following the outreach workshops, Stanislaus County General Services Agency released a RFP in early 2011.

An RFP review process was then conducted and nine (9) new Innovation projects were selected to be funded. Projects did not begin implementation until FY11-12. Selected projects are listed alphabetically and described below:

Project Name and Implementing Contract Agency	Contribution to Learning/Practice
Arts for Freedom - Peer Recovery Arts Project	Focused on increasing quality of services, including better outcomes for individuals of all ages. This project has a mission to learn and demonstrate how an emphasis on what people *can* do rather than what they *cannot* do through artistic expression will reduce stigma so that people can be identified as something

Project Name and Implementing Contract Agency	Contribution to Learning/Practice
	other than their illness or diagnosis. The project will help support and accelerate county-wide transformation by connecting people receiving services to community-based supports.
Beth & Joanna Friends in Recovery – National Alliance for Mental Illness (NAMI)	Focused on increasing quality of services including better outcomes for consumers of mental health services. This project pairs two individuals, a peer: someone who has mental illness and/or co-occurring substance issues, is isolated and needs/seeks support with a pal: someone successfully utilizing recovery practices related to their mental illness and/or co-occurring substance issues. This project will seek to demonstrate that peer support can be effective when offered in the community and parallel to treatment as a short term mentor/mentee relationship. The project will help support and accelerate county-wide transformation by connecting people receiving services to community-based supports.
Building Support Systems for Troubled Children – Ceres Partnership for Healthy Families	Focused on increasing the quality of service and creating better outcomes for troubled youth through a family resource center-based mentoring program that integrates school, community, and family support systems to increase developmental assets in troubled youth ages 7-11 yrs. This project collaboration, will seek to learn and demonstrate new approaches to supporting families with pre-adolescent aged youth who are experiencing behavioral struggles are at risk for higher incidences of involvement in substance abuse and other health/mental health compromising risk behaviors but not necessarily able to access the traditional mental health service system – nor do they necessarily need it. By focus on building developmental assets early the project can demonstrate ways for youth to avoid lifelong involvement with publicly funded systems. The project will help support and accelerate county-wide transformation by addressing the learning priority of improving the well-being of children.
Civility School Learning Project – Center for Human Services	Focused on increasing quality of services including better outcomes by creating ownership of “social culture” at Keyes Elementary and Spratling Middle School in students, classroom teachers, parents, and campus staff through campus-wide introduction of

Project Name and Implementing Contract Agency	Contribution to Learning/Practice
	civility activities and strategies. The project seeks to contribute to practices that will have a positive impact on school campus culture, increase children's developmental assets and strength-based social connections, engage parents and improve their constructive communication with the school personnel, increase teacher/school personnel productivity and develop positive partnerships on behalf of children, and the overall positivity of campus culture. The project will help support and accelerate county-wide transformation by addressing the learning priority of improving the well-being of children.
Connecting Youth Receiving Services to Community-Based Supports – Sierra Vista Child and Family Services	Focused on increasing quality of services including better outcomes with secondary foci of promoting interagency collaboration. Youth will be recruited to participate from those who are currently receiving services at Sierra Vista Child and Family Services, the Drop in Center Family Resource Center (FRC), the North Modesto/Salida Family Resource Center, the Hughson Family Resource Center, and the Bridge. The project seeks to contribute to practice by learning how to assist mental health clinicians in thinking about incorporating recovery and resiliency based approaches and de-stigmatizing community-based activities into treatment, and connecting youth to community based activities that may reduce length of time and intensity of treatment. The project will help support and accelerate county-wide transformation by connecting people receiving services to community-based supports and service providers to become more facile in linking their clients to information and support for more holistic approaches to well-being.
Families in the Park – West Modesto King Kennedy Neighborhood Collaborative	Focused on increasing access to underserved groups through an innovative approach in a culturally specific way of outreaching to young African-American families who spend their days from April to November in West Modesto's Mellis Park. Locating the project in the untypical and accessible location of the familiar neighborhood park is the first step in a culturally specific approach as the park is a place where families feel relaxed and comfortable.

