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

June 3, 2015

Mental Health Services Oversight and Accountability Commission (MHSOAC)
1325 J. Street, Suite 1700
Sacramento, CA 95814

RE: MHSA ANNUAL UPDATE FOR FISCAL YEAR 2015-2016

Dear Colleagues:

Attached please find our Mental Health Services Act (MHSA) Annual Update Fiscal year 2015-2016 for Stanislaus County.

This Annual Update was developed to include a progress report on all MHSA-funded programs and projects. The document incorporates MHSA values, Behavioral Health and Recovery Services (BHRS) Mission and Vision, and valuable input from community stakeholders.

In addition, the document for review by the Mental Health Services Oversight and Accountability Commission (MHSOAC) includes four areas in which funding will be augmented or used to start up new endeavors. The funding for the projects has been approved by MHSA Representative Stakeholder Steering Committee and the Stanislaus County Board of Supervisors.

Per statute AB 1467, we are required to submit Annual Updates and Plan Updates to the MHSOAC. We would appreciate an acknowledgement that you have received this document.

The Annual Update was posted for a 30-day public review and comment period from March 24, 2015 - April 22, 2015. During that period, one informational workshop was held on March 25, 2015. A Public Hearing was conducted by the Stanislaus County Mental Health Board/Advisory Board on Substance Abuse Programs joint meeting on April 23, 2015.

On June 2, 2015, the Stanislaus County Board of Supervisors adopted and certified the Annual Update. It authorized the Auditor-Controller to certify that the fiscal requirements had been met. The document was signed by the Auditor Controller and the Behavioral Health Director on June 2, 2015.

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

Sincerely,

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

cc: Dan Rosas

Enclosure

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** June 2, 2015

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

SUBJECT:

Approval to Adopt the Mental Health Services Act (MHSA) Annual Update for Fiscal Year 2015-2016 and Authorize the Behavioral Health Director to Submit the Annual Update to the Mental Health Services Oversight and Accountability Commission; and Related Actions

STAFF RECOMMENDATIONS:

1. Adopt the Fiscal Year 2015-2016 Mental Health Services Act (MHSA) Annual Update.

2. Authorize the Behavioral Health Director or her designee to sign and submit the Annual Update for Fiscal Year 2015-2016 to the Mental Health Services Oversight and Accountability Commission (MHSOAC).

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

(Continued on Page 2)

FISCAL IMPACT:

The services described in this Annual Update are funded through the State Mental Health Services Act. Appropriations and estimated revenue are being increased by $1,440,000 to $31,798,359 for Fiscal Year 2015-16 compared to $30,358,359 in Fiscal Year 2014-15. This increase is due to the creation of three new programs, which are described in the Annual Update, and the California Mental Health Services Authority (CalMHSA) Statewide Prevention and Early Intervention contribution.

(Continued on Page 2)

BOARD ACTION AS FOLLOWS:

No. 2015-249

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

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

MOTION:

Christine Ferraro

ATTEST: CHRISTINE FERRARO TALLMAN, Clerk

File No.

STAFF RECOMMENDATIONS: (Continued)

4. Authorize funding for California Mental Health Services Authority (CalMHSA) for Statewide Prevention and Early Intervention in the amount of $90,000.

5. Amend the Salary and Position Allocation Resolution to reflect the recommended changes outlined in the staffing impacts section, effective the first pay period after Board of Supervisor' approval.

FISCAL IMPACT: (Continued)

Funding for the three new programs and CalMHSA is allocated as follows:

- $150,000 for Workforce Education and Training (WE&T) – staff training and community workforce development;
- $800,000 for Innovation (INN) – Full Service Partnership (FSP) Co-Occurring Disorders Project;
- $400,000 for Technological Needs (TN) – to expand the evaluation of program outcomes; and
- $90,000 for CalMHSA Statewide Prevention and Early Intervention projects.

There is no General Fund impact associated with this request.

DISCUSSION:

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

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

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

- Updates are required to be adopted by the County Board of Supervisors and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days after adoption; and

- All Plans and Updates are required to include:

  - Certification by the County Mental Health Director to ensure county compliance with pertinent regulations, laws and statutes of the Act, including stakeholder engagement and non-supplantation requirements, and

  - Certification by the County Mental Health Director and the County Auditor-Controller that the county has complied with any fiscal accountability requirements and that all expenditures are consistent with the Act.

Behavioral Health and Recovery Services (BHRS) held Representative Stakeholder Steering Committee (RSSC) meetings on January 30, 2015 and February 27, 2015 to review the content of the Annual Update to determine stakeholder approval of the proposals. Board members were also interviewed regarding their priorities for the use of MHSA funds. The priority areas included reductions in suicide rates, incarceration, stigma, and emergency room visits. In addition, prevention and expanded efforts to address homelessness were priority areas. The Annual Update was then posted for public review and comment on March 24, 2015. A Public Hearing was held by the Mental Health Board on April 23, 2015. No comments were received during the 30-day review and comment period.

During the Mental Health Board Public Hearing, two comments were received from members of the audience. Both members were family members of individuals with serious mental illness. One spoke of her family member with serious mental illness and co-occurring physical illness. She was critical of the shortage of services in the County, especially in a rural area on the west side of the County, and encouraged the Department to develop Program for Assertive Community Treatment (PACT) teams for seriously mentally ill individuals who are difficult to engage and appear to also have medical problems. The other family member with comments is the parent of an individual with co-occurring mental illness and substance use issues. She wanted to see more outreach services to individuals living with these issues.

It was clarified that a Full Service Partnership (FSP) is an Assertive Community Treatment (ACT) team. In part, the proposed Innovation project related to the development of an FSP focused on individuals living with serious mental illness as well as a co-occurring substance use issue will be very close to, if not the same as, a PACT team. Similar to a PACT, this FSP will have a primary care component to it. The team will provide outreach to individuals with co-occurring illnesses, including those that are hard to engage. Also, in September 2014, the Board of Supervisors approved a

Request for Proposals for additional outreach and engagement services to rural communities. This contract should also address concerns about services in the rural west side of the County.

There were no substantive changes to the draft Annual Update document circulated during the 30-day review and comment period. The report was reformatted to make it easier to read and follow. Some additional details were provided for the Innovation projects approved by the RSSC and the Stanislaus County Board of Supervisors on September 30, 2014 in the Plan Update brought to the Board on that date. Additional details were also added with regard to the newly proposed Innovation project described in this Annual Update.

BHRS uses the Results Based Accountability (RBA) framework to measure program outcomes. This framework is designed to answer the question, "Is anyone better off?" by measuring how much was done, how well it was done, and what was the outcome. The attached report details outcomes in this format by each MHSA program.

The following table below highlights three specific outcomes of the four intensive Full Service Partnerships programs, which are the highest, most intensive level of intervention.

Days Homeless*:

Program	# Days 12 Months Prior to Enrollment	# Days Post Enrollment (Annualized)	% Reduction
Homeless Outreach	14,864	1.978	87%
Integrated Forensics	3,202	1,185	63%
High Risk & Senior Access	4,498	308	93%
Totals	**22,564**	**3,471**	**81%**

* Homelessness is not tracked by the Juvenile Justice program.

Days Incarcerated:

Program	# Days 12 Months Prior to Enrollment	# Days Post Enrollment (Annualized)	% Reduction
Homeless Outreach	1,989	677	66%
Juvenile Justice	1,204	844	30%
Integrated Forensics	4,223	867	80%
High Risk & Senior Access	568	31	95%
Totals	**7,984**	**2419**	**68%**

Days Hospitalized:
(Psychiatric*)

Program	# Days 12 Months Prior to Enrollment	# Days Post Enrollment (Annualized)	% Reduction
Homeless Outreach	2,873	582	80%
Integrated Forensics	428	99	77%
High Risk & Senior Access	1,064	177	83%
Totals	**4,365**	**858**	**80%**

* Days Hospitalized (Psychiatric) were not tracked for the Juvenile Justice program.

The proposed Annual Update includes funding to enhance several currently funded projects or components as well as startup funding for one new Innovation project.

The proposed funding for Prevention and Early Intervention (PEI) continues the support for the Statewide PEI Initiatives that include *Know the Signs* Suicide Prevention campaign, *Each Mind Matters* Anti-Stigma campaign, and the Student Mental Health Initiative. Stanislaus County has benefited from the State's efforts in all these areas, These projects address suicide prevention and stigma reduction on a scale that no one county could accomplish. No additional staffing is requested for these existing programs.

The proposed new funding for the Workforce Education & Training (WET) component of MHSA will enable BHRS to offer additional staff trainings and community workforce development. Suicide Prevention, Collaborative Documentation, Trauma-Informed Care, Assertive Community Treatment, and High Intensity Homeless Outreach and Engagement Best Practices are among the County trainings to be offered. Training in suicide prevention is both for the population at large as well as more specialized training for professionals. The engagement techniques expand efforts to deal with homelessness among the most difficult to engage individuals. No additional staffing is requested for these existing programs.

The proposed additional funding for the Technological Needs (TN) component is to be used for Evaluation and Outcomes to build additional infrastructure for new and expanded MHSA programs. This augmentation will fund three additional staff, as addressed in Staffing Impact. BHRS has 64 MHSA programs and needs staffing to adequately maintain and develop data systems to track, retrieve, and analyze data. This comes as the MHSOAC introduces new, stringent reporting requirements for Prevention and Early Intervention and Innovation components. Having meaningful outcome data is also a clear requirement at the state and local levels, including the Board of Supervisors.

The proposed funding for the new Innovation program will support the development of a Full Service Partnership (FSP) project aimed at individuals living with seriously mentally illness challenges as well as co-occurring substance use disorders. Much like PACT models in other states, the project will also insure that treatment and primary care are provided to address potential health risks as well as reducing homelessness, criminal justice involvement, acute psychiatric hospitalizations, and institutionalization, all in alignment with Board priorities. This is a three year project with a total budgeted amount of $1,098,979 for the first year of which $800,000 will be MHSA Innovation funds. Federal Financial Participation (FFP) funds generated by medically necessary Medi-Cal services provided by this FSP program will offset a portion of the full program cost and allow for some Innovation money to be used in year two of operation. Years two and three would be sustained by FFP and MHSA funding. Funding for outcome data gathering and analysis is being built into the overall MHSA proposal. A total of six positions are requested for this FSP project and are addressed in the Staffing Impact.

Though the funding proposed for new and expanded projects in this Annual Update is primarily for county-operated programs, the intent is to maintain the current percentages of county-operated and contracted programs. Currently, the 52% of the programs are county-operated and 48% are contracted. Planning is now ongoing for a Plan Update, which will be brought to the Board of Supervisors in late August or early September. It is expected that the projects proposed in that Plan Update will be primarily subject to a Request for Proposal process.

POLICY ISSUE:

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

STAFFING IMPACT:

The Department is requesting the following positions to support the new Full Service Partnership Co-Occurring Disorders Project:

- Three Behavioral Health Specialists II, who will engage clientele to assess the need for treatment services, demonstrate/utilize crisis intervention techniques, provide 1:1 and group counseling, and provide training to new staff regarding phase-based and mental health treatment.

- Two Mental Health Clinicians, who will provide Co-Occurring Disorder recovery education and treatment, conduct Comprehensive Mental Health Assessments, strategically build and maintain relationships with community partners across the county, participate in a wide range of community collaborative and capacity building

efforts, and provide education to reduce stigma. One of the new positions will be a Coordinator.

- One Administrative Clerk III, who will provide orientation, training, and oversight of work performed by clerical staff and volunteers, create reports, data-base entries, correspondence, and standardized forms of a difficult and sensitive nature from written or recorded sources, and accurately maintain operational records and filing systems

The Department is requesting the following positions to support the expanded Evaluation and Outcomes program:

- One Systems Engineer, who will maintain security and access rights to data collection and reporting systems/tools, set up and maintain virtual server infrastructure, and monitor server and network performance to ensure a proper level of data accessibility.

- One Software Developer, who will work with Performance Measurement staff to determine data needs for MHSA program evaluation, develop and maintain data collection systems, including the integration of evaluation instruments for MHSA programs, and provide technical assistance and training for data collection systems.

- One Staff Services Coordinator, who will assist with the development of MHSA program evaluation plans, coordinate the implementation and monitoring of plans provide technical assistance for the development of MHSA program performance measurements, data collection, and data analysis, provide results and recommendations based on the data.

CONTACT PERSON:

Madelyn Schlaepfer, Ph.D., Behavioral Health Director Telephone 525-6205

StanUp for Wellness!

Support Mental & Emotional Health

Stanislaus County
Behavioral Health and Recovery Services

Mental Health Services Act
Annual Update FY 2015-2016
June 2015

Stanislaus County
Striving to be the Best

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

TABLE OF CONTENTS

Stanislaus County Behavioral Health and Recovery Services (BHRS)

MHSA Planning Office

800 Scenic Drive

Modesto, CA 95350

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

MHSA COUNTY COMPLIANCE CERTIFICATION

County/City: Stanislaus

☐ Three-Year Program and Expenditure Plan
☑ Annual Update

Local Mental Health Director	Program Lead
Name: Madelyn Schlaepfer, Ph.D, CEAP	Name: Dan Rosas
Telephone Number: (209) 525-6205	Telephone Number: (209) 525-5324
E-mail: mschlaepfer@stanbhrs.org	E-mail: drosas@stanbhrs.org
Local Mental Health Mailing Address: 800 Scenic Drive Modesto, CA 95350	

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan or Annual Update, including stakeholder participation and nonsupplantation requirements.

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on Tuesday, June 2, 2015.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached annual update are true and correct.

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

Madelyn Schlaepfer 6-2-2015
Signature / Date

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION[1]

County/City: Stanislaus

☐ Three-Year Program and Expenditure Plan
☒ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director	County Auditor-Controller / City Financial Officer
Name: Madelyn Schlaepfer, Ph.D.	Name: Lauren Klein, CPA
Telephone Number: (209) 525-6205	Telephone Number: (209) 525-5673
E-mail: mschlaepfer@stanbhrs.org	E-mail: kleinl@stancounty.com
Local Mental Health Mailing Address: 800 Scenic Drive Modesto, CA 95350	

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

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

Madelyn Schlaepfer, Ph.D.
Local Mental Health Director (PRINT)

Madelyn Schlaepfer 6-2-2015
Signature Date

I hereby certify that for the fiscal year ended June 30, 2014, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated 2014 for the fiscal year ended June 30, 2014. I further certify that for the fiscal year ended June 30, 2014, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

Lauren Klein, CPA
County Auditor Controller / City Financial Officer (PRINT)

Lauren Klein 6/2/15
Signature Date

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

Message from the Director

"There is no power greater than a community discovering what it cares about."
- Margaret Wheatley, Author

Stanislaus County cares about the mental health of its residents. Funding from the Mental Health Services Act (MHSA) has allowed us to better serve our community and provide needed mental health services to dramatically change lives.

This year's Annual Update reflects our ongoing work and commitment to improve the public mental health system. Our recovery driven programs and services are truly client driven and family focused. In fact, many consumers and family members provided information for our report. We are thankful to them for sharing their incredible stories of health, hope, and resilience.

Behavioral Health and Recovery Services (BHRS) also wishes to recognize members of the MHSA Representative Stakeholder Committee, Mental Health Board, and representatives of partner agencies and community based organizations. Their support and assistance helped guide the development of our planning process to help create this document. We also want to acknowledge the work of BHRS employees for their leadership to fulfill the mission and vision of MHSA.

As an agency, we **Stan**d **Up** for wellness in our community to support mental and emotional health for all residents of Stanislaus County.

MHSA is helping us to stand tall.

Sincerely,

Madelyn Schlaepfer, Ph.D, CEAP
Director

Mental Health Services Act (MHSA) Overview

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

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

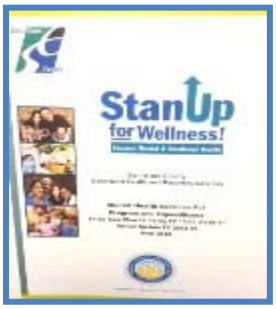
MHSA is made up of 5 components:

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

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

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

Annual Update Overview



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

This report summarizes Stanislaus County's progress in implementing services funded by the Mental Health Services Act (MHSA) and highlights activities during the period July 1, 2013 through June 30, 2014. In addition, the report provides an overview of programs and expenditures that make up the scope of services for each of the MHSA components.

Each plan must also be developed with feedback from community stakeholders. It must also include a public review/comment period and a public hearing conducted by the Stanislaus County Mental Health Board.

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

Demographic Profile at a Glance

Named for the Stanislaus River in the Central Valley, Stanislaus County is located in the heart of California's Central Valley.

It encompasses more than 1,500 square miles in size with a mix of rural, agricultural areas and urban communities along the Highway 99 and Highway 5 corridors.

The city of Modesto is the county seat and the largest city in the county.

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

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

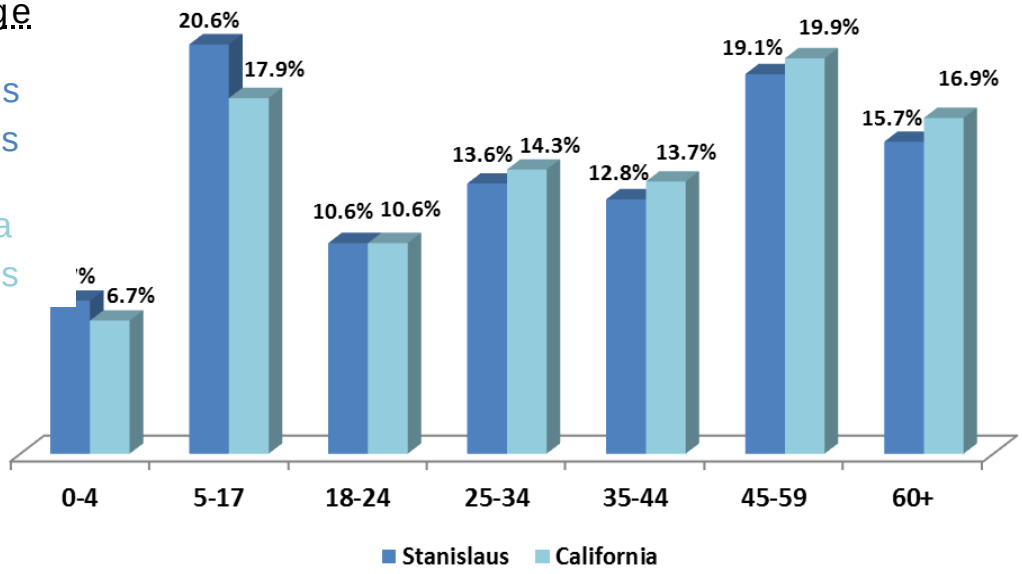
Age[1]

(percentage of residents by age category)

Median Age

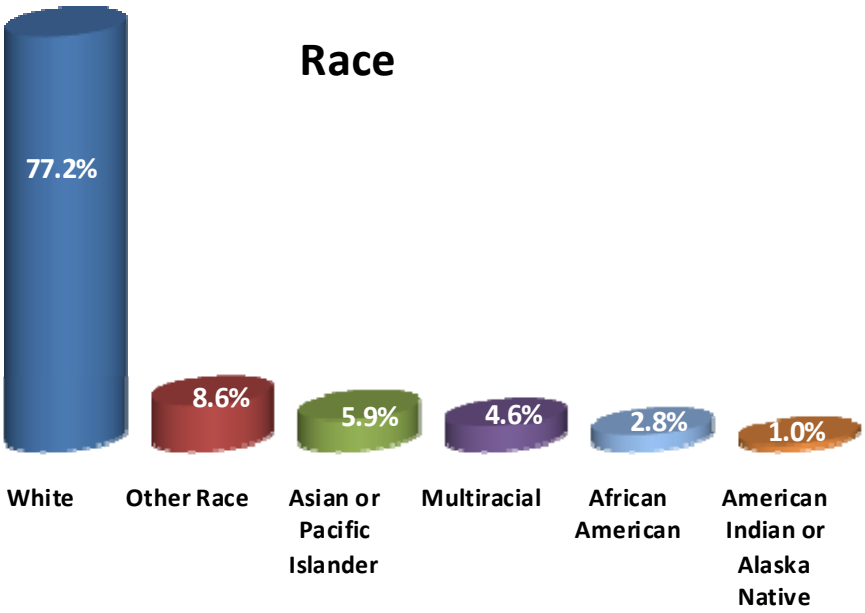
Stanislaus
33.0 years

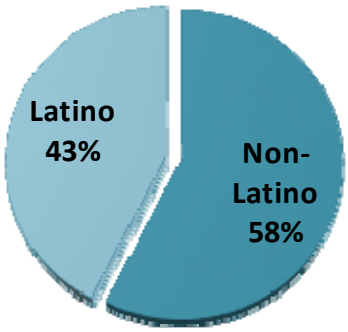
California
35.4 years



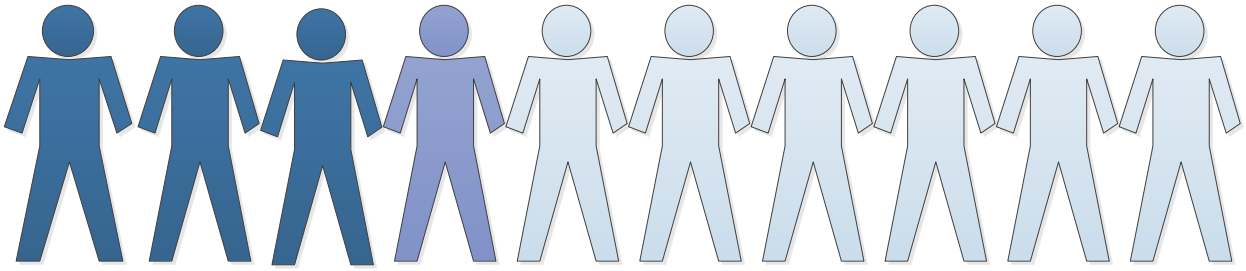
1. U.S. Census Bureau (2013). 2012 American Community Survey (three-year estimates).

Population by Race and Ethnicity[1]





Language[1]



3 in 10 speak Spanish at home

4 in 10 speak a language other than English at home

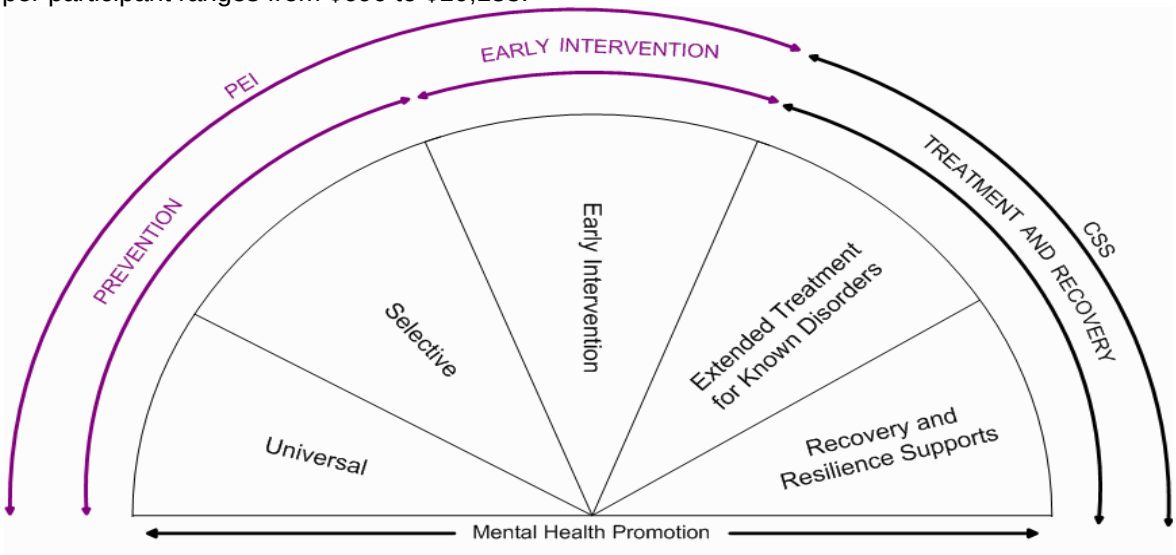
1. U.S. Census Bureau (2013). 2012 American Community Survey (three-year estimates).

MHSA Funding Summary

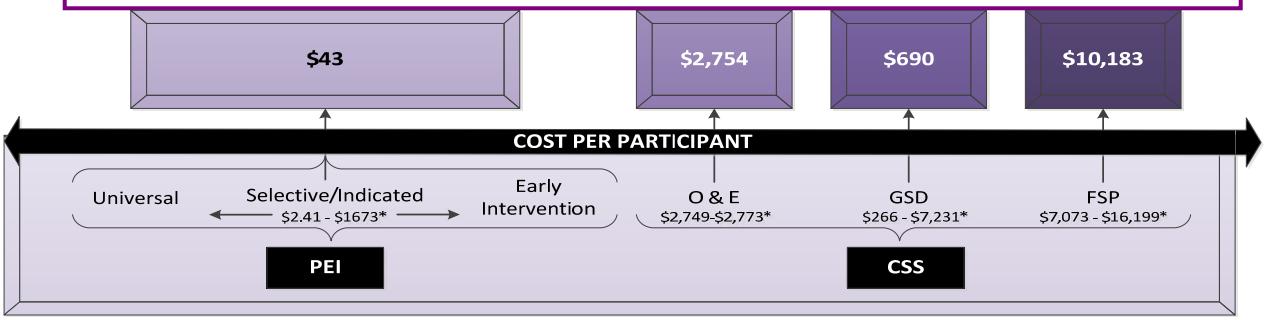
Integrated Plans for MHSA:

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

The diagram also highlights the cost per participant along the service continuum from PEI and INN to the most intensive services in CSS programs. The PEI average cost per participant is $43. The CSS average cost per participant ranges from $690 to $10,183.



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



Calculations based on FY13-14 actual expenditures
***Range of cost per participant for programs in each category**

Focus on Results:

BHRS continues to refine data systems, reporting methods, and develop learning structures to align with the framework of Results Based Accountability (RBA). The focus on results is not solely to collect data but to determine priority measures to learn from the data collection and ultimately improve programs.

A number of BHRS and contracted programs are using the RBA framework to assess their work and impact, and improve participant results. In future annual updates, data and outcomes will continue to be presented in this framework.

Fiscal Sustainability:

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

Counties now receive monthly payments from the California State Controllers office based on a cash available basis. The Mental Health Services Act is a volatile funding source driven by the state of the economy and the way in which state taxes are paid. Cash flow issues are a possibility and BHRS will continue to allocate MHSA funds based on the recommendations set forth by the County Behavioral Health Directors Association of California's (CBHDA) fiscal consultant.

This Annual Update includes FY 2013-14 Actual and FY 2014-15 Budget plans.

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	14,819,359	5,013,505	2,578,793	277,300	736,756	
2. Estimated New FY2015/16 Funding	14,699,334	3,675,156	966,807			
3. Transfer in FY2015/16[a/]	(1,180,000)			310,000	870,000	
4. Access Local Prudent Reserve in FY2015/16						0
5. Estimated Available Funding for FY2015/16	28,338,693	8,688,661	3,545,600	587,300	1,606,756	
D. Estimated FY2015/16 Expenditures	15,766,496	5,971,403	2,074,778	585,957	1,593,252	
E. Estimated FY2015/16 Unspent Fund Balance	12,572,197	2,717,258	1,470,822	1,343	13,504	

J. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	500,000
2. Contributions to the Local Prudent Reserve in FY 2014/15	0
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	500,000
5. Contributions to the Local Prudent Reserve in FY 2015/16	0
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	500,000
8. Contributions to the Local Prudent Reserve in FY 2016/17	0
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	500,000

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

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. FSP-01 Westside Stanislaus Homeless Outreach	3,726,306	2,443,075	1,184,521			98,710
2. FSP-02 Juvenile Justice	972,221	505,555	272,222			194,444
3. FSP-05 Integrated Forensic Team	1,299,307	902,507	391,000			5,800
4. FSP-06 High Risk Health & Senior Access	2,339,034	1,444,837	879,197			15,000
5. FSP-07 Turning Point-ISA	809,000	652,000	157,000			
Non-FSP Programs						
1. O&E-02 Peer Support Team	66,393	0				66,393
2. O&E-02 Housing Program - Garden Gate Respite	1,901,307	1,708,460		45,847		147,000
3. O&E-02 Employment - Garden Gate Restpite	418,565	267,924		65,218		85,423
4. GSD-01 Transition Age Young Adult Drop in Center	1,326,140	944,605	331,535			50,000
5. GSD-02 CERT/Warmline	957,333	957,333				
6. GSD-04 Famillies Together	747,261	684,786				62,475
7. GSD-05 Consumer Empowerment Center	462,686	462,686				
8. Crisis Stabilization Unit	1,488,500	1,164,000	324,500			
9. GSD Portion of Westside Stanislaus Homeless Outreach	1,209,199	814,358	394,840			
10. GSD Portion of Integrated Forensic Team	400,693	400,693				
11. GSD Portion of High Risk Health & Senior Access	497,085	497,085				
12. O&E-03 Outreach and Engagement	140,000	140,000				
CSS Administration	1,846,592	1,776,592				70,000
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	20,607,621	15,766,496	3,934,815	111,065	0	795,245
FSP Programs as Percent of Total	58.0%					

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Prevention	1,577,397	1,577,397				
2. Outreach for Increasing Recognition of early signs of mental illness	208,494	208,494				
3. Stigma Discrimination Reduction	61,000	61,000				
4. Suicide Prevention	199,900	199,900				
5. Outcomes and Evaluation	217,155	217,155				
6. Statewide Initiative	90,000	90,000				
PEI Programs - Early Intervention						
11. Early Intervention	2,935,869	2,865,301	42,388			28,180
PEI Administration	802,056	752,156				49,900
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	6,091,871	5,971,403	42,388	0	0	78,080

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. INN 11 - Collective Wisdom Tranformation	360,000	360,000				
2. INN 12 - Garden Gate Alternate Respite	550,150	550,150				
3. INN-13 - Quiet Time	126,676	126,676				
4. INN-14 - Father Involvement	98,552	98,552				
5. INN-15 - Youth Peer Navigators	43,110	43,110				
6. INN-16 - Co-Occuring Disorders Project	1,098,979	800,000	298,979			
INN Administration	124,890	96,290				28,600
Total INN Program Estimated Expenditures	2,402,357	2,074,778	298,979	0	0	28,600

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce, Education and Training	590,157	585,957				4,200
WET Administration	0					
Total WET Program Estimated Expenditures	590,157	585,957	0	0	0	4,200

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
CFTN Programs - Technological Needs Projects						
11. SU-01 Electronic Health Record	852,865	808,421				44,444
12. SU-02 Consumer Family Access	151,925	144,854				7,071
13. SU-03 EH Data Warehouse	140,366	138,050				2,316
14. SU-04 Document Imaging	103,689	101,927				1,762
15. SU-05 Program Evaluations/Outcomes	400,000	400,000				
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	1,648,845	1,593,252	0	0	0	55,593

COMMUNITY STAKEHOLDER PLANNING AND LOCAL REVIEW

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

The Representative Stakeholder Steering Committee (RSSC) is a vital part of the MHSA planning process. Its role is to provide important input on all plans and updates as well as share information about MHSA with members of their represented sector or group. The RSSC is diverse and made up of more than fifteen communities that include education, social services, senior services, law enforcement, diverse communities, and consumers and family members. Many community members attend the meetings as observers.

COMMUNITY STAKEHOLDERS AND ACTIVITIES

During FY 2013-14, the RSSC convened five times as part of the MHSA planning process. On April 1, 2014, the RSSC met and approved an MHSA Annual Update and Three Year Program and Expenditure Plan. It was approved by the Stanislaus County Board of Supervisors on June 17, 2014.

In addition, the RSSC met four (4) more times to develop and approve a Plan Update that went to the Stanislaus County Board of Supervisors (BOS). The BOS approved the Plan Update on September 30, 2014.

The groundwork for the development of the MHSA document began on May 30, 2014. The timeline and details of the RSSC's work was reported in the Plan Update FY 2014-15 submitted to the MHSOAC in September 2014.

In the Plan Update, stakeholders approved CSS projects and funding amounts for expansion. Two (2) CSS projects were Requests for Proposals (RFPs). Four (4) PEI projects were proposed for expansion and three (3) others were Requests for Proposals (RFPs). One (1) RFP was also proposed for Innovation.

Details about the projects and expansions were included in the Plan Update document and are being reported in this Annual Update FY 15-16. The expansions and RFPs for CSS can be found on pages 19 – 20 of this document. The PEI expansions and RFP information are located on pages 46 – 47. Information about the Innovation (INN) RFP can be found on page 87. Information about Capital Facilities (CF) expansion for the Crisis Stabilization Unit (CSU) is located on page 84 of this document.

On January 30, 2015, community planning began for the Annual Update FY 15-16. The RSSC convened to learn about MHSA funded activities from FY 13-14 and a plan to create a new PEI framework to revise program reporting to be in line with proposed MHSOAC regulations.

On February 27, 2015, the RSSC approved the Annual Update and four (4) funding proposals: PEI: Statewide PEI Initiative - $90,000; Workforce Education & Training (WE&T): Training Costs - $150,000; Innovation (INN): FSP Co-Occurring Disorders Project - $400,000; Technological Needs (TN): Evaluation Outcomes Funding - $400,000. In addition, the RSSC participated in a roundtable exercise to help generate ideas for possible future MHSA funding.

LOCAL REVIEW PROCESS

This Annual Update was posted for 30-day public review and comment March 24, 2014 – April 22, 2014. Notification of the public review dates and access to copies of the Annual Update was made available through the following methods:

- ✓ An electronic copy was posted on the County's MHSA website: www.stanislausmhsa.com
- ✓ Paper copies 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 Spanish speaking 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 through an informational outreach meeting. It was scheduled March 25, 2015 at 1:30 pm in the Main Conference on the BHRS campus located at 800 Scenic Drive in Modesto.

The Stanislaus County Behavioral Health and Recovery Services Annual Update 2015-2016 was posted for 30-day public review and comment period March 24, 2015 - April 22, 2015. A Public Hearing was held at the Stanislaus County Mental Health Board/Advisory Board on Substance Abuse Programs joint meeting on April 23, 2015. No comments were received during the 30-day review and comment period.

During the Public Hearing before the Mental Health Board, two comments were received from members of the audience. Both were family members of individuals with serious mental illness. One also had a family member with serious mental illness and co-occurring physical illness. She was critical of the shortage of services in our county, especially in a rural area on the west side of the county, and encouraged BHRS to develop PACT (Program for Assertive Community Treatment) teams for seriously mentally ill individuals who are difficult to engage and appear to also have medical problems. The other family member with comments is the parent of an individual with co-occurring mental illness and substance use issues. She wanted to see more outreach services to individuals living with these issues.

It was clarified that a Full Service Partnership (FSP) is an ACT (Assertive Community Treatment) team. In part, the proposed Innovation project related to the development of an FSP focused on individuals living with serious mental illness as well as co-occurring substance abuse issues will be close to a PACT team. This FSP will have a primary care component to it. The team will provide outreach to individuals with co-occurring illnesses, including those that are hard to engage. In September 2014, the Board of Supervisors approved a Request for Proposals for additional outreach and engagement services to rural communities. Once this contract is fully in place, concerns about services in the rural west side of the county can begin to be addressed.

Regarding the Annual Update document, there were no substantive changes to the draft circulated during the 30-day review and comment period. The report was reformatted to make it easier to read and follow. Additional details were provided for the Innovation projects approved by the RSSC and the Stanislaus County Board of Supervisors on September 30, 2014 in the Plan Update and the newly proposed Innovation projects described in this Annual Update.

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Executive Summary

According to the National Institute of Mental Health (NIMH) about one in four adults and one in five children in the United States have diagnosable mental disorders. And mental illness is the leading cause of disability among people ages 15-44.

Through the Mental Health Services Act (MHSA), Stanislaus County Behavioral Health and Recovery Services is working to change those statistics. We're building a "help first" system of care to eliminate disparities, promote wellness, recovery, and resiliency, and ensure positive outcomes for people living with mental illness.

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

Highlights

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

- A total of 5,743 individuals were served throughout CSS programs (FSP and GSD funded programs)
- There was an 84.6% decrease in homelessness days for FSP clients (annualization of pre-enrollment versus post enrollment days).
- There was a 69.7% decrease in incarceration days for FSP clients (annualization of pre-FSP versus post enrollment days.)

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

- Ten communities participated in the Asset-Based Community Development program.
- A total of 308 promotores were active in their respective communities making 14,265 contacts through community based collaborative events and activities.
- A total of 121 community residents were trained in Mental Health First Aid.
- An estimated 70,124 individuals were exposed to the StanUp for Wellness Suicide Prevention and Early Psychosis Signs and Symptoms messages through movie screen advertising at Galaxy Theater in Riverbank, Brendan Theatres in Modesto, and Regal Stadium 14 Theatre in Turlock.

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

- A total of 127 trainings were held in Stanislaus County, an increase from 57 trainings in FY 13-14.
- The Consumer Family Member Training and Support program (California Association of Social Rehabilitation Agencies - CASRA based program) reported an increase from 76 participants in FY 12-13 to 116 participants in FY 13-14.

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

- Under CF, architectural design and construction costs were approved to build a Crisis Stabilization Unit (CSU) in Stanislaus County. The CSU will address the significant increase in the number of acute psychiatric inpatient hospitalizations and augment the 24/7 secure mental health services continuum.
- Under TN, 386 staff members were trained in the initial Electronic Health Record (EHR) Clinical Assessments. This included all systems of care, and 46% of those trained were contract providers, while the rest were BHRS staff.
- A total of 16 new Assessments and clinical forms were installed ranging from one (1) page to more than 20 pages

Innovation (INN) funds and evaluates new approaches that increase mental health access to the unserved and/or underserved communities. Innovation projects can also promote interagency collaboration and increase the quality of services. BHRS had 11 unique learning projects during FY 13-14. The projects addressed several learning questions. Among them were the following:

- Would building a welcoming and inclusive community that provides opportunity for those with a mental illness to step away from and not be their illness while working and learning side by side with others increase self-esteem, promote recovery, and reduce stigma?
- Does making connections to community-based peer supports improve the experience of recovery and decrease the length of time and intensity of needed treatment?
- Does creating a “culture of civility” have an impact on emotional wellness outcomes and improve development assets for children in a school environment?

Community Services and Supports (CSS)

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

CSS is the largest component and makes up 80% of county MHSA funding. It provides funds for direct services to individuals with severe mental illness and children with serious emotional problems. The culturally competent services are focused on wellness, recovery, and resiliency while integrating the service experience for clients and families. Long term supported housing is also part of CSS funding. Stanislaus County has nine CSS programs including four FSP programs, four GSD programs, and one O&E program. There are no changes to CSS programs for FY 2015-2016.

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

FY 13-14 Programs:

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

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

FY 13-14 Programs:

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

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

FY 13-14 Programs:

- O&E-02 – Supportive Housing Services

CSS Budget

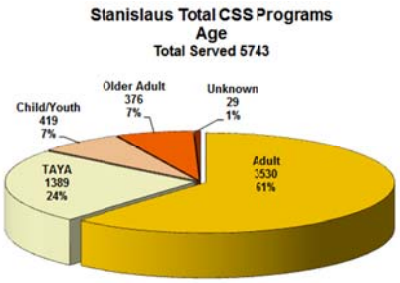
FY 2013-14 Actual	FY 2014-2015 Budgeted
$10,304,125	**$12,644,807**

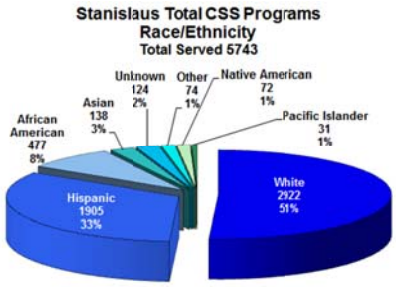
CSS Demographics

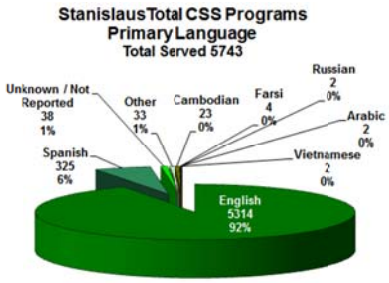
MHSA data collection and reports focus on how many individuals were served and whether programs were meeting service targets. Data collected provides an indication of how programs are doing in reaching unserved/underserved and diverse populations.

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

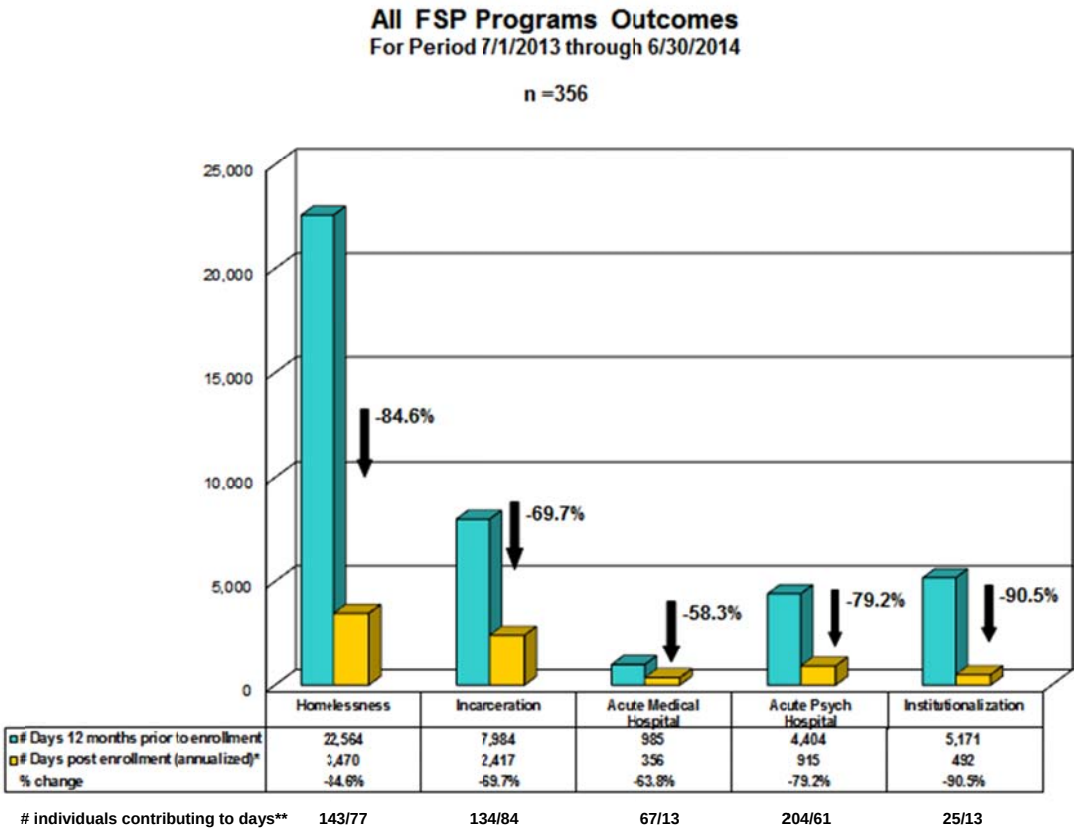
All percentages shown in graphs are rounded to the nearest percent and therefore may not equal 100%.



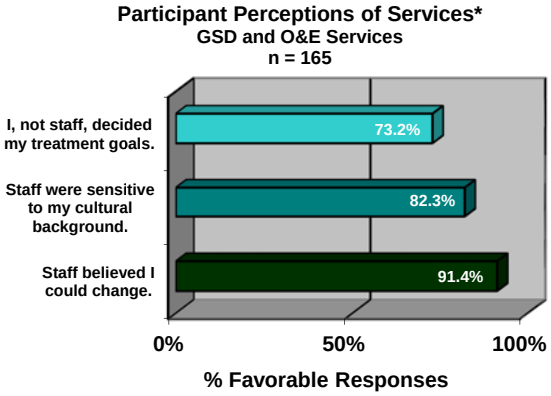


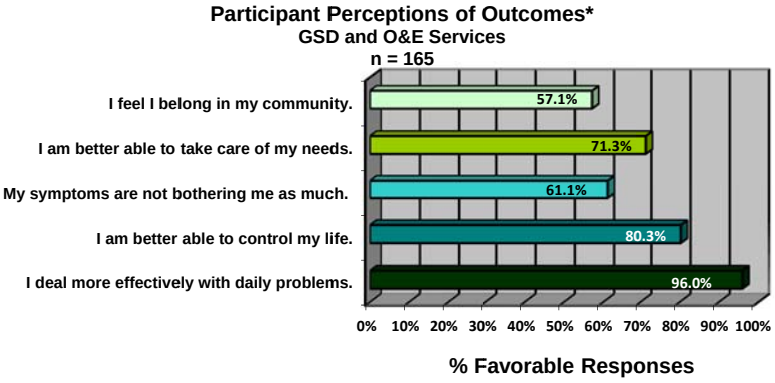


CSS Highlights



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

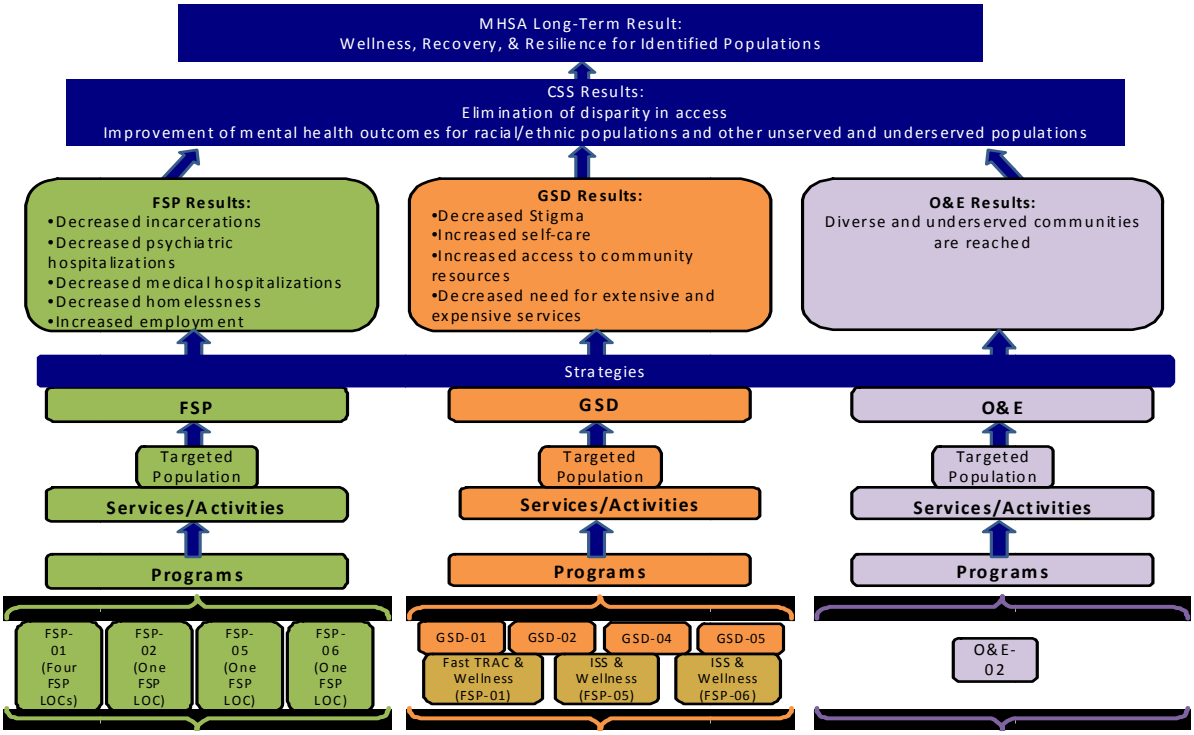




* This survey was developed through a collaborative effort of consumers, the Mental Heatlh Statistics Improvement Program (MHSIP) community, and the Center for Mental Health Services.