Project Name and Implementing Contract Agency	Contribution to Learning/Practice
	Mental health problems that contribute to lack of success in school (and later life) can be directly linked to lack of preparation for school, lack of effective parental support to attend school regularly and ongoing lack of internal resources (developmental assets) during the school years. It is anticipated that a significant number of parents/guardians and some children who will participate in the project will be identified as having mental health/behavioral needs that contribute to this problem throughout the lifespan. This project seeks to contribute to learning culturally specific way of outreaching to young African-American families with pre-school children that are currently unserved and experience significant barriers to connecting with needed mental health services and increasing school readiness. The project will help support and accelerate county-wide transformation by improving the well-being of children
Integration Innovations – Stanislaus County Health Services Agency	Focused on increasing the quality of services including better outcomes, for adult and older adult individuals of all cultures, and ethnicities who receive medical and psychiatric care in a primary care clinic setting. Stanislaus County needs a project like this to increase the quality of services offered to medically high-risk populations, including uninsured and underinsured individuals who have psychiatric illnesses and/or substance abuse issues co-occurring with chronic disease such as diabetes and hypertension. Access to peer supports is not currently included in primary care service delivery and has the potential to achieve better outcomes for overall well-being including health and mental health. This project will help support and accelerate county-wide transformation by connecting people receiving services to community-based supports and expanding treatment options for people struggling with both substance abuse and mental illness.
Promoting Community Wellness – Tuolumne River Trust	Focused on a new community-based approach that proposes to increase access to underserved groups through a combination of family-oriented outdoor programming and capacity for resident-led neighborhood improvements as “therapies” to address

Project Name and Implementing Contract Agency	Contribution to Learning/Practice
	wellness issues in the Airport Neighborhood. Traditional approaches to addressing mental wellness issues tend to focus on treating the patient and the symptom without dealing with the physical conditions that often contribute to illness. Yet research tells us that environment, both where we live and how we perceive our surroundings, plays an important role in our overall health. The project has a mission to learn what methods change a community's attitude toward and connection with its natural and urban environments as well as come to embrace the important role nature has in the overall increase in health and vitality of its residents. The project will help support and accelerate county-wide transformation by connecting people receiving services to community-based supports and improving the well-being of children.
Revolution Project – Center for Human Services	Focused on promoting interagency and community collaboration. Revolution Project seeks to engage adults who own businesses or have other civic leadership roles to learn what it takes to resolve existing conflicts with youth from nearby schools and build partnerships that transform mental health in the rural, underserved Westside community of Patterson. It is expected that increasing youths' high expectations and opportunities for meaningful participation will lower the incidence of involvement in substance abuse and other health/mental health compromising risk behaviors as well as increase youths' resilience, mental and emotional wellness, and academic success. This innovative project seeks to attract the interest of youth and adults from diverse cultures and ethnic groups throughout Stanislaus County and create a new model for youth leadership in civic-minded roles as a way to improve the emotional and mental wellness of youth through strengthened relationships. The project will help support and accelerate county-wide transformation by improving the well-being of youth.

Example of Results Shown in RBA Framework	
• 10 Innovation projects are underway in Stanislaus County • Approximately 60 people participated in innovative budget project meetings • Sixty-eight (68) stakeholders participated in outreach workshops in preparation for the RFP release.	How Much?
• Participants in innovative budget process reported in feedback forms, experiencing high degrees of trust, safety, and mutual respect in the process. • 9 Innovation projects are based in learning objectives that build community and agency capacity to support wellness, recovery and stigma reduction • A participant comment from outreach workshops in preparation for RFP release: "Handouts, presenters, open and constructive dialog all excellent."	How Well?
• Participant comment from innovative budget process meeting: "I really appreciate how open this whole process is. It makes me feel like my opinion really counts…" • Participant comment from outreach workshops in preparation for RFP release: "I learned more details about the intention of this "project" and about what is required for proposals to be approved."	Is Anyone Better Off?