Community Planning Process and CSS Expansions

The Community Services and Support component plays an important role in reaching the desired MHSA long-term results of wellness, recovery, and resilience for identified populations. Below is the CSS component for FY 2013-2014 displayed in the Theory of Change Framework, which was presented during the stakeholder process.



CSS Expansions:

On May 30, 2014, the Representative Stakeholder Steering Committee convened to learn about the community planning process and Community Services and Supports (CSS). The discussion centered on expanding CSS programs in a strategic way to reach more consumers and family members. The Theory of Change (TOC) framework was introduced to community members. In addition, Requests for Proposals (RFP) were planned for two of the CSS projects.

The RSSC unanimously approved funding proposals for the Plan Update on July 18, 2014 for Three-Years (FY 2014-2015, FY 2015-2016, and FY 2016-2017) for the following. (See Table 1 for annual costs).

List of CSS Expansions

FSP-01 Josie's TRAC
FSP-01 FSP Access and Supports
FSP-02 Juvenile Justice (GSD Funds)
FSP-07 Turning Point ISA
GSD-01 Josie's Place
GSD-02 CERT/Warmline
GSD-04 Families Together
GSD-05 Consumer Empowerment Center
GSD-06 CSU-Operational Costs
O&E-02 Supportive Housing Services (Intensive Transitional Housing)
O&E-02 Supportive Housing Services (Vine Street Emergency Housing)

CSS Request For Proposals

O&E-02 Supportive Housing Services (Transitional Board and Care)
O&E-03 Outreach and Engagement

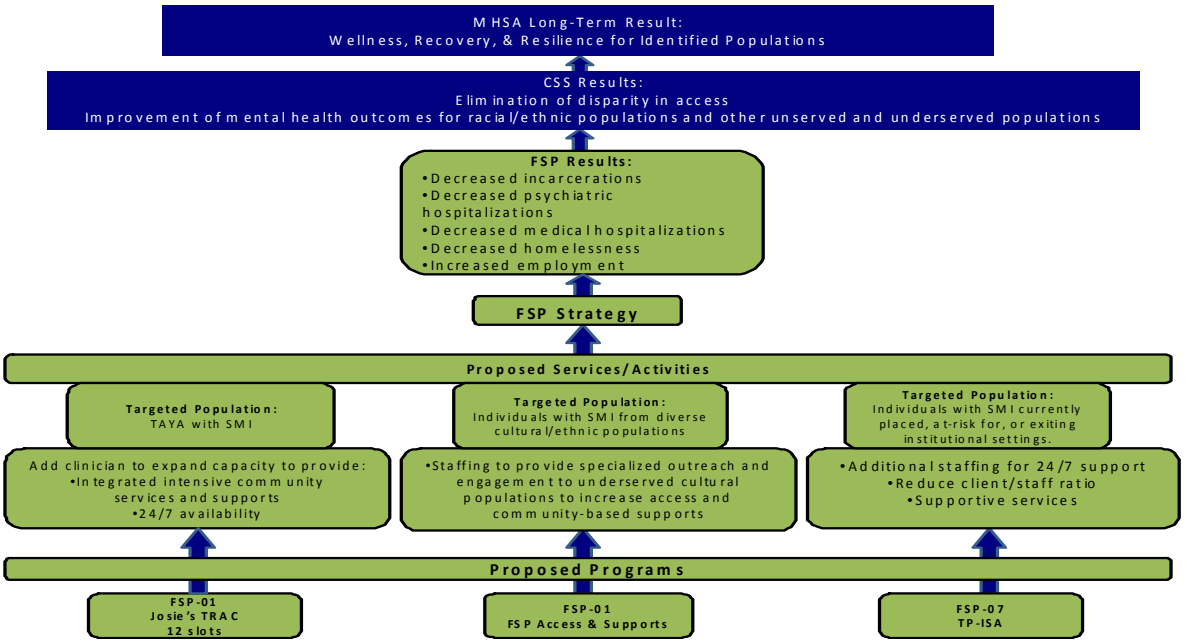
Table 1

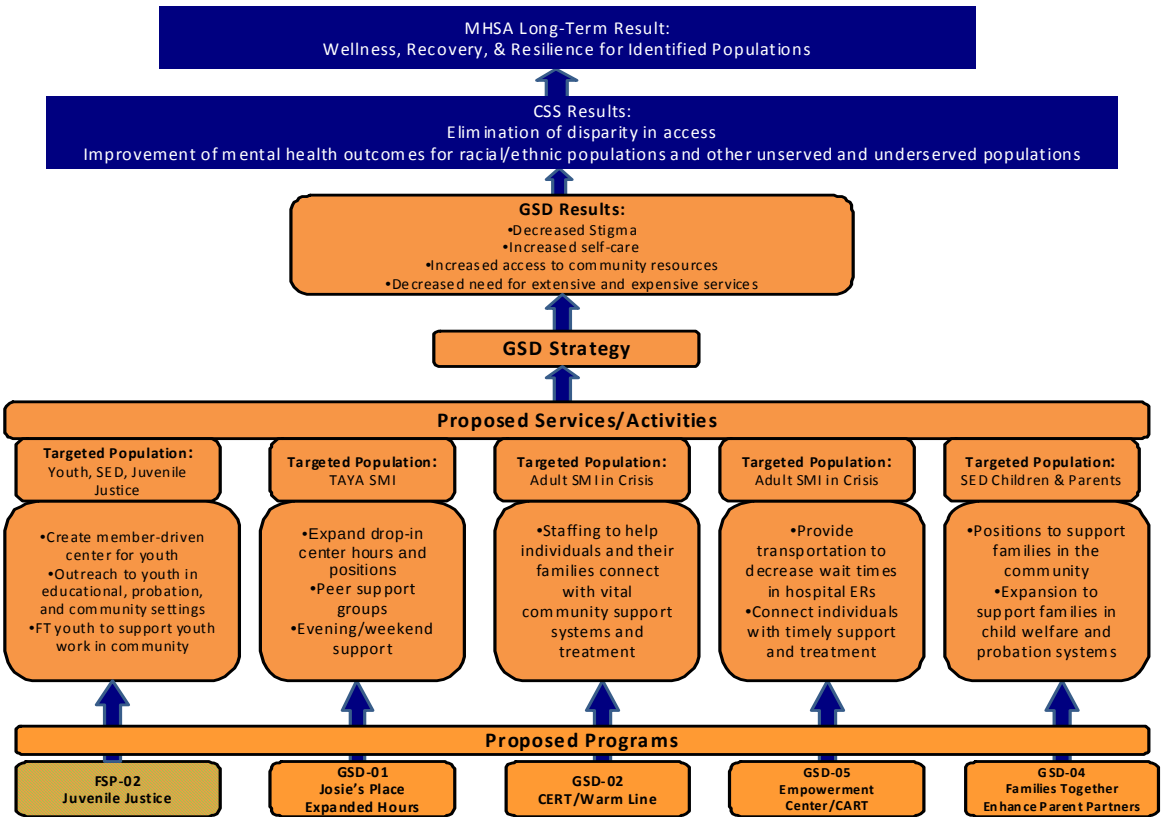
Community Services & Support (CSS) - Expansions	FY2014/15	FY2015/16	FY2016/17	Total
FSP-01 Josie's TRAC	$139,000	$145,000	$149,000	$433,000
FSP-01 FSP Access and Supports	$128,000	$133,000	$138,000	$399,000
FSP-02 Juvenile Justice (GSD Funds)	$226,000	$235,000	$243,000	$704,000
FSP-07 Turning Point ISA	$628,000	$652,000	$675,000	$1,955,000
GSD-01 Josie's Place	$131,000	$131,000	$131,000	$393,000
GSD-02 CERT/Warmline	$321,000	$321,000	$321,000	$963,000
GSD-04 Families Together	$358,000	$358,000	$358,000	$1,074,000
GSD-05 Consumer Empowerment Center (CART)	$58,000	$58,000	$58,000	$174,000
GSD-06 CSU - Operational Costs		$1,164,000	$1,280,000	$2,444,000
O&E-02 Supportive Housing Services (Vine Street Emergency Housing)	$65,000	$65,000	$65,000	$195,000
O&E-02 Supportive Housing Services (Intensive Transitional Housing)	$364,000	$364,000	$364,000	$1,092,000
O&E-02 Supportive Housing Services (Transitional Board and Care)	$95,000	$95,000	$95,000	$285,000
O&E-03 Outreach and Engagement	$140,000	$140,000	$140,000	$420,000
Total CSS Funding	$2,653,000	$3,861,000	$4,017,000	$10,531,000

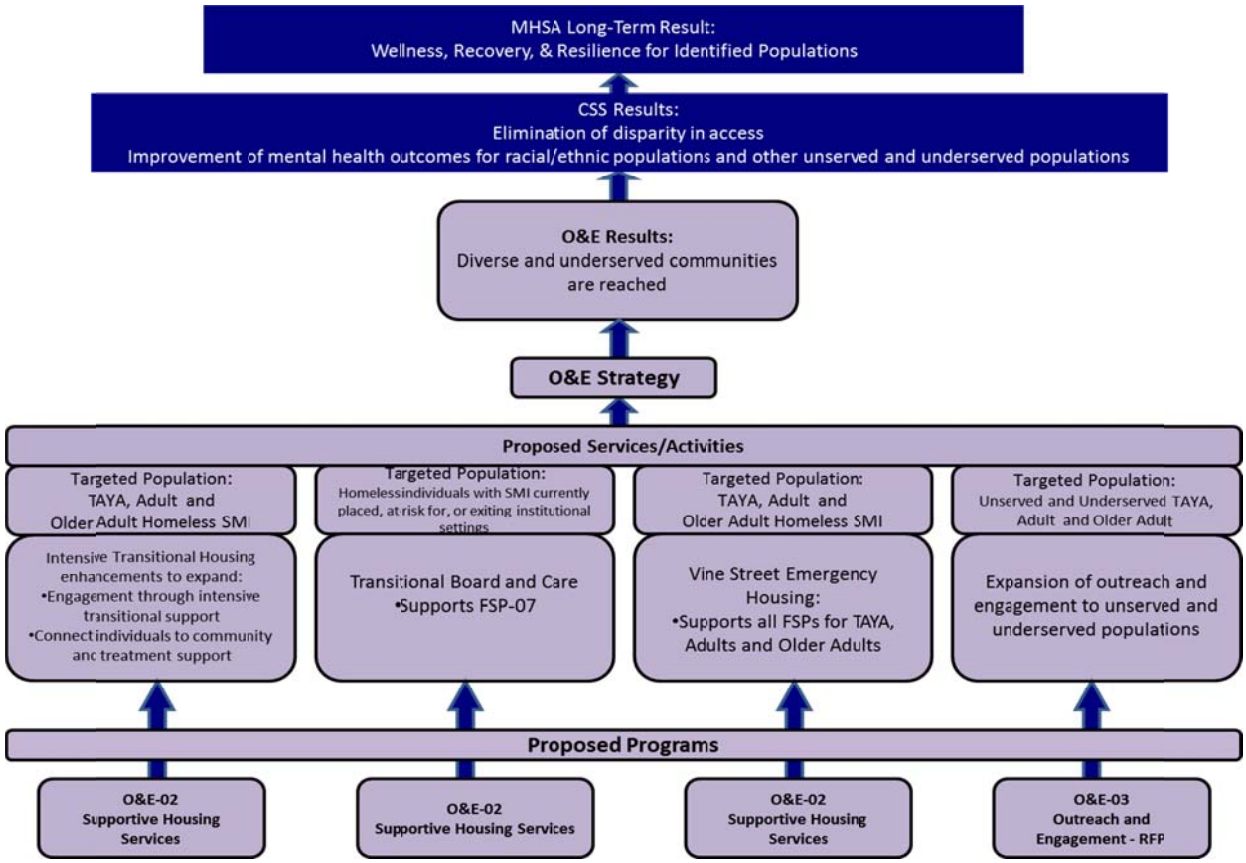
CSS FY 14-15 – Requests for Proposals	
O&E-02 Supportive Housing Services (Transitional Board and Care) *	$95,000
O&E- 03 Outreach and Engagement **	$140,000
Total CSS Funding for Requests for Proposals	$235,000

*Successful RFP bidder will receive $95,000 per year up to 3 years
**Successful RFP bidder will receive $140,000 per year up to 3 years

The following represents these CSS expansions and RFPs within the CSS Theory of Change framework, delineating FSP, GSD, and O&E strategies. Narrative details are provided after the framework.


MHSA Long-Term Result:
Wellness, Recovery, & Resilience for Identified Populations
CSS Results:
Elimination of disparity in access
Improvement of mental health outcomes for racial/ethnic populations and other unserved and underserved populations
FSP Results:
•Decreased incarcerations
•Decreased psychiatric hospitalizations
•Decreased medical hospitalizations
•Decreased homelessness
•Increased employment
FSP Strategy
Proposed Services/Activities
Targeted Population:
TAYA with SMI
Targeted Population:
Individuals with SMI from diverse cultural/ethnic populations
Targeted Population:
Individuals with SMI currently placed, at-risk for, or exiting institutional settings.
Add clinician to expand capacity to provide:
•Integrated intensive community services and supports
•24/7 availability
•Staffing to provide specialized outreach and engagement to underserved cultural populations to increase access and community-based supports
•Additional staffing for 24/7 support
•Reduce client/staff ratio
•Supportive services
Proposed Programs
FSP-01
Josie's TRAC
12 slots
FSP-01
FSP Access & Supports
FSP-07
TP-ISA


MHSA Long-Term Result:
Wellness, Recovery, & Resilience for Identified Populations
CSS Results:
Elimination of disparity in access
Improvement of mental health outcomes for racial/ethnic populations and other unserved and underserved populations
GSD Results:
•Decreased Stigma
•Increased self-care
•Increased access to community resources
•Decreased need for extensive and expensive services
GSD Strategy
Proposed Services/Activities
Targeted Population:
Youth, SED, Juvenile Justice
Targeted Population:
TAYA SMI
Targeted Population:
Adult SMI in Crisis
Targeted Population:
Adult SMI in Crisis
Targeted Population:
SED Children & Parents
•Create member-driven center for youth
•Outreach to youth in educational, probation, and community settings
•FT youth to support youth work in community
•Expand drop-in center hours and positions
•Peer support groups
•Evening/weekend support
•Staffing to help individuals and their families connect with vital community support systems and treatment
•Provide transportation to decrease wait times in hospital ERs
•Connect individuals with timely support and treatment
•Positions to support families in the community
•Expansion to support families in child welfare and probation systems
Proposed Programs
FSP-02
Juvenile Justice
GSD-01
Josie's Place
Expanded Hours
GSD-02
CERT/Warm Line
GSD-05
Empowerment Center/CART
GSD-04
Families Together
Enhance Parent Partners


MHSA Long-Term Result:
Wellness, Recovery, & Resilience for Identified Populations
CSS Results:
Elimination of disparity in access
Improvement of mental health outcomes for racial/ethnic populations and other unserved and underserved populations
O&E Results:
Diverse and underserved communities are reached
O&E Strategy
Proposed Services/Activities
Targeted Population:
TAYA, Adult and Older Adult Homeless SMI
Intensive Transitional Housing enhancements to expand:
•Engagement through intensive transitional support
•Connect individuals to community and treatment support
Targeted Population:
Homeless individuals with SMI currently placed, at risk for, or exiting institutional settings
Transitional Board and Care
•Supports FSP-07
Targeted Population:
TAYA, Adult and Older Adult Homeless SMI
Vine Street Emergency Housing:
•Supports all FSPs for TAYA, Adults and Older Adults
Targeted Population:
Unserved and Underserved TAYA, Adult and Older Adult
Expansion of outreach and engagement to unserved and underserved populations
Proposed Programs
O&E-02
Supportive Housing Services
O&E-02
Supportive Housing Services
O&E-02
Supportive Housing Services
O&E-03
Outreach and Engagement - RFP

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) provides services to transitional aged young adults (TAYA), adults, and older adults who have co-occurring issues of mental health and substance abuse. They're also uninsured or underinsured and involved with other agencies. The goals are to reduce the risk for emergency room use, contact with law enforcement, homelessness, and psychiatric hospitalization.

SHOP offers 3 levels of care: 1) Full Service Partnership (FSP) 2) Intensive Support Services and 3) Wellness/Recovery. This approach allows individuals to enter the program at an appropriate level of service for their needs and then move to a lesser or greater level of care as needed.

The FSP level of care has 4 tracks: 1) Westside SHOP, 2) Partnership Telecare Recovery Access Center (Partnership TRAC), 3) Josie's Telecare Recovery Access Center (Josie's TRAC) and 4) Modesto Recovery Services Trac (MRS TRAC). Full service partnership strategies include integrated, intensive community services and supports with 24/7 availability with a known service provider. SHOP utilizes a "housing first" approach with recovery and client- and family-centered focus that inspires hope.

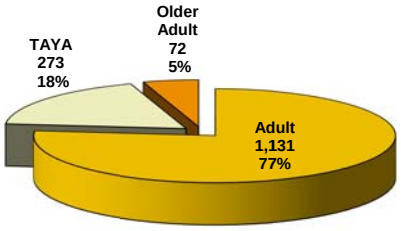
Intensive Support Services (ISS) has 1 track. It's called the Fast TRAC and is funded by General System Development (GSD) dollars. The Wellness/Recovery level of care has the Wellness TRAC. Group supports led by clinical service staff are offered to individuals, as are peer-led wellness/recovery support groups. All levels of care include a multi-disciplinary approach. SHOP also includes a GSD Transition TRAC. Staff from this TRAC focus on discharges from the acute psychiatric inpatient hospital in Stanislaus County. The team will track individuals who are not open to behavioral health services prior to hospitalization and engage those who are not open to services post-hospitalization to connect them to resources. The aim is to prevent re-admissions to inpatient psychiatric services.

The estimated number of individuals to be served in FY14-15 is 294; 164 in Full Service Partnership and 130 in Intensive Support Services and Wellness/Recovery.

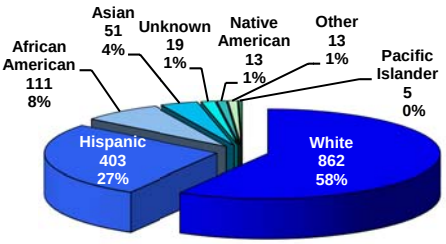
In the 2014 MHSA stakeholder planning process, a program expansion was approved by the group and included in the June 2014 Annual Update adopted by the Stanislaus County Board of Supervisors.

Demographics

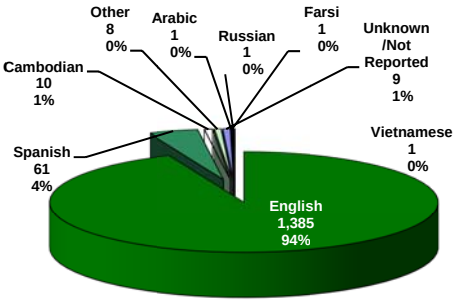
Age
Total Served 1,477



Race/Ethnicity
Total Served 1,477



Primary Language
Total Served 1,477



This expansion allows the Transition TRAC to add staff to expand community outreach efforts and focus on the discharges from the new Psychiatric Health Facility (PHF). The team will include individuals who are not open to services post-hospitalization in an effort to connect them to resources to help prevent re-admissions to inpatient psychiatric services.

In September 2014, MHSA stakeholders also approved two other program expansions that were included in a Plan Update also adopted by the Stanislaus County Board of Supervisors.

Three Year Program Expansion/Josie's TRAC:
This would provide additional staffing for specialized outreach and engagement to underserved cultural populations and increase access and community based supports. It would also add one clinician to provide integrated intensive community services and supports.

Three year Program Expansion/FSP Access and Supports:
This expansion is a specific FSP level outreach and engagement strategy targeting underserved and unserved at risk populations. Services include the following: Intensive outreach and engagement to Spanish speaking populations; Community based clinical assessment and screenings; Responsive assessment scheduling for target populations; Culturally appropriate consumer and family supports development; Service coordination and linkages to community based peer and family support.

More details about the expansions will be included in reporting of activities for FY 14-15.

Highlights for FSP Level of Care

Program highlights include the implementation of three important phases of the Electronic Health Record. This included implementation of Treatment Plans in July 2013; Dr.'s Homepage including the feature of e-prescribing in August of 2013; and various assessments in June 2014. The implementation of these three phases has increased Telecare's ability to provide interactive (Collaborative Documentation) and quality services to our consumers, as well as collaboration with our county partners.

With the Affordable Care Act fully implemented, most consumers were assisted in obtaining Medi-Cal. This has increased accessibility to medications that work well with the severely mentally ill.

With the expansion in the Full Service Partnership TRAC, and Josie TRAC, the ability to serve individuals in a timely manner has increased. Clients who are hospitalized have greater access (10 days or less) to begin services with no interruption in medication services.

In March of 2013, a new unique program was added to the FSP team. This program (MRS TRAC) provides intensive case management services to 12 existing clients opened to a county program. Services are provided to assist in stabilizing clients while they continue receiving their psychiatric medications from the county. Once stabilized, they return to their original case management team.

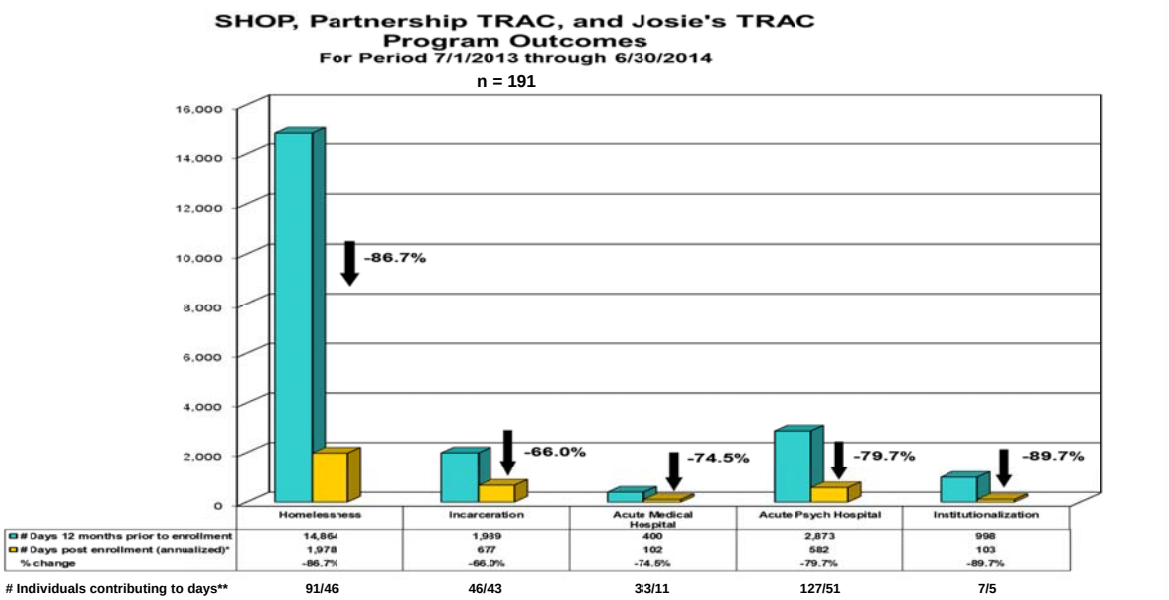
In preparation for re-certification for CARF (September 2014), significant improvements were made in the internal audit process and 100% of client records were audited. This identified areas of training necessary. A wide variety of trainings were completed including Cognitive Behavioral techniques, MATRIX model (substance abuse), and Motivational Interviewing.

During FY 13-14, there was additional staffing with employees hired from diverse ethnic backgrounds. Several of the new hires included individuals representing the Hispanic community. Two Assyrian staff members who speak multiple dialects were also hired.

Highlights for GSD Levels of Care

The FAST TRAC, Wellness TRAC, and Transition TRAC teams have seen the following successes this fiscal year. Among them:

- The Fast TRAC/Wellness teams were chosen to be a Collaborative Documentation pilot program for Stanislaus County as a means to ensure client and staff work together in the recovery process.
- Fast TRAC/Wellness has worked hard to insure that uninsured clients have received coverage through the new Affordable Care Act.
- Clients continue to receive the benefits of their case manager's efforts to obtain and maintain for them. This is often done in collaboration with the Stanislaus County Housing Teams.
- Fast TRAC and Wellness staff continue to experience the achievement of clients as they graduate back into the community.
- The Transition TRAC team reached 300 individuals that required a crisis evaluation resulting in 849 crisis contacts, slightly more than 70 per month. Of these evaluations, 477 hospital admissions were avoided or 56%.
- There were 28 individuals who had five or more crisis contacts before opening to the Transition TRAC. Their number of crisis contacts was 194. Since opening to Transition TRAC, these same individual admits have been reduced to a total of 47 admits, a reduction of over 75%.
- Of the 382 Transition TRAC individuals desiring case management services, 289 (77%) were successfully linked to service providers and resources.
- Telecare worked closely with BHRS Leadership to build and implement an innovative database system to track and maintain information for the Transition Team's work.



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

Challenges for FSP Level of Care

The overwhelming number of clients who require specialty AOD treatment in addition to mental health services has been a challenge. Many of the severely mentally ill are unable to benefit from traditional treatment models because of their inability to focus. In addition, individuals with documented history of AOD have difficulty being approved for SSI benefits. Not having a viable income makes it difficult for them to become self-supportive and move through their recovery.

With the increase of services granted to serve the severely mentally ill, there is a shortage in adequate Board and Care homes. Because of this, board and care providers will often take a less intensive client ahead of someone who may be a "flight risk". There are continued challenges with placement issues for the most severely mentally ill.

Housing individuals who continue to use drugs and/or alcohol continues to be a challenge. Their behaviors while actively using often result in termination from housing programs or room and boards. Many of the mentally ill with a co-occurring disorder remain homeless due to this problem.

Challenges for GSD Level of Care

Transportation issues are often challenges with these teams. One goal is to encourage clients to use resources other than those provided by their case manager. An example is taking public transportation. This allows for building of skills that clients will need to use once they graduate. Finding individuals outside of the hospital can be another challenge. Many are homeless are unable to provide a residence or contact number to be reached. This can become difficult for team members to make follow-up contact.

Program Results for FSP Level of Care	
• A total of 204 individuals were served • The average number of clinical services was 44	**How Much?**
• 125% of annual target of individuals served was met (Target=164) • The average length of FSP services was 667 days • 88% (45/51) of surveyed clients were satisfied with services • 84% (42/50) of surveyed clients said that "Staff believed I could change"	**How Well?**

• 75% (36/48) of surveyed participants indicated they deal more effectively with daily problems as a result of services • 64% (32/50) of surveyed participants indicated that they feel they belong to their community as a result of services	**Is Anyone Better Off?**
Program Results for FSP with GSD Funding	
• A total of 1,302 individuals were served (across all levels of care) • Of the 1,222 individuals seen at the hospital by the Transition TRAC team, only 300 (25%) of those seen from July 1- June 30 were re-admitted • Of the 382 Transition TRAC individuals desiring case management services, 289 (77%) were successfully linked to service providers and resources	**How Much?**
• 100% (18/18) of surveyed clients reported being satisfied with services • 76% (13/17) of surveyed clients indicated that “Staff believed I could change”	**How Well?**
• 71% (12/17) of surveyed participants indicated they deal more effectively with daily problems as a result of services* • 35% (6/17) of surveyed participants indicated that they feel they belong to their community as a result of services* • 58% (14/24) reported that they are better able to take care of their needs* *Mental Health Statistics Improvement Program (MHSIP) Consumer Survey	**Is Anyone Better Off?**

This program provides 24 hours a day, seven (7) days a week crisis response and on-site intensive mental health services to high risk youth in the Juvenile Justice behavioral health program and their families. This Full Services Partnership (FSP) expands the Juvenile Justice Mental Health Program to target youth on formal or informal probation who are diagnosed with a serious mental illness or a serious emotional disturbance.

Many are victims of trauma and have not successfully been engaged by traditional methods of treatment. As a result, they tend to become more seriously ill, have more aggressive behavior, and higher rates of incarceration and institutionalization. The FSP is designed to do "whatever it takes" to engage youth and their families. The program goals are to reduce recidivism, out of home placement, homelessness, and involuntary hospitalization and institutionalization.

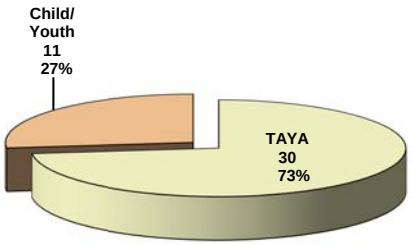
Many of the high risk youth are from racially and ethnically diverse communities. Some may be uninsured or underinsured and live in families that are difficult and resistant to engage. And, often times, there's a history of domestic violence, gang involvement, and multi-generational incarceration. Due to the severity of the serious emotional disturbance, the levels of aggression involved in the crimes committed and continued recidivism, these youth are often made formal wards of the court and are at persistent risk of out-of-home placement.

In FY 14-15, there are no changes in the population to be served and strategies to be used. During the 2014 MHSA Stakeholder planning process, a program expansion using General System Development (GSD) funding was recommended in an MHSA Plan Update and later approved by the Stanislaus County Board of Supervisors on September 30, 2014. The expansion will provide the following: three full time transitional-aged staff members with lived experience to support and mentor youth, provide outreach in education, probation, and community settings, and help create a member driven youth center. More details about the expansion will be reported in activities for FY 14-15.

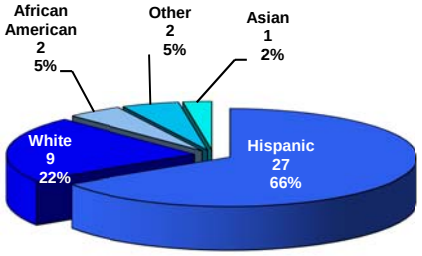
The estimated number of individuals to be served in FY14-15 will be a total of 25 at any given time; 13 child/youth and 12 transition age young adults.

Demographics

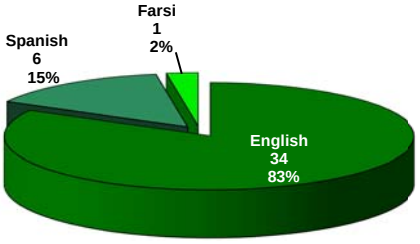
Age
Total Served 41



Race\Ethnicity
Total Served 41



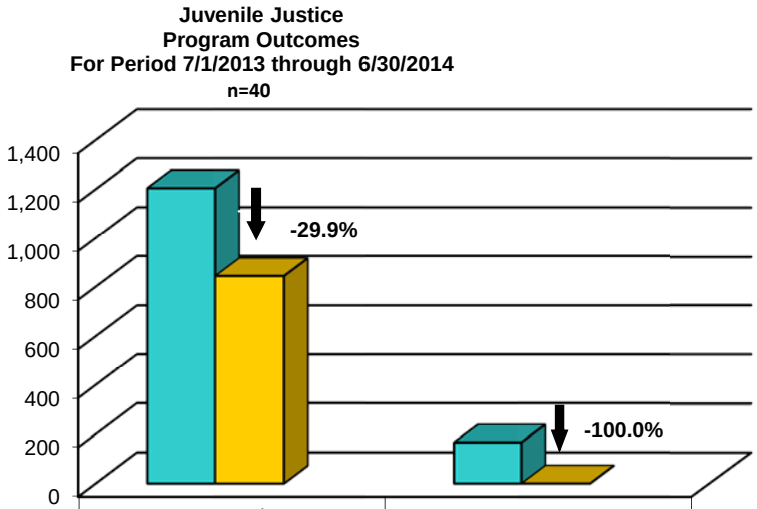
Primary Language
Total Served 41



Highlights

Juvenile Justice continues to offer Youth Leadership and Youth in Mind programs to give young people access to support that encourages their development of leadership skills. Transition-aged staff led the youth leadership meetings and helped support, mentor, and educate youth group members.

Aggression Replacement Training (ART), an evidenced-based program aimed at teaching positive alternatives to aggression, was offered and successfully completed by five of the program youth. Two staff members from the Juvenile Commitment facility were trained in ART so that groups could be provided to those in custody to ensure that youth had continued access to the needed service.



	Incarceration	Acute Medical Hospital
# Days 12 months prior to enrollment	1,204	166
# Days post enrollment (annualized)*	844	0
% change	-29.9%	-100.0%
# individuals contributing to days**	33/17	2/0

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

Challenges

Adding parent support services and hiring a parent mentor to serve parents with youth was a challenge for the program. Implementation of these administrative issues remains a top priority this fiscal year.

Program Results	
• A total of 40 individuals were served (unduplicated number of participants) • The average number of clinical services per individual was 26 • The average number of case management services per individual was nine (9)	**How Much?**
• 164% (40/25) of annual targeted number of individuals served was met (Target=25) • The average length of FSP services was 377 days	**How Well?**
• 88% (7/8) of surveyed participants indicated they deal more effectively with daily problems as a result of receiving services* • 100% (8/8) of surveyed participants indicate that "People will listen and understand when I need to talk" * • 75% (6/8) of surveyed participants reported that they are better able to cope when things go wrong* *Mental Health Statistics Improvement Program (MHSIP) Consumer Survey	**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 transition age young adults (18 – 25 years), adults (26 - 59 years) and older adults (60+ years) who have a serious mental Illness or co-occurring substance abuse issues. It's a population also 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 a state hospital, and linkages to existing community support groups. Both service recipients and family members are offered education regarding the management of both mental health issues, benefits advocacy, and housing support. Culturally and linguistically appropriate services are provided to diverse consumers.

Partner collaboration is central to reducing disparities and achieving an integrated service experience for consumers and family members. In addition to law enforcement agencies and probation, collaboration occurs with agencies including Turning Point Community Programs, Salvation Army, United Samaritans Homeless Services, and Golden Valley Health Clinics (a Federally Qualified Health Clinic).

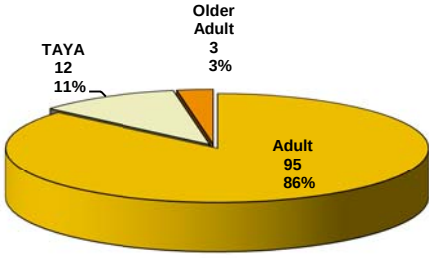
A combination of Full Service Partnership (FSP) and General System Development (GSD) funds provides 3 levels of care: Full Service Partnership, Intensive Support Services, and Wellness/Recovery.

In FY14-15, there are no proposed changes in the population to be served and strategy to be used. In the 2012 MHSA stakeholder planning process, a program expansion was recommended which included the following: serve an additional 12 transition age young adults and adults in FSP, increase staff capacity to provide Intensive Services and Support level services, and enhance peer support team for this target population beginning in February 2013.

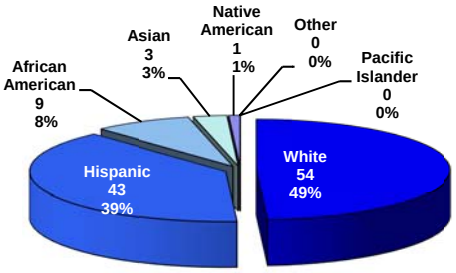
The estimated number of individuals projected to be served in FY14-15 is 92; 52 full service partnership level and 40 in intensive support services or wellness/recovery levels.

Demographics

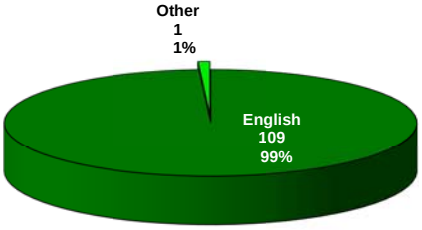
Age
Total Served 110



Race\Ethnicity
Total Served 110



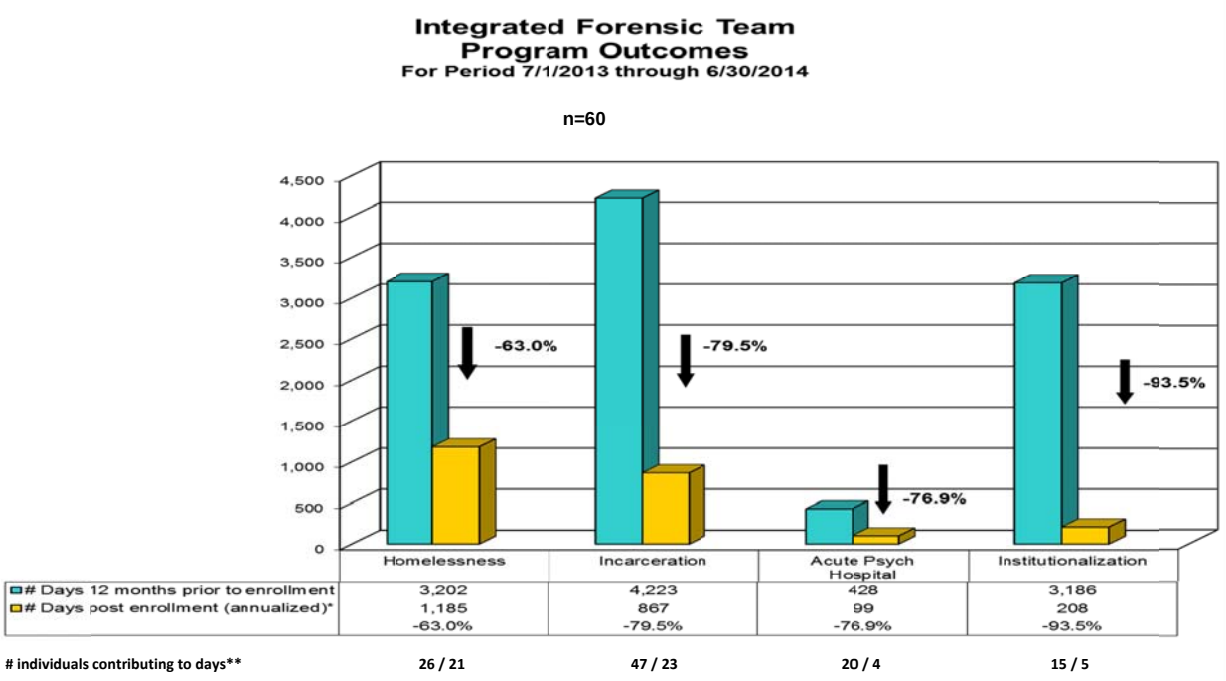
Primary Language
Total Served 110



Highlights

An ongoing success is Mental Health Court. It's part of IFT and would not exist without the countywide support it receives from BHRS, the Probation department, Sheriff's Office, District Attorney's Office, Public Defender's Office, and the Superior Court. In the past year, we have served fifteen clients with four (4) graduating from the program.

The IFT treatment team has several standing weekly groups for clients. All of the groups are now Evidenced-Based or Promising Practices. IFT conducts Moral Reconation Therapy, Seeking Safety, and Substance Abuse Management Modules among other groups based upon need or request.



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**Number of individuals contributing to days – Individuals 12 months prior/Individuals post enrollment
Note: Institutionalization represents a combined count for State Hospital and Long Term Hospital

Challenges

Criminal Justice realignment and local jail overcrowding may be contributing to a lower than expected referral rate. While the Forensic System of Care has additional programs and staff that compliment IFT, which includes in custody mental health clinicians, it can be difficult to engage clients that are in and out of custody quickly.

A positive challenge may be related to the Affordable Care Act. The number of uninsured and underinsured clients has decreased. Clients now have more options and can qualify for traditional behavioral health programs. They don't have to opt for a Forensic program that works closely with probation. While there are many advantages for clients with such a program arrangement, it's understandable that some clients may choose other options for treatment.

Program Results	
• A total of 56 individuals were served in the program • The average number of clinical services was 17 • The average number of case management services was 18	**How Much?**
• 108% (56/52) of the targeted number of individuals served was met (Target=52) • The average length of FSP services was 470 days • 85% (12/14) of surveyed clients were satisfied with services • 92% (12/13) of surveyed clients indicated that "Staff believed I could change"	**How Well?**
• 79% (11/14) of surveyed participants indicated they deal more effectively with daily problems as a result of receiving services* • 77% (10/13) of surveyed participants indicated they feel they belong to their community as a result of services* • 85% (27/34) of surveyed participants reported that they are better able to take care of their needs* *Mental Health Statistics Improvement Program (MHSIP) Consumer Survey	**Is Anyone Better Off?**

CSS - High Risk Health & Senior Access (FSP- 06)
Operated by Behavioral Health and Recovery Services in the Managed Care/Older Adult Services

The High Risk Health and Senior Access (HRHSA) program is a full service partnership that became operational in FY 2010-11. Target populations include 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. Older adults may also have functional impairments related to aging. Outreach and engagement services are focused on engaging diverse ethnic/cultural populations and individuals, as well as those who have mental illness and are homeless. The program also serves those at risk of homelessness, institutionalization, hospitalization, or nursing home care or frequent users of emergency rooms.

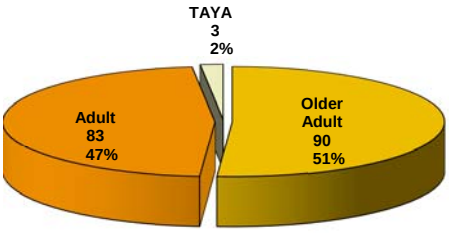
Strategies include 24/7 access to a known service provider, individualized service plans, a multidisciplinary treatment approach, wellness and recovery focused group and peer support, linkage to existing community support groups, peer support and recovery groups for individuals with co-occurring health 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 and General System Development funds provides three (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 if necessary. Graduated level of care allows more individuals to access the full service partnership level of service when needed.

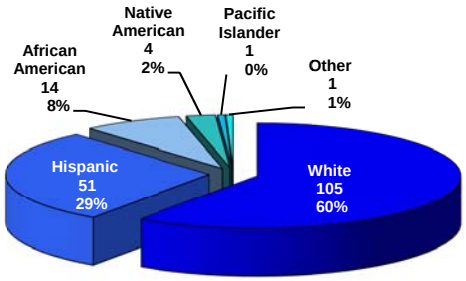
In FY14-15, there are no proposed changes to the population to be served and strategies to be used. The estimated number of individuals to be served in FY 14-15 will be a total of 125.

Demographics

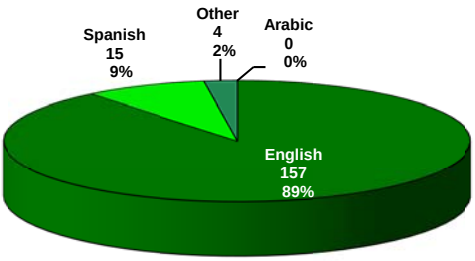
Age
Total Served 176



Race\Ethnicity
Total Served 176



Primary Language
Total Served 176

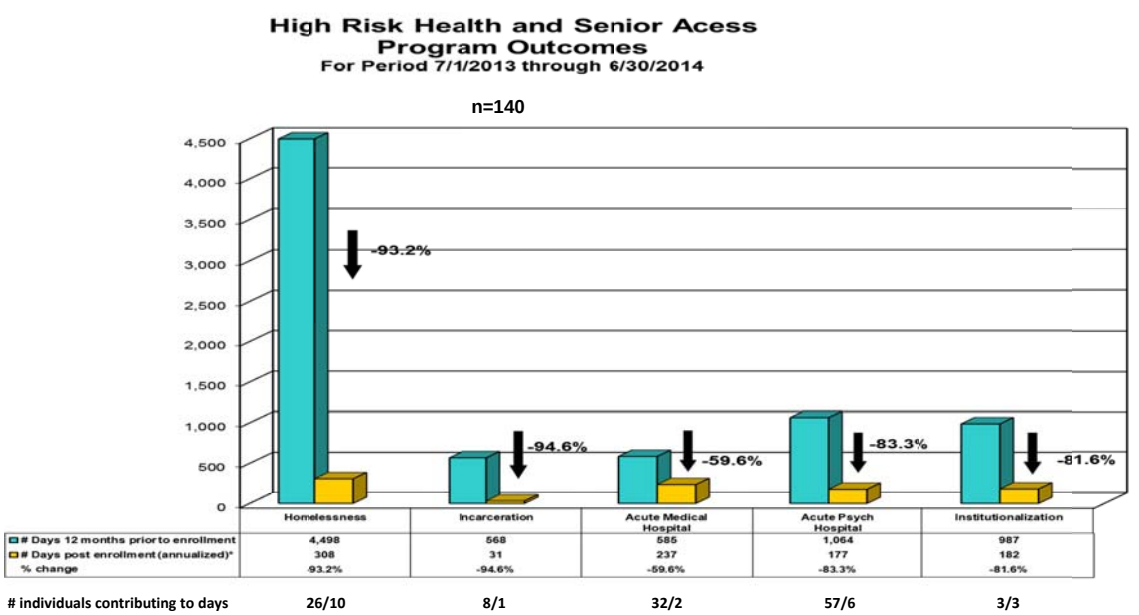


Highlights

The Peer Support/Volunteer program continues to grow and provide activities and support to clients. In addition, they are involved in different community service projects where individuals with potential mental health issues can receive help. The program has grown to just under 30 individuals. These individuals are community volunteers, former clients, and current clients.

This program has also created a supportive physical environment where clients and peers can relax and socialize with other. They have developed both inside and outside areas that are welcoming and provide a place of safety. They run a clothes closet and are involved with one of the community agencies that supplies food to needy families and individuals.

During the past year, HRHSA has revised its intake process that has resulted in improved access for clients. The outcome of this change is approximately a 66% increase in assessments being completed, still within the same time frame.



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

Challenges

Space continues to be a challenge for the program. With the growth of the volunteer program and program needs, the current location provides challenges to accommodate current staffing and programing needs.

There has also been a turnover in leadership. The previous manager left the program October 2013 and a part-time interim manager provided oversight until a new manager could be hired. As of the beginning of August 2014, a new program manager was hired and is working with staff to provide the needed leadership and support.

Program Results	
• A total of 173 individuals participated in the program • The average number of clinical services per client was 26 • The average number of case management services per client was 13	**How Much?**
• 141.8% of annual targeted number of individuals served was met (Target=122) • The average length of FSP services was 482.3 days • The number of individuals exiting FSP because goals were met or moved to lower level of care was 16% (27/173 Partnership), 26% (45/173 Discharged from FSP), 60% (27/45 discharges) • 92% (36/39) of surveyed clients reported being satisfied with services*	**How Well?**
• 81% (30/37) of surveyed individuals indicated they deal more effectively with daily problems as a result of services* • 63% (22/35) of surveyed individuals indicated that they feel they belong to their community as a result of services* • 85% (27/34) of surveyed individuals reported that they were better able to take care of their needs* *Mental Health Statistics Improvement Program (MHSIP) Consumer Survey	**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 is a membership-driven "clubhouse" type center for diverse transition age young adults (TAYA) with mental illness. Outreach to and participation from Gay, Lesbian, Bi-sexual, Transsexual and Questioning (LGBTQ) youth are included in the cultural sensitivity of services provided.

The center has two service teams: Josie's Place Intensive Services and Supports (ISS) and a Full Service Partnership (FSP) called Josie's TRAC operated by Telecare Recovery Access Center. The teams provide case management, therapy, and psychiatric services in English, Spanish, Laotian, and Thai languages. The following peer support groups are offered: Seeking safety, aggression reduction therapy, gender specific peer support, and an active LGBTQ support group.

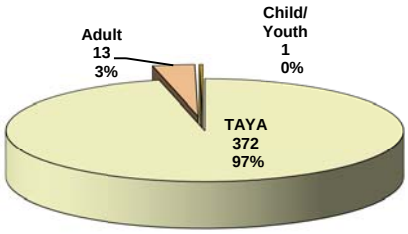
Josie's Place is also home to the Young Adult Advisory Council (YAAC), a consumer-based group that provides leadership opportunities for youth to get involved in daily activities. For FY14-15, there are no proposed changes in the population to be served and strategies to be used.

As part of the MHSA planning process, the Representative Stakeholder Steering Committee on July 18, 2014 approved a funding plan that included expansions for Josie's Place and Josie's TRAC. The three year funding provided the following: $433,000 for FSP-01 Josie's TRAC and $393,000 for GSD-01 Josie's Place. The expansions will increase staffing and provide increased access to the drop-in center for underserved populations. This was included in the MHSA Plan Update approved by Stanislaus County Supervisors on September 30, 2014. More details about the expansion will be reported in activities for FY 14-15.

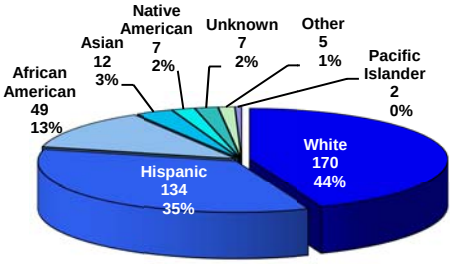
The estimated number of individuals projected to be served in FY14-15 is 250.

Demographics

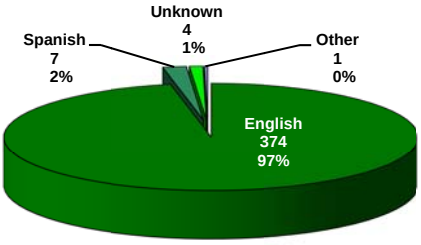
Age
Total Served 386



Race\Ethnicity
Total Served 386



Primary Language
Total Served 386



Highlights

Josie's Place is proud of its community outreach efforts and was a presence at several events including the Modesto Pride Conference, Mental Health Diversity Week, and Community Outreach and Youth Leadership forums. There was also an opportunity for youth at the drop-in center to "give back" to the community. Youth conducted canned food drives for TAYA with families in need and provided coffee and doughnuts to the homeless in Modesto.

The approved expansion of Josie's Place and Josie's TRAC are other highlights that will greatly improve services and access. The funding will add two new Clinical Services Technicians to expand hours of the Drop-In Center and accommodate the underserved TAYA adults. The expansion of Josie's TRAC will provide the program with additional staffing capacity to expand the FSP to include 10 to 12 more clients.

Challenges

The TAYA population is always shifting due to constantly changing life circumstances. Working with young people to build their ego strength and skills is a challenge. Getting to the Drop-In Center can be another challenge for students who attend school or work jobs. Transportation is another barrier due to limited bus service.

Program Results	
• A total of 454 individuals (200 from ISS and 254 from Drop-In Center) were served at Josie's Place • The average number of clinical services per individuals was five (5) • The average number of case management services per individual was 10	**How Much?**

• 169% of the annual targeted number of individuals served was met (Target=150) • The average length of treatment is between eight (8) months to one (1) and a half years for the Service Team • The average length of treatment for TRAC is one (1) and a half years	**How Well?**
• 71% (32/45) of surveyed participants indicated that they deal more effectively with daily problems as a result of receiving services* • 54% (24/45) of surveyed participants indicated that they feel they belong to their community as a result of receiving services* • 62% (28/45) of surveyed participants reported that they better able to take care of their needs* *Mental Health Statistics Improvement Program (MHSIP) Consumer Survey	**Is Anyone Better Off?**

Referred to as the "Community Emergency Response Team (CERT)/Warm Line", the BHRS operated CERT program combines consumers with a team of licensed clinical staff to provide interventions in crisis situations. The "Warm Line", administered under a contract with Turning Point Community Programs, is a telephone assistance program. It provides non-crisis peer support, referrals, and follow-up contacts.

The program serves children, transition age youth, adults and older adults. The primary focus is on acute and sub-acute situations of children and youth with serious emotional disturbances (SED) and individuals with serious mental illness.

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

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

There are no proposed changes in the population to be served and strategies to be used in FY 14-15. The estimated number of individuals projected to be served is 3000.

Highlights

The Warm Line program exceeded expectations serving an additional 69 callers over the 1,000 callers listed in its contract goal. The Warm Line also answered a total of 23,029 calls this fiscal year, an increase of 12.8% or 2,608 calls from the previous year.

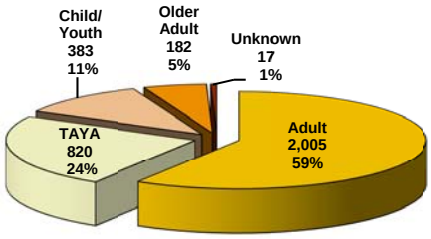
Staff continued efforts to attend trainings to provide the best services and resource knowledge to the community. Among the trainings: Applied Suicide Intervention Skills training (ASIST), Mental Health First Aid, Cultural Competency, and Community Capacity Building.

Challenges

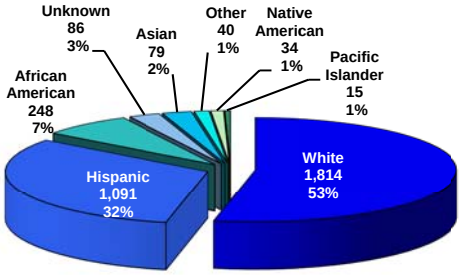
CERT has moved locations twice in the last year. While each move is a challenge, the team was able to work together to provide seamless services to the community. Staffing has also been a challenge but the existing team has been flexible to ensure client care did not suffer.

Demographics

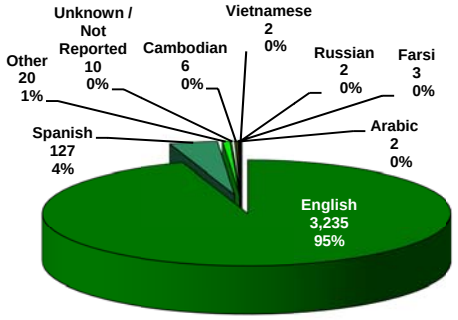
Age
Total Served 3,407



Race/Ethnicity
Total Served 3,407



Primary Language
Total Served 3,407



Program Results	
• A total of 2,527 individuals were served through CERT (unduplicated number of participants) • A total of 1,414 individuals were served through Warm-Line (unduplicated number of participants) • A total of 33,355 calls were received through the Warm Line asking for peer support, community resources, Medi-Cal providers, and information	**How Much?**

• 114% of the annual targeted number of individuals served was met. (Target=3000) • 100% (5/5) of surveyed CERT clients were satisfied with services* • 100% (5/5) of surveyed CERT clients indicated that “staff believed that I could change.”* • 94% of participants that completed a client satisfaction survey said the services they received were helpful* • 95% of participants that completed a client satisfaction survey said they were satisfied with how the staff interacted with them* • 94% of participants that completed a client satisfaction survey said they were satisfied with the support and resources provided*	**How Well?**
• 100% (3/3) of surveyed participants indicated they deal more effectively with daily problems as a result of services* • 100% (3/4) of surveyed participants indicate that they feel they belong to their community as a result of services* *Mental Health Statistics Improvement Program (MHSIP) Consumer Survey	**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 is the MHSA funded program at the Family Partnership Center (FPC). The goal is to provide mental health services to families in a one-stop-shop experience. Joined by the Parent Partnership Project, Kinship Support Services, and the Family Partnership Center Mental Health Team, the program provides a wide variety of support services to meet the need of diverse families. Services include peer group support and help with navigating mental health, Juvenile Justice, and Child Welfare systems.

The Parent Partnership Project promotes collaboration between parents and mental health service providers. Kinship Support Services provide services to caregivers, primarily grandparents raising grandchildren. Family Partnership Mental Health provides mental health and psychiatric services, and linkage to the other programs.

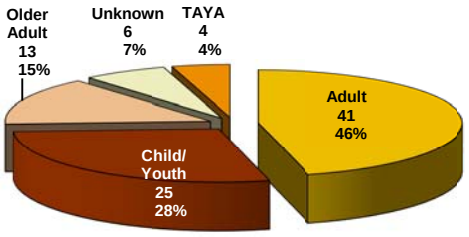
In FY14-15, there are no proposed changes in the population to be served and strategies to be used. In the 2014 MHSA stakeholder planning process, a program enhancement was approved and was included in a Plan Update adopted by the Stanislaus County Board of Supervisors on September 30, 2014.

The expansion will provide the following: Enhance parent partner capacity to expand to families in Child Welfare and Probation Systems by having them engage with families entering each identified system, provide support to families engaged in Pathways to Well-being (Katie A) Child and Family teams, and hire four staff members. More details about the expansion will be reported in activities for FY 14-15.

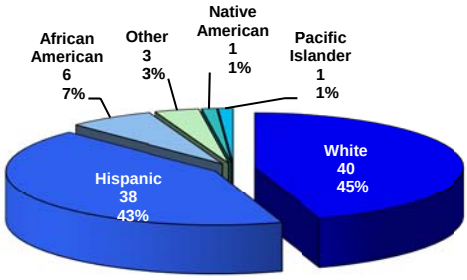
The estimated number of individuals projected to be served in FY14-15 is 80.

Demographics

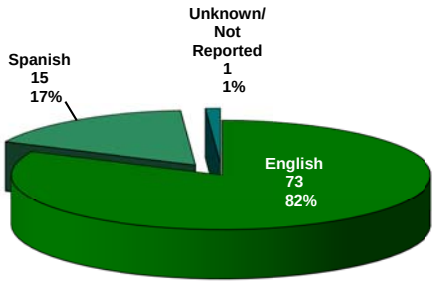
Age
Total Served 89



Race/Ethnicity
Total Served 89



Primary Language
Total Served 89



Highlights

The Family Partnership Center Consulting Committee (FPCCC) is a group of parents/caregivers who have used FPC services and wish to serve in an advisory capacity. A subgroup of the committee has embraced the task of recruiting and training volunteers, as well as helping to operate a volunteer program. They have been instrumental in providing volunteers for the center's Clothes Line clothing giveaway program.

The Beading Group continues to grow, offering opportunities for parents/caregivers to join others to relax, make something creative either for themselves or others, and feel a sense of accomplishment. The group meets weekly and has two volunteers who assist with the group.

Challenges

Staffing was a challenge for the program with the number of parents/caregivers seeking support exceeding capacity to provide services. Hiring volunteers was also a concern. However, a new Director of Volunteer Services has since been hired and is working with the program to help bridge the staffing gaps.

Program Results	
• A total of 89 individuals were served in the program	**How Much?**
• Program served 111% of annual targeted number of individuals (Target=80) • 100% (4/4) of surveyed clients reported being satisfied with services*	**How Well?**
• 100% (3/3) of surveyed participants reported that they are better able to take care of their needs* *Mental Health Statistics Improvement Program (MHSIP) Consumer Survey	**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 they can flourish emotionally while developing skills. It is a culturally diverse place where individuals gain peer support and recovery-minded input from others to reduce isolation, increase the ability to develop independence and create linkages to mental health and substance abuse treatment services.

CEC is 100% staffed by behavioral health consumers and family members. A culinary training program called The Garden of Eat'n is part of the center. This program provides an opportunity for people to learn food preparation, sanitization, catering, and safe food practices with the goal of gainful employment after completing their training. CEC offers group space for all consumer and family organizations to reserve for meetings.

CEC staff assists members in obtaining community resources and linkages to housing, employment, and education. As a team, they provide peer support and introduce self-sufficiency tools and coping techniques to members. These skills are designed to enhance personal empowerment and professional confidence. Safe and ethical social behaviors appropriate for the community, workplace or a shared living environment are introduced and modeled to members. Opportunities are available that promote self-determination, empowerment, lifelong learning, and employment and training.

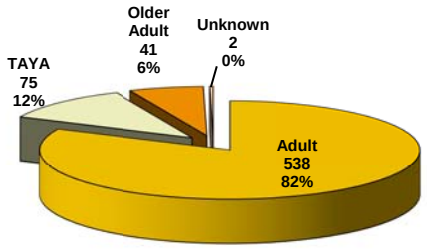
GSD-05 also includes funding for the Community Activities and Rehabilitation Transportation (CART) program operated by Turning Point Community Programs. CART is a transit service that provides consumers and their families with greater access to support all aspects of their participation in community activities.

In the 2014 MHSA stakeholder process, a program expansion was approved and included in a Plan Update adopted by the Stanislaus County Board of Supervisors on September 30, 2014. The expansion provides the following: Vital transportation needs to decrease wait times in hospital emergency departments, connect individuals with timely support and treatment, and provides a CART driver with shared lived experiences to engage clients in recovery and resiliency. More details about the expansion will be included in reporting of activities for FY 14-15.

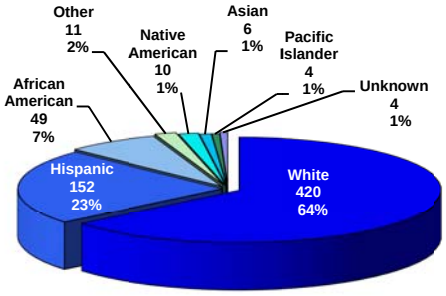
The estimated number of individuals projected to be served in FY14-15 is 500.

Demographics

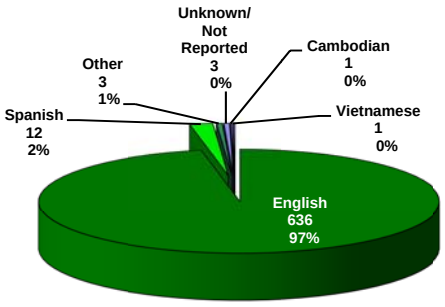
Age
Total Served 656



Race\Ethnicity
Total Served 656



Primary Language
Total Served 656



Highlights

CEC has developed an "Empowerment Center Support" program (also known as ECS) that takes volunteerism to another level of support. ECS participants are center members that commit to completing 12 support groups and then "graduating" to an ECS for the center. They complete tasks like sweeping the center or taking out the trash, greeting folks at the center, engaging with other members and also complete trainings directly connected to mental health and recovery. Many participants have gone further in their journey to get Facilitator's trainings and assist in co-facilitation and further support for their fellow members.

Another highlight is the BHRS Volunteerism program. Participants take this route to further their experience in a more formal setting and develop a relationship with BHRS. Several of the participants are active students focused in the field of Mental Health. Also, as expansions in the county happen, CEC is pleased to share that several participants have been offered employment via these expansions.

CEC also maintains community participation. CEC Members participated in the Cultural Competence and Mental Health Summit Northern Region Summit XIX as liaisons for a community training. Also, CEC members have participated in a Peer Summit in which peers presented their stories and lived experiences to community members participating in summit training. CEC Members actively take part in community events, galleries and panels to present their experiences.

They also enjoy accepting invitations of question and answer venues to colleges and universities. CEC continues to strive in community alliance and is an active member in local boards and committees. CEC is also very excited to participate in ongoing collaborations/trainings that encourage healthy growth and independence for our members and staff.

Challenges

Transportation: As CEC does not have a vehicle for transportation, this significantly limits participation from folks that are out of Modesto or do not do well traveling on the bus.

Funding: Program funding is limited as well, so CEC relies heavily on fundraising efforts to help pay for trips, activities, supplies, bus tickets and document fees (IDs, birth certificates) that prevent folks from utilizing services in the community.

Stigma: As the program has inherited a large homeless population, it's important to consistently educate members on accurate services that are provided and maintain MHSA obligations to ensure program criteria are met with every new member. As homelessness may be a challenge a member faces, the focus is on their connection to mental health and how CEC can support them and their mental health needs. However, CEC remains diligent in expressing the fact that homelessness is not a criteria for services.

Media/Marketing: This has been a challenge. CEC is interested in partnering with PEI and its marketing campaigns to collectively highlight support for mental health.

Program Results	
• A total of 658 individuals were served at the CEC (unduplicated number of participants)	**How Much?**
• 164% of annual targeted number of participants served was met (Target=400) • 91% (51/56) of surveyed clients said they were satisfied with the services they received* • 90% (46/51) of surveyed clients indicated that "Staff believed I could change"	**How Well?**
• 78% (40/51) of surveyed participants indicated they could deal more effectively with daily problems as a result of services* • 69% (35/51) of surveyed participants indicated that they feel they belong to their community as a result of receiving services* • 78% (38/49) of surveyed participants reported that they are better able to take care of their needs* *Mental Health Statistics Improvement Program (MHSIP) Consumer Survey	**Is Anyone Better Off?**

At its inception, the primary function of Garden Gate Respite (GGR) was as an outreach tool to introduce individuals from unserved and underserved populations to mental health services through a welcoming and engaging environment, in the context of a home-like setting. GGR was originally developed as an AB-2034 "housing first" program, a value which remains a priority, given its significant focus in the context of collaborations with the Stanislaus County Behavioral Health and Recovery Services (SCBHRS) Housing Outreach program, and other SCBHRS-contracted outreach and engagement programs.

GGR continues to function in this regard. However, beginning in 2006, expansion of the program in keeping with community stakeholder priorities was facilitated with MHSA funding. In July of 2013, another such opportunity (with no change/relationship to funding) arose concurrently with the advent of the Garden Gate Innovative Respite Project (GGIRP), a new MHSA Innovation Project, when it was determined that the best practices of the GGIRP should also be applied to GGR.

While not a treatment program, the result has been an enhancement of GGR's productive and collaborative partnerships with SCBHRS, its contractors, and other community organizations, to empower guests in moving toward recovery through the augmentation of in-house Case Management and support services focused on addressing basic needs, developing resources, community support/connections, and resiliency. To increase the network of supports and services GGR staff is available to connect guests with efforts to engage and partner with outside agencies have heightened.

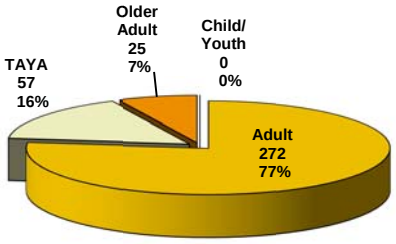
GGR continues to operate as a 6-bed facility, open 24 hours a day, seven (7) days a week, 365 days a year situated in a residential neighborhood, adjacent to GGIRP and the SCBHRS Transitional Housing program apartment complex, for which GGR provides limited ancillary support to residents.

Staff members of GGR represent diverse cultures, including individuals with lived experience as consumers or family members of mental health service consumers.

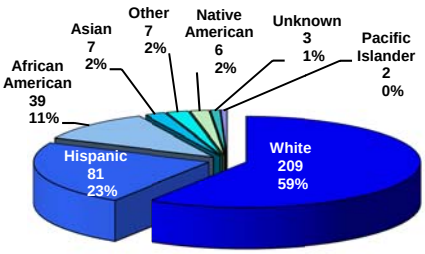
Individuals served include Transition Age Young Adults (age 18 minimum), Adults and Older Adults from diverse populations who are either known or suspected to have significant mental health issues, are either homeless or at risk of homelessness, and at risk of: incarceration, victimization, and /or psychiatric hospitalization. Law enforcement and SCBHRS-contracted outreach and engagement programs initiated the majority of referrals to GGR in FY 13-14.

Demographics

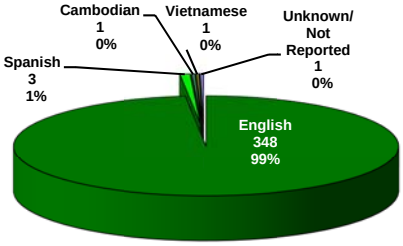
Age
Total Served 354



Race\Ethnicity
Total Served 354



Primary Language
Total Served 354



There are no proposed changes in the population to be served and strategies to be used. The estimated number of individuals projected to be served in FY 14-15 is 372.

Highlights

Program highlights included the ability to apply the enhanced services of the GGIRP to GGR. With the addition of on-sight Case Management staff came the ability to provide more comprehensive referrals and follow-up to maximize the likelihood that an individual's stay at Respite would be productive, and help move toward securing a stable living situation or connect with resources needed to reduce the likelihood that formal SCBHRS mental health services might be needed. For those already linked to SCBHRS, it could minimize factors that influence utilization of emergency and crisis services. On-site groups and presentations from outside resources have been valuable enhancements to the program.

Heightened outreach efforts have broadened the array of agencies with which to collaborate. The development of new data collection tools has significantly increased confidence that data collection efforts

are yielding more meaningful results, and have allowed staff members to have some objective way to gauge the success of their efforts to support individuals in their journey of recovery.

Challenges

Challenges encountered throughout the enhancement of GGR services included long-time staff orienting to a different approach to service provision from conceptual (e.g. intention and focus of services, roles in relation to different and unique functions among various job classifications) to practical considerations (e.g. new and higher volume of documentation and data collection).

Although ultimately a highlight, the initial development and refinement of new data collection tools, and the accompanying need for a compatible new platform for storing and analyzing data was also a challenge, although the work of the SCBHRS team that actually built that platform minimized what could have been an overwhelming challenge.

Additional challenges have included balancing the substantial need to outreach to other agencies to orient them to services and develop collaborative relationships with a wide array of community resources. The enhancement of services, with limited orientation to outside agencies has, as times, contributed to temporary barriers to communication and collaboration. Also, off-site presentations interfere with consistency of services due to limited availability of program supervisors during these times. Challenges also arise in terms of maintaining status and function of an Outreach & Engagement (rather than treatment) program, but still needing to be proactive in the provision of services and supports that allow a stay at Garden Gate to be a meaningful experience for someone moving, or to help someone move, toward recovery.

Despite the ability to provide consistent support and encouragement for individuals to engage in constructive and recovery-oriented activities in the community, transportation remains a barrier. Garden Gate was not initially intended or budgeted to provide assistance with transportation. Although bus passes are made available on a limited basis, anxiety, low motivation, cognitive impairment, and physical limitations are some of the factors that continue to inhibit guests from independently accessing resources in the community.

Program Results	
• A total of 354 individuals were served (unduplicated number of participants) • A total of 1,014 referrals were provided to individuals • Between April and June 2014,100 individuals took active steps to connect with a community support/resource referral provided by staff • Between April and June 2014, 79 individuals who took active steps to connect with a community support/resource referral were successful in doing so • 62% (353/570) of individuals referred were either homeless or at risk of homelessness at the time of admittance • 45% (256/570) of individuals referred were either at risk of arrest or engaging in criminal activity*	**How Much?**
• 369% of annual targeted number of individuals served was met (Target=96) • 100% (12/12) of surveyed individuals reported being satisfied with services* • 92% (11/12) of surveyed individuals indicated that “staff believed I could change”** • 43% of individuals were discharged to a stable housing or residential treatment environment	**How Well?**
• 80% (8/10) of surveyed individuals indicated they deal more effectively with daily problems as a result of services* • Between April and June 2014, 47% (60/127) of individuals were referred for the purpose of preventing an acute psychiatric inpatient stay • 72% (87/121) of individuals endorsed either “Strongly Agree” or Agree” to the statement, “I have been able to connect with peers who are mental health consumers”*	**Is Anyone Better Off?**

• 86% (101/121) endorsed either “Strongly Agree or “Agree” to the statement “My contact with peers has helped me feel supported”* • 74% (90/121) of individuals endorsed either “Strongly Agree” or “Agree” to the statement “I feel more hopeful and empowered in my ability to cope”* *GGRC Guest Satisfaction Survey ** Mental Health Statistics Improvement Program (MHSIP) Consumer Survey	

Supportive Housing Services (O&E 02)

Supportive Housing Services include Transitional Housing, Permanent Housing, and outreach and employment programs for homeless and mentally ill residents of Stanislaus County.

In FY 13-14, a total of 139 clients received housing services while 144 clients received assistance with employment services such as job coaching and resume writing.

An integral part of Supportive Housing Services is the community partnerships. BHRS partners with the Stanislaus County Housing Authority, the city of Modesto, and the Community Services Agency to provide housing units to serve this population. The Department of Rehabilitation is another important partner.

Supportive Housing Services also includes long term supported housing funds. The one-time funds were appropriated from CSS funds in FY 07-08. In 2008, Stanislaus County was assigned $4.8 million by CalHFA to hold in a sub-account.

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 had to be leveraged with other forms of financing (e.g. Housing and Urban Development, HUD). In addition, long term supported housing had to be designed with the goal of establishing and/or strengthening partnerships that result in development of housing that reflects local priorities. The housing also had to expand safe, affordable options for individuals with serious mental illness or youth with serious emotional disturbance and their families.

On July 18, 2014, MHSA stakeholders approved funding for three years to expand O&E 02 to include $1,092,000 for Intensive Transitional Housing and $195,000 for Vine Street Emergency Housing. Stakeholders also approved issuing of a Request for Proposal (RFP) for Transitional Board and Care in the amount of $285,000. In addition, an RFP for an O&E3 for Outreach and Engagement was also approved. The funding amount for the RFP is $420,000. The expansions were included in the MHSA Plan Update approved by the Stanislaus County Board of Supervisors on September 30, 2014.

Highlights

Bennett Place is an 18-unit apartment complex in Modesto for low income people with mental health disabilities. Construction began in January 2014. Bennett Place celebrated a grand opening in July 2014 with its first tenants moving in on August 27, 2014.

Bennett Place provides the mentally ill in Stanislaus County with the foundation they need to build stable lives. The complex consists of eight one-bedroom apartments and 10 studio apartments for transition age young adults (TAYA) and older adults. It also includes a community center. The tenants are Behavioral Health and Recovery (BHRS) clients. BHRS provides case management services and helps clients with financial management, job skills, scheduling medical appointments, and other needs.

The project on Lincoln Avenue cost nearly $5.2 million to build. About $3 million came from the city of Modesto through federal housing money. About $2.2 million is MHSA funding. Bennett Place is currently at capacity and individuals who live there are thriving in their community.

Challenges

There continues to be a lack of funding designated for affordable housing. This presents a challenge as MHSA housing funds are intended to be leveraged with other funds to develop housing projects. Funding has recently started to slowly come back around as the economy has become stronger.

These funds have strict program rules and limited flexibility that cause barriers to a local environment that does not have the housing development resources of larger counties.

Another challenge is that the Housing and Support Program has grown over the past several years and the staffing has stayed the same.

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Prevention Early Intervention (PEI)

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

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

Stanislaus County has eight (8) PEI projects that include eighteen (18) programs. Many have more than one contracted agency to implement the program in communities across Stanislaus County. Each program has a unique approach that incorporates community-based interactions with service recipients that strive to include MHSA values of cultural competency, community collaboration, wellness, recovery/resiliency, client/family driven services, and an integrated service experience.

The projects are as follows:

- Community Capacity Building
- Emotional Wellness Education/Community Support
- Adverse Childhood Experience Interventions
- Child/Youth Resiliency and Development
- Adult Resiliency and Social Connectedness
- Older Adult Resiliency and Social Connectedness
- Health/Behavioral Health Integration
- School/Behavioral Health Integration

Program Budget

FY 2013-14 Actual	FY 2014-2015 Budgeted
$3,339,648	**$4,333,961**

Highlights

- Ten communities participated in the Asset-Based Community Development program.
- A total of 308 Promotores were active in their respective communities making 14,265 contacts through community based collaborative events and activities.
- An estimated 70,124 individuals were exposed to the StanUp for Wellness Suicide Prevention and Early Psychosis Signs and Symptoms messages through movie screen advertising at Galaxy Theater in Riverbank, Brendan Theatres in Modesto, and Regal Stadium 14 Theatre in Turlock.
- A total of 121 community residents were trained in Mental Health First Aid.
- Thirty-eight students successfully completed Aggression Replacement Training (ART) and were able to apply it successfully to their lives.
- A total of 1,261 Stanislaus County residents received behavioral health services in a primary care setting.
- A total of 11,455 students participated in the Nurtured Heart Approach, a school based mental health early intervention program.
- A total of 237 seniors were screened for mental health services.
- A total of 655 individuals attended 46 In Our Own Voice presentations aimed at reducing the stigma of mental illness.

Challenges

- Developing a new leadership structure and establishing guidelines and procedures was challenging for the ABCD program.
- Some Promotores groups had challenges with data collection.
- Staffing changes was a barrier for some programs.

PEI Expansions

On June 13, 2014, MHSA stakeholders convened to examine PEI programs and incorporate the TOC framework. There was discussion to strategically expand PEI programs and augment services to reach more individuals. One Request for Proposal (RFP) is planned for this funding cycle. The RSSC unanimously approved funding proposals on July 18, 2014 for Three-Years (FY2014-2015, FY2015-2016, and FY2016-2017) for the following. The funding proposals were part of a Plan Update approved by the Stanislaus County Board of Supervisors on September 30, 2014. (See table 1 for annual costs).

Community Capacity Building Initiative

- Promotores Community Mental Health Outreach

Adverse Childhood Experience Interventions

- Early Psychosis Intervention Services

Health/Behavioral Health Integration

- Decrease Client/Staff Ratios

Underserved Cultural and Ethnic Populations School Behavioral Health Integration

- Nurtured Heart
- Creating Lasting Student Success (CLaSS)

PEI Request For Proposals

One Request for Proposal (RFP) is planned to address one or more of the following three areas of focus:

- Community Capacity Building Initiative/Community-Based Early Intervention Services
  Provide individual and group early intervention and treatment services to promote recovery-related functional outcomes for mental illness early in its emergence; may include services to parents, caregivers, and other family members of persons with onset of mental illness; provide outreach services in community settings.
- Adult Resiliency and Social Connectedness/Community Based Peer Support
  Provide peer support for individuals experiencing onset of severe mental illness (SMI); integrate peer support model into prevention, early intervention, treatment providers, and community-based settings; provide integrated peer support model linking individuals receiving services from PEI/treatment providers with community-based peer support; incorporate strategies including but not limited to, stigma reduction.
- School Behavioral Health Integration/Capacity Building and Training
  Provide training on early identification of student mental health issues including prevention and early intervention

PEI Project Expansions (per year)	
Community Capacity-Building Initiative • Promotores/Community Mental Health Outreach	**$185,000**
Adverse Childhood Experience Interventions • Early Psychosis Intervention Services	**$125,000**
Health/Behavioral Health Integration • Decrease clients/staff ratios • Underserved Cultural & Ethnic Populations	**$125,000** **$150,000**
School Behavioral Health Integration • Nurtured Heart • CLaSS	**$150,000**
Total Expansions	**$735,000**

PEI - Requests for Proposal	
Community Capacity-Building Initiative • Community Early Intervention Services	**$250,000 per year**
Adult Resiliency and Social Connectedness • Community-Based Peer Support Development	
School Behavioral Health Integration • Capacity Building & Training	

As noted earlier in this document, this Annual Update also includes the use of one-time state augmentation funds that must be expended before July 1, 2015. An additional stakeholder community planning process began in May 2014 focused on ongoing, sustainably funded projects, which may be both new programs and augmentations of current programs/projects.

The following are descriptions of the programs/projects proposed and approved for one-time PEI funding:

PEI/Statewide Campaign (Stigma and Discrimination Reduction, Suicide Prevention, and Student Mental Health - $232,931

CalMHSA, the Joint Powers Authority that was established in 2009, was originally created to more effectively implement three statewide PEI projects through a single entity. Using funds that counties have assigned back to the California Department of Mental Health, three statewide initiatives were funded with these dollars. The three initiatives are Stigma and Discrimination Reduction, Suicide Prevention, and Student Mental Health. The funding for these initiatives will end on June 30, 2014. CalMHSA is requesting that counties consider funding the initiatives for an additional year. Ideally, counties could contribute between 4% and 7% of their PEI allocation. Stanislaus County has benefited from all three of these initiatives. For example, many have seen the signs posted on freeways and in cities statewide, referencing “Know the Signs”. In both Spanish and English, these signs provide information about resources for suicide prevention. “Each Mind Matters” has provided a wealth of information and publicity statewide focused on reducing the stigma and discrimination associated with mental illness. Lastly, the Student Mental Health Initiative has funded projects locally in K-12 schools, Modesto Junior College, and California State University, Stanislaus. Given the amount of one-time funds that the county must expend, the stakeholders endorsed funding the statewide initiatives at the 7% level. According to the most recent information on the PEI allocation for Stanislaus County, this would amount to $232,931.

PEI/Adverse Childhood Experience Intervention Project - Early Psychosis Intervention/LIFE Path - $125,000

Another successful PEI program has been the Early Psychosis Intervention program or LIFE Path. This collaborative partnership with CSU, Stanislaus is very significant since many individuals experience their first symptoms of psychosis in late adolescence and early adulthood. Often this occurs when individuals start attending college. Having this resource available enables early interventions that can significantly decrease

PEI RESTRUCTURING PLAN

To comply with new proposed PEI statewide regulations and address anticipated MHSA future growth funding, BHRS is revisiting its current PEI Plan and has begun the process of revising it to align with the new PEI regulations framework.

The proposed changes include a PEI structure redesign that focuses on coordinated and consistent program results and outcomes to strengthen all MHSA PEI programs. The restructuring plan will also include changes on how programs report data. There will also be proposed changes to existing programs to better serve the needs of those at risk of or with mental illness in Stanislaus County. The BHRS Leadership Team presented the plan to the MHSA Representative Stakeholder Committee on February 27, 2015 and it was approved by stakeholders.

The following illustrates how PEI programs will be structured and categorized in the new PEI redesign:

Prevention

1. Promotores/Community Behavioral O&E
    a.) 9 Promotores Projects
    b.) 5 Community Behavioral Health O&E
2. Community-Based Youth Resiliency
3. Friends are Good Medicine Peer Support
4. NAMI Training & Education
5. SCOE School-Based Behavioral Health Capacity Building
6. Peer Recovery Arts Project Downtown-based Peer Support

Early Intervention

1. West Modesto PEI
2. Community Health Center PEI
3. El Concillio PEI
4. Catholic Charities PEI
5. Child Sexual Abuse PEI
6. LifePath Early Psychosis Intervention
7. School Behavioral Health Integration

Outreach for Increasing Recognition of Early Signs of Mental Illness

1. StanUp for Wellness: BHRS & Community Supports Awareness & Education
2. Mental Health First Aid
3. Network of Care

Stigma & Discrimination Reduction

1. StanUp for Wellness: Each Mind Matters Education and Awareness

Suicide Prevention

2. StanUp for Wellness: Know the Signs Education and Awareness
3. Suicide Prevention Collaborative
4. ASIST Training

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

2015/2016 Revised PEI Plan Structure	**Previous Program Name** *Program names changes only*
CalMHSA Statewide Initiative	
Suicide Prevention & Stigma Discrimination Reduction	
Prevention	
Community Behavioral Health Outreach and Engagement:	Asset-Based Community Development
Promotores/Community Health Outreach Workers	No Change
Community Youth Resiliency Initiative	Youth Leadership
Friends are Good Medicine Peer Support	No Change
Peer Recovery Art Project	No Change
Early Intervention	
West Modesto PEI	No Change
Community Health Center Behavioral Health	Health/Behavioral Health Integration
Latino Behavioral Health PEI	No Change
Child Sexual Abuse PEI	No Change
LifePath Early Psychosis Intervention	No Change
Catholic Charities PEI	No Change
Outreach for Increasing Recognition of Early Signs of Mental Illness	
NAMI Training & Education	NAMI In Our Own Voice NAMI Parents and Teachers as Allies
Behavioral Health Services Awareness & Education	Mental Health Promotion Campaign
Stigma Discrimination Reduction	
Each Mind Matters Awareness & Education Campaign	Mental Health Promotion Campaign
Stanislaus County Office of Education Capacity Building Initiative	No Change
Suicide Prevention	
Know the Signs Awareness & Education Campaign	Mental Health Promotion Campaign
Stanislaus County Office of Education Capacity Building Initiative	No Change

Proposed Program Changes:

New Strategy: Access and Linkage to Treatment
BHRS continues to act on its commitment to reduce disparities by partnering with the community to increase access across the spectrum of care, from prevention, early intervention, treatment and community-based support. To support the development and alignment of these efforts, both in the department and in the community, BHRS will reassign a PEI Staff Services Coordinator to the BHRS Ethnic Services and the Cultural Competency Oversight Committee. The primary role will be to coordinate the department's cultural competency and disparities education effort.

Outcomes

- Increase access to underserved/unserved ethnic and cultural populations

Strategies

- Engagement
    - Community-based behavioral health collaborative development and support -- Supporting the LGBTQ, Assyrian Wellness, Stanislaus Asian American Community Resource, Latino Access and other communities as needed.
    - Policy development to address disparities and access
    - Cultural competency plan and initiatives development and support
    - Public and private sector partnership development in implementing access, suicide prevention, and anti-stigma campaigns.
    - Targeted ethic and cultural populations Mental Health First Aid training
- Outreach
    - Community education and training
    - Targeted ethnic and cultural populations outreach focused on access, suicide prevention, and anti-stigma

Program Revision: School Behavioral Health Integration (SBHI)
All PEI SBHI programs will align services using the School Behavioral Health Consultation model. The SBHC model builds and enhances a continuum of behavioral health supports at a school site by focusing work in five context areas: 1) teacher and staff support, 2) whole school support, 3) student support, 4) family support, and 5) crisis support.

Program Revision: National Alliance for the Mentally Ill (NAMI)
The NAMI program was originally funded to provide the In Our Own Voice and Parents and Teachers as Allies school-based Training. As the NAMI program gained access to communities and schools, the community requested additional NAMI training and education presentations. To help broaden the impact of the program and meet community needs, the program will now provide all NAMI approved training and education programs. The program has experienced success in reaching communities with anti-stigma and mental health education training and education. The budget will be expanded 24%.

Program Revision: Friends are Good Medicine (FGM)
The FGM program target population will focus on families of adults with serious mental illness and/or with a recent hospitalization. The program will add the additional strategy of outreach to families and connecting them to peer and community support. There is no budget impact.

Program Revision: Child Sexual Abuse PEI
BHRS partners with Parents United Sexual Abuse Treatment Team to address the trauma associated with child sexual abuse. The program provides additional Spanish speaking programming for adults who were molested as children and establishes a 24-hour/7 day a week Warm Line for individuals and families affected by child sexual abuse. There is also a Peer Sponsorship component where volunteers provide support to families having experienced child sexual abuse. The program has experienced continued growth among Latinos with a 47% penetration rate in FY 2014. The expanded target population will now include Latino communities. There are no changes to the budget.

Program to be Discontinued: Children Are People
BHRS recommends ending the Children Are People program as of June 2015. Even though the program experienced successful outcomes, the program resources would be best utilized within the SBHI project

where the strategies are similar and will align with PEI Regulations. The $75,000 will be moved from the Youth Leadership program to the SBHI budget.

Program to be Discontinued: Asset-Based Community Development
BHRS recommends ending the ABCD program as of June 2015. The program's focus was on addressing behavioral health issues utilizing the ABCD model. While the program did see significant increased capacity for communities to address behavioral health issues by focusing on increasing community-based protective factors, BHRS recommends discontinuing the program as implemented due to lack of substantive outcomes that will align with the new PEI regulations. However, the Promotores/Community Behavioral Health Outreach and Engagement program will continue to engage existing partners and utilize successful strategies learned through this project.

Program to be Discontinued: Faith/Spirituality-Based Resiliency and Social Connectedness
BHRS recommends ending this county operated program. After a few program redesigns, it has been found that this strategy is not efficient as a stand-alone program. However, the Community Behavioral Health Outreach and Engagement program will continue to engage faith/spirituality communities to increase behavioral peer and community supports for their members. The budget will be reduced.

PEI Restructuring Plan Approval

On February 27, 2015, the MHSA Representative Stakeholder Steering Committee (RSSC) endorsed moving forward with the restructuring plan using the Gradients of Agreement matrix. All stakeholders present voted in favor of making the program changes and aligning PEI with new proposed MHSOAC regulations.

PEI Statewide Initiative Funding Proposal

At the same meeting on February 27, 2015, the RSSC also endorsed spending $90,000 for the PEI Statewide Initiative through CalMHSA. All stakeholders present approved the proposal using the Gradients of Agreement matrix. One stakeholder endorsed the proposal with a minor point of contention citing a concern that funding should go directly to local schools.

PEI – Community Capacity Building Initiative (CCBI)

With the focus on underserved cultural populations, CCBI aims to increase a community's capacity to address existing needs and disparities in mental health care and well-being and to develop and strengthen protective factors.

Utilizing Asset-Based Community Development strategies, the project focuses on leadership development, organizational capacity, and community capacity building. CCBI also supports the Promotores/Community Health Worker model by employing and training behavioral health workers to address mental health disparities and increase protective factors in their own neighborhoods. They act as liaisons with BHRS and lead well-being, risk reduction focused projects.

Programs

- **Asset-Based Community Development (ABCD)**
  ABCD funding helps local communities to develop and implement community-driven plans to strengthen and improve recovery, resiliency and mental health protective factor outcomes within neighborhoods and ethnic, cultural, un-served and underserved populations. Strategies include, but are not limited to: asset mapping mental health supports, behavioral health leadership development, partnership development to increase mental health supports within communities, mental health training, stigma reduction campaigns, and suicide awareness campaigns and training.

  To support these community-driven efforts, BHRS provides facilitation, planning and data support to help communities track progress on their priority results over time. Time limited funding support is also available to help jump start community activities.

  As noted above, BHRS recommends ending the ABCD program as of June 2015. The Promotores/Community health Outreach and Engagement program will continue to engage existing partners and utilize successful strategies learned through this project.

- **Promotores and Community Health Workers (P/CHW)**
  Promotores and Community Health Workers play a critical role in developing opportunities for community members to gather, belong, and exercise their leadership to improve their personal well-being and that of their community. They plan and support community-led interventions that sustain well-being, reduce the "mental illness" stigma, and connect isolated individuals to a community of support. The latter intervention reduces the risk of serious illness in the future, as social isolation is often linked to a variety of negative outcomes.
  Promotores and community health workers serve as true agents of change to create neighborhoods that promote wellness to reduce risk factors. Since they live in the communities they serve, they have a self interest in the results of community well-being projects.

- **The Community Outreach and Engagement (O&E)**
  O&E was established to recognize special activities needed to reach diverse, underserved communities with high need that are disproportionately unserved by traditional types of mental health services. Two community based organizations provide education, depression screenings, transportation services, and resource linkages to individuals and families that are reluctant to enter traditional agency services.
  Each organization seeks to reduce stigma and support access to more intensive services. The services are culturally competent, client/family-focused, and promote recovery and resilience while maintaining respect for the beliefs and cultural practices of individuals served. Emphasis is placed on diverse communities including Hispanic, African American, Southeast Asian, Native American, and Lesbian, Gay, Bisexual, Transgender, and Questioning (LGBTQ).

  - **West Modesto King Kennedy Neighborhood Collaborative (WMKKNC)** focuses on increasing outreach into neighborhood-based supports that honor cultural practices by hiring individuals from the neighborhood. Among the objectives: 1.) Provide mental health depression screenings; 2.) Provide mental health referrals for West Modesto residents in need of specialty services; 3.) Provide peer support sessions for depression and substance abuse; 4.) Continue operation of the Wellness Drop-in Center in West Modesto.
  - **El Concilio: Latino Behavioral Health** focuses on outreach to promote and educate the community on mental health and substance abuse recovery to underserved and unserved 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 ways that honor their culture and way of life.

Highlights

- **Asset-Based Community Development (ABCD)**
  - A total of 10 communities participated in the ABCD program. The communities are as follows: Citizen's for a Healthy Community- Hughson, Manos Unidas – South Modesto, Southeast Stanislaus Promotores Network – Empire, Denair, Waterford, Hughson. Other communities are St. Stanislaus, Waterford Improvement Team (WIT), Beyond the Walls (14 congregations in Stanislaus County), and A Way to Wellness – West Modesto.
  - Community leaders and residents participated in activities to increase community wellness, increase mental health protective factors, and enhance community capacity building. Among the events: a citywide child safety event in Hughson, Love Hughson, a city beautification project, family cultural events for migrants in Empire, and a Family Health and Wellness Fair at St. Stanislaus. The events drew hundreds of people.
  - Health and wellness "Messages from the Pulpit" were delivered to 14 congregations in Stanislaus County. These messages reached an estimated 1,050 congregation members.
- **Promotores and Community Health Workers (P/CHW)**
  - 3 Promotores networks within the program (Ceres, Turlock, and Salida) are serving and supporting the homeless population with activities tailored to support the well-being of the homeless individuals.
  - The Promotores program has been recognized as a promising, culturally defined practice. The program is currently completing a Promising Practice Process addressing the needs of staff, evaluation, and sustainability.
  - Most community Promotores networks have created a Facebook page where they upload their event announcements, pictures, and offer support to on another.
- **The Community Outreach and Engagement (O&E)**
  - **West Modesto King Kennedy Neighborhood Collaborative (WMKKNC)**
    - A new aspect for the program is licensed clinicians to work with members of the community. During the program year, counselors began their orientation and their outreach efforts. They met with 28 individuals for a total of 56 sessions filling a niche that was previously handled through referrals.
    - WMKKNC connected with 674 individuals, primarily meeting with people in their homes to share mental and behavioral health resources. Of the individuals seen, 354 were female and 317 were male with three unknown/no responses. Initial intakes from the door-to-door outreach were 266 (39%), Drop-In Wellness center 100 (15)%, and 111 (16%) from Individual Needs Assessment/Screenings.
    - Peer-led support groups for substance abuse (49 sessions with 259 attendees) and depression (37 sessions with 317 attendees) were held at the Wellness Drop-In Wellness Center.
  - **El Concilio: Latino Behavioral Health & Recovery Services (LBHRS)**
    - Support group attendance levels were sustained in Waterford, Hughson Family Resource Center, Hanshaw Middle School (South Modesto), Keyes Healthy Start, Pride Center, and Grayson Community Center.
    - Support group members reported a decrease in symptoms related to stress, anxiety, and depression, and reported higher emotional health and well-being.
    - Representatives from LBHRS attended Stanislaus Behavioral Health Recovery Services (BHRS) collaborative meetings in FY 13-14.

Challenges

- **Asset-Based Community Development (ABCD)**
  - Developing a new leadership structure and establishing guidelines and procedures was a challenge.

- Motivating participants and getting more community members involved was a challenge for some groups.

➢ **Promotores and Community Health Workers (P/CHW)**
- There were challenges to data collection.
- Some groups reported challenges with attendance at monthly meetings.
- Lack of child care remains a barrier for community Promotores attending activities with their families.

➢ **The Community Outreach and Engagement (O&E)**
- **West Modesto King Kennedy Neighborhood Collaborative (WMKKNC)**
  One challenge for the Wellness Drop-In Center was having enough volunteers for a Family Fun Day event. The concern was resolved during the second half of the year due to increased attendance. Scheduling mental health appointments for individuals who fail to show up was a challenge. One strategy is to provide initial counseling over the phone.
- **El Concilio: Latino Behavioral Health & Recovery Services (LBHRS)**
  Serving a high volume of individual assessment requests with one full-time and one part-time clinician continues to pose challenges.

Program Results	
➢ **Asset-Based Community Development (ABCD):** • 4,685 participants (duplicated number) attended Citizens for a Healthy Community events/activities to strengthen behavioral health and well-being supports for Hughson residents • 385 participants (duplicated number) attended Way to Wellness community events/activities to strengthen behavioral health and well-being for West Modesto residents • 4,775 participants (duplicated number) attended Manos Unidas community events/activities to strengthen behavioral health and well-being for Modesto residents • 1,475 participants (duplicated number) attended Southeast Stanislaus Promotore Network (SESPN) community events/activities to strengthen behavioral health and well-being support for Empire, Denair, Waterford and Hughson residents • 700 participants (duplicated number) attended St. Stanislaus community events/activities to strengthen behavioral health and well –being support for West Modesto residents • 1,500 participants (duplicated number) attended Waterford Improvement team community events/activities to strengthen behavioral health and well-being support for Waterford residents. ➢ **Promotores:** • Approximately 308 Promotores were active in their respective communities • 167 trainings were provided • 706 support sessions were provided • Approximately 14,265 contacts were made through community-based collaborative events/activities ➢ **West Modesto King Kennedy Neighborhood Neighborhood Collaborative (WMKKNC):** • 7 active peer support group facilitators were trained • 100 individuals were contacted through the Drop-in Wellness Center • 266 households were contacted • 231 individuals were screened for depression • 28 individuals received one-on-one counseling sessions • 96 support group sessions were attended by 576 (duplicated number)	**How Much?**

participants • 205 participants were referred for mental health services • 42 community events/activities were held focusing on education and promotion of behavioral health ➢ **El Concilio: Latino Behavioral Health and Recovery Services (LBHRS):** • 380 contacts were made through 29 presentations about the Promotores/Promotoras model • 4 Promotores were identified and trained • 606 contacts were made through 18 community events/activities • 378 (duplicated number) were made through 18 peer support groups • 140 screenings and/or individual assessments were completed	
➢ **Promotores:** • 89% (8/9) of community led Promotores reported increased mental health knowledge and skills • 89% (8/9) of community led Promotores trained at least 5 other Promotores in their respective communities ➢ **West Modesto King Kennedy Neighborhood Collaborative (WMKKNC):** • 93% (133/143) of participants reported satisfaction with program services • 48% (133/276) of referrals were for mental health services • 100% (26/26) of participants who received transportation services arrived to mental health appointments on time ➢ **El Concilio: Latino Behavioral Health and Recovery Services (LBHRS):** • 152 referrals were received from CBO and/or other agencies through community outreach • 71% (271/380) of participants were Spanish monolingual speakers	**How Well?**
➢ **Promotores:** • 89% (8/9) of community led Promotores reported increased confidence • 89% (8/9) of community led Promotores reported increased leadership skills • 103 community projects were led/initiated by Promotores indicating increased leadership • 35% of local network meetings were planned and co-facilitated by community Promotores, indicating increased leadership ➢ **West Modesto King Kennedy Neighborhood Collaborative *WMKKNC):** • 90% (129/143) of participants reported increased well-being • 100% (140/140 of participants reported that they can now talk to other about important things • 91% (129/141) of participants reported being more hopeful about their future ➢ **El Concilio: Latino Behavioral Health and Recovery Services (LBHRS):** • 91% (128/141) of participants reported increased well-being during and/or after one-on-one therapy	**Is Anyone Better Off?**

PEI - Emotional Wellness Education/Community Support

Universal and selective prevention strategies are at the core of this community project. A countywide support group/public information project called "Friends are Good Medicine" is helping to develop and expand social support networks for at risk individuals and families across Stanislaus County.

Another community effort, the "StanUp for Wellness" campaign, focuses on developing unique strategies that address specific culturally underserved populations. The goal is for families, educators, health care providers, and young people to recognize mental health problems and seek or recommend appropriate services.

Programs

- **Mental Health Promotion Campaign (MHPC)**
  The MHPC is a countywide multimedia campaign that includes mental health and wellness messages aimed at increasing protective factors in communities and reducing the stigma associated with mental health issues including those co-occurring with substance abuse. The aim is 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 (FGM)**
  FGM is designed to be a resource and provide information and support to community self-help groups. This program promotes community-based self-help efforts in both the general and professional community. It provides leadership training and consultations.

Highlights

- **Mental Health Promotion Campaign (MHPC)**
  - **Promotores Video:** A local PR company successfully completed the project, a promotional video to highlight the work of the Promotore network throughout Stanislaus County. The aim is to help the Latino community fully understand the approach to emotional health and well-being through the work of Promotores and to help demystify and reduce the stigma associated with mental health issues.
  - **Connecting Campaign:** A graphic design company developed a series of advertising slogans to compliment the "StanUp for Wellness" Campaign. These ads were used as part of a focus group with BHRS staff and PEI community partners to find the best visuals to depict the campaign.
  - **StanUp Website:** The project was completed and the website launched to become one of the main tools for community outreach. The website was also translated into Spanish to reach the Latino population. Work continues to highlight existing programs and self-help programs in efforts to provide more community resources.
  - **Theatre Ads:** The ad campaign was considered a successful effort by PEI program staff. Screen advertising was placed again in Galaxy Theatre in Riverbank, Brenden Theatre in Modesto, and Stadium 12 Theatres in Turlock. Brenden Theatres had the highest volume of moviegoers to see the StanUp for Wellness Suicide Prevention and Early Psychosis Signs and Symptoms campaign messages on movie screens. Another six month campaign was launched at the theatres which reached thousands of moviegoers in Stanislaus County. The ads ran through July 2014.
  - **PEI Program Technical Support:** The program worked with the "Be a Friend" campaign to develop a more sophisticated graphic design of their logo. A marketing plan was also developed to integrate the campaign into the community.
  - **CSU, Stanislaus:** Work was initiated with CSU, Stanislaus and Modesto Junior College on an outreach strategy campaign aimed at suicide prevention.
  - **Technical Assistance Trainings**: A curriculum for the marketing and public relations training was developed for PEI programs.
- **Friends are Good Medicine (FGM)**
  - FGM continues to provide support and services to strengthen the capacity of the self-help and a peer support group network in Stanislaus County. It has maintained the online directory of more than 200 self-help/peer support groups focused on supporting the behavioral health of residents.

- FGM has begun to address the issue of suicide and embraced the *Know the Signs* statewide awareness campaign.
- FGM staff attended community events to help raise awareness of mental health issues and held community trainings in English and in Spanish

Challenges

- **Mental Health Promotion Campaign (MHPC)**
  - Coordinating trainings among partners was challenging.
- **Friends are Good Medicine (FGM):**
  - The online directory was not ideal in reaching underserved/unserved populations who have limited or no internet access. The program is addressing the issue by developing a print version of the directory to be printed 4 times a year with 5,000 copies per printing job.
  - Due to restrictions on social media within Stanislaus County networks, social media marketing of FGM was a challenge. BHRS is allocating mental health promotion campaign funding to support FGM marketing efforts to better promote the online and print directory.
  - Keeping in contact with individuals to check on progress of support groups they may have started or taken over from another facilitator has been difficult. A system to contact and monitor each group and individual is being developed.

Program Results	
Mental Health Promotion Campaign (MHPC): • An estimated 70,124 individuals were exposed to the StanUp for Wellness move screen messages on Suicide Prevention and Early Psychosis Signs and Symptoms through advertising at Galaxy, Brenden, and Stadium theatres • A total of 7 MHPC projects were completed to raise awareness of mental health. **Friends are Good medicine (FGM):** • 121 individuals were trained in Mental Health First Aid • 134 individuals were trained in Peer Support Group Facilitation • There were 53,753 hits on the FGM website; 6,162 unique IPs (website visits)	**How Much?**
Friends are Good Medicine (FGM): • 97% (130/134)of individuals trained would recommend Group Facilitator Training to others • 98% (131/134) of support groups reported increased number of group participants after being listed in the FGM Directory • 99% (132/134) of individuals reported improved understanding and knowledge of subject after attending Group Facilitator Training • 93% (113/121) of individuals reported that the MHFA training was beneficial	**How Well?**
Friends are Good Medicine (FGM): • 98% (132/134) of individuals reported that their skills have improved after attending Group Facilitator Training	**Is Anyone Better Off?**

PEI - Adverse Childhood Experience Interventions

This project addresses the community need for expanding responses to childhood traumatic experiences including child sexual abuse, early onset of serious mental disorders, and the involvement of Juvenile Justice. It provides services to at-risk children and youth, trauma exposed youth and their families, and persons experiencing the early onset of serious mental disorders.

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 10 week program consists of 30 sessions of intervention training and is divided into three components - social skills training, anger control training, and training in moral reasoning.

  The ART group consisted of the following components:

  - 10 weeks (30) sessions of intervention training and was divided into three components - 1) Social skills training, 2) Anger control training, 3) Training in moral reasoning.
  - There were pre-engagement and one-on-one meetings with each participant.
  - ART has been implemented in schools and juvenile delinquency programs across the country and throughout the world. It was first developed for aggressive and violent adolescents who were incarcerated in juvenile institutions. ART has now been adapted for child and youth in schools and mental health centers to reduce aggressive and antisocial behavior and to promote anger management and social competence.
  - Well-being groups are an hour long and weekly. Participants learn relationship enhancing skills.

- **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 program provides additional Spanish speaking programming for adults who were molested as children and establishes a 24-hour/7 day a week Warm Line for individuals and families affected by child sexual abuse. There is also a Peer Sponsorship program where volunteers provide support to families who have experienced child sexual abuse.

- **Early Psychosis Intervention: LIFE Path**
  LIFE Path is a program designed to provide Early Intervention services for 14 – 25 year-olds who have experienced initial symptoms of psychosis. The program provides intensive treatment for consumers, families, caregivers, and significant support persons. The services are tailored to meet the unique needs of each participant and may include screening and assessment, diagnosis, individual and family counseling, and crisis and relapse prevention. 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)**
  - A total of 38 students successfully completed Aggression Replacement Training (ART) at Elliott Alternative Education Center and Central Valley High School in Ceres during the 13-14 school year. These young men were able to grasp the concepts of ART and apply it successfully to their lives. During a staff meeting, several teachers reported that students were actually using the skills outside of group.

- **Expanded Child Sexual Abuse Prevention and Early Intervention (ECSAPEI)**
  - 21% of program speaking engagements were in Spanish
  - 32 support groups were conducted

- **Early Psychosis Intervention: LIFE Path**
  - Life Path was recognized as a highlighted exhibitor for the UC Davis 9th annual conference on psychotic disorders. This was LIFE Path's third year as an exhibitor.
  - LIFE Path established a collaboration with California State University, Stanislaus, in Turlock. CSU granted the program another year of campus working space to meet with students and faculty to address crisis needs of students and provide services.
  - The program continues to maintain its 100% return rate of students to their academic settings for those that had to leave school due to their challenges with experiencing symptoms of psychosis. LIFE Path has consumers that have successfully completed their programmatic needs and have been able to successfully return to their baseline along their developmental trajectories as evidenced by returning to work and school and becoming community advocates for mental health.
  - LIFE Path staff consulted with other early psychosis intervention and prevention programs in the Central valley and have been requested to replicate the LIFE Path program in Merced, Fresno, and Tuolumne counties.

Challenges

- **Aggression Replacement Training (ART)**
  - How to effectively use incentives as a means to cognitively reinforce attendance in the voluntary group is a challenge.
  - Another challenge is helping group members to successfully complete the program curriculum in the face of day to day stressors and life concerns.
  - The program also faces limited available staffing hours; at least two-fulltime staff would help support and sustain the continued growth of this program.
- **Expanded Child Sexual Abuse Prevention and Early Intervention (ECSAPEI)**
  - Addressing the sensitive topic of child sexual abuse can present challenges when these topics are discussed in community presentations.
- **Early Psychosis Intervention: LIFE Path**
  - Transportation for consumers and procurement of an occupational therapist are challenges for the program. Office space is also an issue.

Program Results	
Aggression Replacement Training (ART): • 53 youth participated in the ART program • 18 one-on-one sessions were held with youth • 29 of 36 students received pre-engagement consultation • The program convened 3 well-being groups: o Hutton House Wellness Group: 14 youth o Mattox Youth Center: 14 youth o Stanislaus County Youth Leadership Network (SCYLN): 103 youth **Expanded Child Sexual Abuse Prevention and Early Intervention (ESCAPEI)** • 705 individuals attended 19 sexual abuse prevention trainings • 235 calls were made to the Warm line program **Early Psychosis Prevention: LIFE Path:** • 120 phone consultations were made with various members of the community including mental health service providers, schools, consumers, consumer family members regarding information about early psychosis intervention • 185 individuals attended 21 community presentations • 69 screenings were completed to access program eligibility • 29 multi-family group sessions were held	**How Much?**

➢ **Aggression Replacement Training (ART):** • 72% (38/53) of participants completed the program ➢ **Expanded Child Sexual Abuse Prevention and Early Intervention (ESCAPEl):** • 199 individuals began treatment • 21% (4/19) of speaking engagements were conducted in Spanish • 32 AMAC (Adults Molested as Children) support group meetings were held ➢ **Early Psychosis Prevention: LIFE Path:** • 100% (258/258) of attendees at community presentations demonstrated increased awareness of the early signs of psychosis • 98% (47/48) of individuals who were determined ineligible for the program were successfully connected to other community resources • 26% (9/34) of individuals have met goals and exited program • 98% (42/43) of individuals who were determined eligible for the program entered the program	**How Well?**
➢ **Aggression Replacement Training (ART):** • ART: Since the completion of ART, one individual is now attending Heald College. She and another group member have become Youth Advocates for Mental Health Awareness and Anti-Stigma within the county's local Youth In Mind chapter. One of the males in the ART group was awarded his school's Student of the Month award shortly after his completion of the ART program this past year. • WELL-BEING: By providing groups at Hutton House and the Maddux Youth Center, staff reports that young people are able to implement the skills learned and apply them to other settings. Some youth at Hutton House keep group materials and use them in sessions with their counselors. ➢ **Early Psychosis Prevention: LIFE Path:** • 96% of individuals in the program who were on med were medication compliant • 88% of individuals in the program had decreased hospitalization • 94% of individuals in the program reported that their family lives are stabilizing	**Is Anyone Better Off?**

PEI - Child/Youth Resiliency and Development

This project highlights 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 youth leadership development efforts. The partnerships include:
  - Sierra Vista Child and Family Services (SVCFS) - The Bridge Community Center/Bridge Youth Builders
  - Hughson Family Resource Center (HFRC) - Youth Connection/Hughson Youth Council
  - Center for Human Services (CHS) - Patterson Teen Center
  - West Modesto King Kennedy Neighborhood Collaborative(WMKKNC) – Project Uplift/Leadership for the Future

  LRP are school and/or community-based programs for youth ages 14-19 that enhance internal strengths and resiliency, prevent involvement with substance abuse and violence, and help youth avoid school failure and involvement with Juvenile Justice. Activities include resiliency groups, adventure and outdoor activities, community service opportunities, conflict resolution, social skills training, and peer mentoring.
- **Children are People (CAP)**
  CAP is a program designed for children of alcoholic or substance abusing parents/caregivers. CAP is a psycho-educational program designed to address the problems of children in third through fifth grades that are exposed to family substance abuse. The program consists of 8-10 sessions in a small group setting. Each weekly session includes opening and closing exercises and a topic for learning/discussion that address a specific psychosocial concern children may encounter. The program provides training and supervision to staff and qualified volunteers at different sites within the county.

Highlights

- **Bridge Youth Builders (BYB)**
  - An average of 20 active Bridge Youth Builders (13 years and under) participated in the program and 22 afterschool events were held. A total of 50 participants (19 years and under) participated in youth led events.
- **HFRC Youth Leadership**
  - Youth participated in a Backpack Project and assembled more than 450 backpacks for needy students in 17 different southeast Stanislaus schools. Supplies were sorted by grade level from kindergarten through 12 grades.
  - A total of 11 high school seniors participated in the program. Everyone graduated from high school and 9 are pursing college.
- **Patterson Teen Center Lifeplan**
  - The program engaged 91 participants with 16 Youth Mentors and provided services to Del Puerto High School, Patterson High School, and the Grayson community.
  - Members facilitated various community engagement projects such as mentoring and outreaching to middle school youth
- **Leadership for the Future/Project UPLIFT**
  - A total of 287 youth (unduplicated count) participated in the youth program
  - A total of 113 youth participated in four “feed the Homeless” events sponsored by the Modesto Rotary Club in partnership with Omega Psi Phi Fraternity and held at the Salvation Army.

- **Children Are People (CAP)**
  - A highlight of the program is the sense of support and empowerment that's developed in the classroom. Students demonstrate a collective ownership and responsibility of the classroom. Trusting relationships develop which allow students to seek support individually and in small groups to work through challenges.
  - CAP is designed to be a highly individualized process. Sessions are developed based on classroom interest and discussions, creating opportunity for variety.

Challenges

- **Bridge Youth Builders (BYB)**
  - Student's lack of motivation or interest in project
  - Lack of supplies
  - Need for additional Youth Advisors
- **HFRC Youth Leadership**
  - Transportation is an issue for some youth.
  - The program is run on a weekly basis and to fit all its activities in 10 to 12 hours, the group is prioritizing what's important. It has also enlisted the help of volunteers to assist with record keeping and event support.
- **Lifeplan**
  - Time constraints were a challenge. There are additional sites and students who would like to have Lifeplan services. However, time is limited to after school meetings in most cases.
  - Program staff changes were an issue.
- **Leadership for the Future/Project UPLIFT**
  - Transportation to and from events was challenging along with volunteer opportunities.
  - The program has begun to see a decline in parental participation.
- **Children Are People (CAP)**
  - Program staffing changes posed a challenge. One school site had a total of 3 different teachers during program implementation and a couple of other new teachers post-completion.

Program Results	
Bridge Youth Builders: • An average of 20 active Bridge Youth Builders (13 years and under) participated in the program • 22 afterschool events were held • There were 50 participants (19 years and under) at youth led events • 21 members participated in the Bridge Youth Council • 24 community service projects were initiated **HFRC Youth Leadership:** • 28 youth participated in YOUth LEADership (ages 14-19) • 7 youth were 13 years of age and younger • 5 youth led service learning projects • 118 youth participated in community service activities, projects, and events **Lifeplan:** • 5 Lifeplan groups were formed • 91 individuals participated in the group (unduplicated number) • 26 Lifeplan outreach activities were implemented • 16 individuals became new Youth Lead mentors **Leadership for the Future/Project UPLIFT:** • 287 youth participated (unduplicated number) • 94 youth participated in college tours • 294 youth participated in leadership trainings • 368 youth activities and events were held	**How Much?**

➢ **Children Are People (CAP):** • 166 children participated in CAP groups and individual services • 2 schools/organizations implemented the CAP program	
➢ **Bridge Youth Builders:** • 100% (21/21) of participants reported satisfaction with program services • 100% (21/21) of participants reported an understanding of the 40 developmental assets ➢ **HFRC Youth Leadership:** • 22% of youth joined YOUth LEADership as a result of participating in youth leadership training ➢ **Lifeplan:** • 88% (67/76) of students were eligible to graduate from Lifeplan • 96% (48/50) of students indicated that they have contacted a person from the Board of Directors (board members work with students on their Lifeplans) since the conclusion of the program • 100% (50/50) of students responded that they would recommend the program to a friend ➢ **Leadership for the Future/Project UPLIFT:** • 98% (101/103) of youth responded they feel valued by adults • 98% (100/102) of youth responded they feel they have been given the opportunity to lead community services activities	**How Well?**
➢ **Bridge Youth Builders:** • 100% of Bridge Youth Council members reported increased self-efficacy • 100% of Bridge Youth Council members reported improved leadership skills ➢ **HFRC Youth Leadership:** • 71% of youth reported that they feel their leadership abilities have grown • 69% of youth reported increased leadership skills ➢ **Lifeplan:** • 86% (45/52) of participants reported an increase in positive self- confidence • 98% (51/52) of participants reported an increase in positive outlook for the future • 94% (55/58) of participants reported an increase in connectedness to their community • 87% (73/83) reported increased leadership skills • 100% (50/50) reported that they have used skills learned in the Lifeplan since the program ended ➢ **Leadership for the Future/Project UPLIFT:** • 98% (101/103) of youth reported “very good” or “good” relationships with adults • 98% (100/102) of youth reported positive community service experiences • 96% (97/101) of youth reported that they are “more likely to continue education or training: • 96% (97/101) of youth reported that they are more hopeful or better prepared for their future	**Is Anyone Better Off?**

PEI - Adult Resiliency and Social Connectedness

By providing opportunities for social support, this project serves adults with the goal of reducing the stigma and discrimination related to having a mental illness. It reduces 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 them.

Programs

- **In Our Own Voice (IOOV)**
  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 and encourages faith based communities and spirituality groups throughout Stanislaus County to create increased social support and social connections for adults experiencing 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 allow faith-based organizations to provide education and information about behavioral health concerns that reduce stigma, enhance emotional wellness, increase protective factors, and support recovery.

  As noted above, BHRS recommends ending this county operated stand-program. The Community Behavioral Health Outreach and Engagement program will continue to engage faith/spirituality communities to increase behavioral peer and community supports for its members.

Highlights

- **In Our Own Voice (IOOV)**
  - Program staff trained 6 (six) new speakers; 2 (two) from Oakdale, 1 (one) from Waterford and six (6) from Modesto.
  - Staff introduced program to inmates in county jail
  - Staff gave presentations to Modesto Police Crisis Intervention Team (CIT)
- **Faith/Spirituality-Based Resiliency and Social Connectedness**
  - Facilitated faith communities and spiritual groups to create increased social support to promote emotional health and well-being
  - Completed work on faith/spirituality marketing materials including pamphlet, flyers, and power point presentations
  - Created database of faith/spirituality leader contacts
  - Created asset mapping of faith based recovery supports
  - Served as liaison to strengthen partnerships with other PEI programs

Challenges

- **In Our Own Voice (IOOV)**
  - Staffing was a challenge for the program as it lost three Spanish speakers.
  - Finding venues for speakers in Juvenile Hall, group homes, and foster care was also difficult.
- **Faith/Spirituality-Based Resiliency and Social Connectedness**
  - Creating trust and relationships with faith based leaders was challenging. But there were some in roads established through constant networking.

Program Results	
➢ **In Our Own Voice (IOOV):** • 665 individuals attended 46 presentations by IOOV speakers • 20 peers were active speakers for IOOV ➢ **Faith/Spirituality-Based Resiliency and Social Connectedness:** • 266 faith/spirituality leaders were contacted to increase behavioral health supports within their communities • 11 collaborative meetings were held with faith/spirituality leaders • 224 attendees from the faith/spirituality community attended Mental Health First Aid trainings • 150 people attended collaborative meetings (Mindfulness, Recovery Modesto, Youth Faith, Assyrian Wellness Collaborative)	**How Much?**
➢ **In Our Own Voice (IOOV):** • There is increased awareness about the program with interest from new venues • Interest about the program from other counties is also growing ➢ **Faith/Spirituality-Based Resiliency and Social Connectedness** ➢ 88% of faith/spirituality leaders were recruited to increase behavioral health supports in their communities ➢ 87% of Mental Health First Aid (MHFA) attendees indicated that they are able to assist a person who may be dealing with a mental health problem or crisis to seek professional help ➢ 87% of MHFA attendees indicated that they are able to assist a person who may be dealing with a mental health problem or crisis or seek professional help ➢ 88% of faith/spirituality leaders indicated that their questions/concerns were addressed by a mental health consultant	**How Well?**
➢ **In Our Own Voice (IOOV):** • Some speakers have gotten jobs and others are going to college. Some speakers are volunteering in the community. ➢ **Faith/Spirituality-Based Resiliency and Social Connectedness:** • 88% of faith/spirituality leaders indicated that mental health consultation increased their knowledge/skills	**Is Anyone Better Off?**

PEI – Older Adult Resiliency and Social Connectedness

This project is operated by Aging and Veterans Services and funds new programs and strategies designed to reach physically impaired and socially isolated seniors who are at higher risk of depression and suicide. It includes four programs to address psychosocial impacts of trauma and onset of depression, and other disorders including co-occurring disorders in older adults. All program strategies address stakeholder-identified community needs related to increasing supports in all age groups and to improve access to services.

Programs

- **Program to Encourage Active, Rewarding Lives for Seniors (PEARLS)**
  PEARLS is an individualized program where a counselor visits at-risk seniors in their homes to offer help by teaching problem solving techniques and encouraging increased social and physical activities. The program was in operation from July through March and replaced with a new program, Brief Intervention Counseling (BIC), for the rest of the fiscal year.

  Brief Intervention Counseling (BIC): Provides early intervention services defined as "short duration" (3 to 9 months) and low intensity. The services are provided before the onset of a mental health disorder by "reducing risk factors or stressors, building protective factors, and increasing social supports". Individuals must have a counseling session with their mental health clinician.

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

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

- **Senior Center Without Walls (SCWW)**
  SCWW is a phone-based program with offerings similar to activities you would find at a senior center. Once registered, each senior receives a monthly calendar of events. They can call in to join in group discussions, fun games, or learn about current health topics. This program offers a book club, support groups and much more.

Highlights

- **PEARLS/BIC/SPC/FV:**
  - A total of 102 senior were enrolled in of the Older Adults PEI services
  - A total of 237 seniors were screened for mental health services
  - 30 outreach events/presentations in the community were held
  - 36 seniors participated in Brief Intervention Counseling (BIC)
  - 39 seniors participated in the Friendly Visitor program (FV)

Challenges

- **PEARLS/BIC/SPC/FV:**
  - Staffing has been a challenge for the programs.

Program Results	
➢ **PEARLS/BIC/SPC/FV:** • Refer to program highlights section • 22 seniors participated in Senior Peer Counseling (SPC) • 30 seniors participated in the PEARLS program	**How Much?**

➢ **PEARLS/BIC/SPC/FV:** • 62% (146/237) of referred seniors enrolled in one of the PEI programs (BIC, PEARLS, SPC, FV) or received care coordination • 51% (65/127)of participants completed satisfaction surveys • 85% of SPC volunteers indicated that they feel supported at supervision meetings • 59% (15/30) of participants completed the PEARLs program • 88% (36/41) of participants indicated that their Friendly Visitor volunteer was supportive	**How Well?**
➢ **PEARLS/BIC/SPC/FV:** • 11% (4/36) of participants met their goals and existed the BIC program • 73% (11/15) of PEARLS participants reported improved PHQ-9, a measure of depression, scores	**Is Anyone Better Off?**

PEI – Health/Behavioral Health Integration

This project expands on an effective model of behavioral health integration with primary care that is currently used in four Golden Valley Health Center (GVHC) clinics and two Health Services Agency (HSA) medical offices within Stanislaus County. Clinicians and psychiatrists are embedded in the clinics that serve primarily underserved cultural communities.

The project is the result of a collaborative planning process that involved diverse stakeholders throughout the county. It interfaces with several other projects in the PEI plan to ensure continuity of care to older adults, children and youth, and adults who are at risk of depression and suicide due to untreated behavioral health issues.

The project is implemented through the following six clinic sites:

- Hughson Medical Office
- Ceres Medical Office
- Turlock Golden Valley Health Center
- Newman Golden Valley Health Center
- Patterson Golden Valley Health Center
- South Modesto Hanshaw Middle School

Highlights

- Preliminary reports show a decrease in depression from the Patient Health Questionnaire (PHQ-9) for patients with two visits or more.
- Group attendance has grown and increased access to treatment.
- Patients have self-reported decrease in anxiety and depression.
- Patients asked to attend pain management treatment groups continue to participate after meeting group requirements.
- "Brown Bag" sessions continued to bring together psychiatry, medical and behavioral health providers to consult on cases, encourage team building, and share information on best practices for treatment of various mental health illness.

Challenges

- Data collection and staffing posed a challenge.
- Staff to patient ratio appears too high.
- There's a need for additional funding to hire another behavioral health provider to expand services at Turlock clinic.

Program Results	
• A total of 1,261 Stanislaus County residents received behavioral health services in a primary care setting • There were 2,874 behavioral health visits/encounters • There were 31 group therapy sessions • A total of 321 behavioral health patients had three or more visits	**How Much?**
• 61% (770/1261) of patients were Hispanic, a target population for this project • 35% (440/1261) of patients preferred language was Spanish • 76% (954/1261) of patients had no previous experience with BHRS	**How Well?**
• 21% (56/263) of patients showed improved PHQ-9 scores	**Is Anyone Better Off?**

PEI – School - Behavioral Health Integration

This early intervention project serves at-risk children, youth, educational professionals, and parents. The 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 multifaceted activities including embedding a mental health clinician within a school setting to provide behavioral health consultation, substance abuse problem identification, referrals, and support for educational professionals and parents. The selective prevention program also provides mental health screenings and early interventions for students with behavioral and emotional problems.

This project is based on elements from a variety of successful program models including school-based mental health consultation, student assistance programs, classroom-based mental health education and intervention programs, and in-service programs for school professionals.

Programs

- **Student Assistance and School-based Consultation Program:** BHRS has partnered with two community based organizations to implement this program in area school districts.
  - **Nurtured Heart Approach (NHA)**
    Center for Human Services (CHS) in Patterson Unified School District: 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: to build the capacity of each school to enhance the emotional resiliency of their students through the school-wide implementation of the Nurtured Heart Approach. The NHA is a system of relationships where all energy and attention is directed to what is going right, and little or no energy is given toward negative behaviors or choices. The program unites students, teachers, and parents in their efforts to build a more positive school community.
  - **Creating Lasting Student Success (CLaSS)**
    Sierra Vista Child and Family Services (SVCFS) in Modesto City Schools: CLaSS is a prevention and early intervention model that strives to see students succeed at home, at school, and in the community. It's built upon strength-based and evidenced-based practices that have proven results. CLaSS seeks to work with children who are considered "at risk" for behavioral issues that lead to problems at school and in the home. CLaSS consultants are trained to work with children, their families and teachers by helping them develop action plans that everyone can follow. The focus is on helping children succeed.
- **Parents and Teachers as Allies (PTAA)**
  NAMI-operated Parents and Teachers as Allies education program helps families and school professionals identify the key warning signs of early-onset mental illnesses in children and adolescents in schools. It focuses on the specific, age-related symptoms of mental illnesses in youth. PTAA emphasizes that families and school professionals are natural allies in working to ensure that youth with early-onset mental illnesses receive timely and appropriate treatment.

Highlights

- **Student Assistance and School-Based Consultation Program**
  - **Nurtured Heart Approach (NHA)**
    - Parent workshop trainings were completed along with staff trainings at the Patterson Unified School District After School program; trainings for teachers and staff at Apricot Valley and Las Palmas Elementary Schools were also held.
    - Each school at the start of the school year hosted a celebration focusing on student greatness and anti-bullying.
    - NHA facilitated a "Greatness Campaign" to help ignite greatness in students at Las Palmas and Apricot Valley schools. The campaign was introduced in classrooms and gave students an opportunity to participate by coming up with creative ways to express their greatness.
    - Throughout the school year, students reported a steady commitment to Nurtured Heart values (58.5% in Quarter 2 and Quarter 4 survey data).
    - Teachers reported less job stress related to student behavior as the year progressed (4.2% in Quarter 2 compared to 2.7% in Quarter 4).

- **Creating Lasting Student Success (CLaSS)**
  - ❖ There was increased capacity seen throughout the schools; surveys from teachers found continued increases in student self-confidence, mutual respect, and classroom participation
  - ❖ Home visits were increased to parents whose students needed more individual attention to shore up gains and provide referrals
  - ❖ Consultants became a part of the fabric of the schools

➢ **Parents and Teachers as Allies (PTAA)**
- Program staff gave presentations to more than 267 staff members and parents in Denair, Hughson, Empire, and Modesto; MJC nursing program asked the program for presentations indicating the need for student mental health services
- The program was asked to present to the school SARB Board
- A different outreach effort to Hispanic communities was initiated at James Marshall and Alberta Martone Elementary Schools. Presentations were given at the sites and parents requested that PTAA host a support group.

Challenges

➢ **Student Assistance and School-Based Consultation Program**
- **Nurtured Heart Approach (NHA)**
  - ❖ Voluntary staff participation in the program was a challenge. A total of 42 staff was trained.
  - ❖ Administration of parent feedback surveys was difficult; staff worked collaboratively with schools and teachers to brainstorm ways to promote parent involvement
  - ❖ The program faced some staffing changes.
- **Creating Lasting Student Success (CLaSS)**
  - ❖ Matching staff with chosen school sites can be a challenge with each school site having its own unique culture and strengths.

➢ **Parents and Teachers as Allies (PTAA)**
- Time constraints were an issue. Many schools have a limited number of hours for staff development.
- Recruiting bilingual presenters was a challenge.

Program Results	
➢ **Nurtured Heart Approach (NHA):** • 1,455 students participated in the program • 53 teachers/staff received mental health consultations • 42 teachers/staff (duplicated number) participated in trainings • 76 students received short term early intervention services • Four (4) students received long term mental health services • 132 staff/teachers received mental health consultations ➢ **Creating Lasting Student Success (CLaSS):** • 132 staff/teachers received mental health consultations • 161 students received mental health consultations • 103 parents received mental health consultations • 32 classroom presentations were given • 737 individual counseling sessions or strength-based, skill-building activities were provided to students	**How Much?**

➢ **Nurtured Heart Approach (NHA):** • 58.5% (1223/2090) of students showed an increase in commitment to NHA values • 76.5% (39/51) of teachers indicated a commitment to NHA values ➢ **Creating Lasting Student Success (CLaSS):** • 95% (74/78) of parents reported positive response to services • 100% (11/11) of students reported positive response to services • 97% (93/96) of teachers/staff reported positive response to services	**How Well?**
➢ **Nurtured Heart Approach (NHA):** • Only 3% (2/61) of teachers reported job stress related to student behavior • 67% (2/3) of parent reported being connected to school ➢ **Creating Lasting Student Success (CLaSS):** • 90% (44/49) of students demonstrated improved behavior at home and a school • 96% (46/48) of students did not enter formal mental health services • 95% (91/96) of families reported decreased stress related to child behavior	**Is Anyone Better Off?**

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Workforce Education and Training (WE&T)

The Workforce Education and Training (WE&T) component of MHSA provides funding to help improve and build the capacity of the mental health workforce. The goal is to develop a diverse and well-trained workforce skilled in delivering a culturally competent integrated service experience to clients and their families. Equally important are community collaboration efforts to increase protective factors. WE&T funds are a one-time allocation and do not provide direct services.

Stanislaus County had 6 programs operating during FY13--14:

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

Progress in FY 13-14 included the continuation of multiple training courses offered; establishment of stipend and fiscal incentive programs to support career pathways; and the further development of volunteer program protocols and processes.

Program Budget

FY 2013-14 Actual	FY 2014-2015 Budgeted
$ 231,700	$ 460,157

Highlights

WE&T trainings continued their integration with BHRS trainings resulting in exciting, robust growth in FY 13-14. A total of 127 trainings were held in Stanislaus County, an increase from 57 trainings in FY 12-13. The Consumer Family Member Training and Support program (CASRA) also saw an increase from 76 students in FY 12-13 to 116 students in FY 13-14.

A full time Director of Volunteer Services was hired in March 2014 to oversee the Consumer and Family Volunteerism program. A total of 77 people volunteered at 10 BHRS sites in FY 13-14.

Challenges

The downturn in the local economy remains a barrier making it challenging to create and fill Stanislaus County public mental health jobs. As it did last year, BHRS continues to access needs in the department.

Augmentation/Restoration of WE&T – Targeted Financial Incentives to Increase Workforce Diversity

In the FY 2013-2014 Annual Update, the Workforce Development Council recommended adding up to 22 stipends for FY 2014-2015 for students in Master of Social Work (MSW), Master of Science (MS) in Psychology, and Bachelor of Arts (BA) in Psychology at CSU, Stanislaus. These stipends would be for full-time and part-time students. If funds remain after awarding these stipends, funding may be available to assist students at Modesto Junior College with some of their expenses.

Stakeholders endorsed a proposal to allocate up to $200,000 for stipends and other student expenses.

WE&T Training/Training Costs Funding Proposal

On February 27, 2015, the MHSA Representative Stakeholder Steering Committee (RSSC) endorsed a funding proposal to spend $150,000 for staff training and community workforce development. The funding will go to trainings on topics such as Suicide Prevention, Collaborative Documentation, and Trauma Informed care. Using the Gradients of Agreement matrix, sixteen stakeholders voted to endorse the proposal.

The WE&T proposal was included in a block with two other funding proposals: Innovation-FSP Co-Occurring Disorders Project ($800,000) and Technological Needs Evaluation Outcomes ($400,000).

One stakeholder endorsed the block of proposals with a minor point of contention. The concerns were in regard to the Innovation project and the size of the funding amount and need for clearer learning goals.

WE&T – Workforce Development

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

The goal of training is to further the implementation of MHSA essential elements throughout the existing workforce and expand capacity to implement additional components of MHSA. The trainings addressed a variety of key content identified during the planning process. Among them:

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

Training was offered to BHRS and organizational provider staff to enhance knowledge and skills, especially in the areas of recovery and resilience and evidence-based practices.

Highlights

The training plan for fiscal year 13-14 was supported by funding from MHSA, WE&T and PEI. A total of 127 courses were offered; 100 courses for BHRS staff and contract staff and 27 courses for our prevention partners in the community. This is an increase of 70 courses from last year. A total of 2,781 staff, contract staff, and community members attended training this fiscal year. This is an increase of 988 participants from last fiscal year.

BHRS has a core competency policy which outlines specific mandatory courses for each job classification that staff is required to take. In addition, courses are offered on evidence-based treatment, cultural competency and stigma reduction to improve staff attitudes, knowledge and skills. Some examples of evidence based treatment courses include: ASIST Suicide Intervention Training, Seeking Safety, Motivational Interviewing, and California Brief Multicultural Scale Training.

Challenges

At times, keeping up with the volume of trainings has been challenging. This year we offered 45 courses on trainings to learn the new electronic health recordkeeping system in addition to the ongoing courses offered. The Children's System of Care staff was also required to attend trainings for to learn about the new Katie A requirements.

Program Results	
• 127 trainings were provided • 2,781 BHRS/contractor staff/community members attended	**How Much?**
• 95% of participants reported improved understanding and knowledge of the subject (n=628) • 90% participants reported that the course content included concepts that were evidence-based and/or best practice (n=619) • 84% of participants agreed that the training content included family/consumer perspectives (n=593) • Providing Culturally Competent Care LGBTQ youth – "Excellent facilitator! Exercises were useful." (Written comment from participant on the course evaluations)	**How Well?**
Other written comments from participants on the course evaluations: • Multicultural Training- "I think this course has really opened my mind. It has been interesting, interactive, and well presented." • Motivational Interviewing – "Really feel like I will be able to put this into practice."	**Is Anyone Better Off?**

Group Facilitator Training story:

Last year I received a call from a staff member at the Veterans Medical Facility in Modesto asking if I could come and talk to some veterans who were getting ready to graduate from a Post- Traumatic Stress Syndrome (PTSD) management session. The veterans had grown to like each other during the sessions and were curious to see if I would know of any way they could still meet and be of support to each other.

I told them about peer support and in my opinion I thought a peer support group would be exactly what they may need. Four of the Veterans then signed up for my Group Facilitator Training and they attended each class without fail. The Veterans Administration in the meantime informed the group they could no longer have them at their facility due to space limitations. I was able to secure a meeting place in our facility at 800 Scenic and the group started meeting every Tuesday afternoon at 1:30 in the Main Conference Room. The group has grown steadily and I can see big improvements in the demeanor of the participants. And the leaders that took the training are now reaching out in the community to help other veterans still in tremendous need.

I was told a story about a homeless veteran who came into the meeting in an old broken down borrowed wheelchair. He told the group that he was living in an abandon shack in Salida. The group appointed some of the guys to help the veteran to get to future meetings and appointed others to help him find suitable housing. Some of the leaders then contacted some connections they had at the Veterans Administration and found out that the man was a Vietnam Era Veteran and had benefits available to him such as medical, housing, and a monthly income of about $800.00. The guys found him a nice place in Modesto. They were also instrumental in getting the Veterans Administration to hire an in-home caretaker for their fellow veteran.

This is what peer support and groups are all about - peers helping themselves by helping others. With minimal support from the county, the veterans were able to organize and help a fellow Veteran. This in turn has raised the hopes of the veterans and now you can see that the focus is switching from a “what happened to us back then” to what can we do to help those that are now walking the road.

Tim White , Behavioral Health Advocate, Coordinator
BHRS Friends are Good Medicine Program

WE&T Consumer Family Member Training & Support

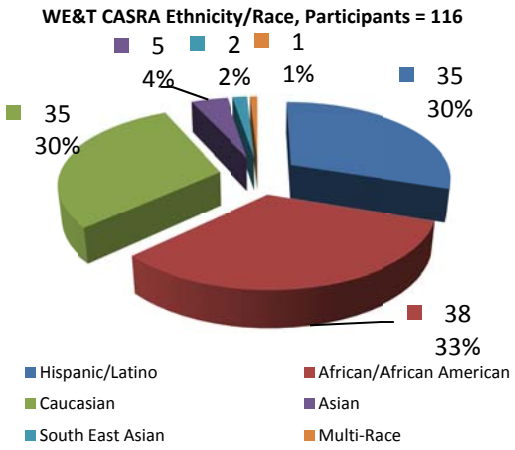
Operated by Human Resources and Training Division of Behavioral Health and Recovery Services in Partnership with Modesto Junior College and Community-Based Organizations

In partnership with Modesto Junior College (MJC), the California Association of Social Rehabilitation Agencies (CASRA) based program provides a structure to integrate academic learning into real life field experience in the adult public mental health system. Before this partnership, MJC didn't have a mental health curriculum. The initiative taken by BHRS to purchase the CASRA curriculum signifies the efforts to fill the gaps for employment of consumers and family members.

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

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

Demographics



Highlights

One of last year's challenges has been met and now it's a highlight of the CASRA based program. The program has not only increased the recruitment of Asian/Pacific Islander students but it has also recruited several other ethnicities into the behavioral health field. All CASRA students are either consumer/family members or they come from a diverse and underserved community.

A total of 116 students received CASRA stipends in FY 13-14. Ten CASRA students completed the academic requirements and a minimum of 2,500 field experience hours making them eligible for National CASRA certification. Five (5) CASRA volunteers were hired in the public mental health system, three (3) by BHRS and two (2) by community partner agencies.

Challenges

The amount of time and assistance needed to help coordinate placements for CASRA participants that match their interests has been a challenge. The challenge is being met with help from the Volunteer Program and its director.

Program Results	
• 116 CASRA students representing diverse ethnicities/cultures received education stipends • 21 students received field placement with BHRS • Two (2) CASRA orientations and five (5) classroom presentations were held at MJC to raise awareness about the program	**How Much?**
• 100% of CASRA stipend recipients have lived experience as consumers/family members of consumers or are from diverse cultural backgrounds	**How Well?**
• 10 CASRA students completed the academic requirements and a minimum of 2,500 hours and are eligible for National CASRA certification • Five (5) CASRA volunteers were hired in the public mental health system; three (3) by BHRS and two (2) by partner agencies	**Is Anyone Better Off?**

WE&T Expanded Internship & Supervision Program
Operated by Human Resources and Training Division of Behavioral Health and Recovery Services in collaboration with CSU, Stanislaus

This program addresses the challenges of identifying internships and providing clinical supervision in the mental health field. In FY 13-14, those challenges were met through partnerships with community organizations and academic institutions in the following ways:

- MSW/MA student internships in public mental health
- Undergraduate nursing and LVN students from MJC and CSU, Stanislaus practicum placement in public mental health
- Supervision workshops for staff that provide clinical supervision for MSW associates and MFT interns.

Highlights

A total of 14 master's level students were placed in a BHRS service site for clinical supervision from the CSUS, Stanislaus Social Work or Psychology program. All 14 students completed their internship hours. In addition, two (2) clinical supervision workshops were provided to licensed clinical staff to develop additional capacity for offering clinical supervision within the licensed individual's agency.

Challenges

Identifying staff willing to provide supervision to field placement students and unlicensed staff continues to be a challenge given increasing demands on direct service providers.

Program Results	
• 12 master's level MS/MSW students were placed in internships for clinical supervision • Two (2) Clinical Supervisor workshops were provided to clinical supervisors	**How Much?**
• 12 students successfully completed their internships and were satisfied with their placements	**How Well?**
• 100% of MS/MSW internship students completed their internship hours.	**Is Anyone Better Off?**

WE&T - Outreach and Career Academy

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

Outreach and Career Academies were established in response to strong community input to outreach to junior high and high school students to raise awareness about behavioral health and mental health careers. One community-based organization participated in the project in FY13-14.

The West Modesto King Kennedy Neighborhood Collaborative (WMKKNC) sponsored a Wellness Project at Mark Twain Junior High School. As part of their learning, students participated in skits, scenarios, and discussions on issues important to them such as stress, self-esteem, and healthy relationships. They also learned how these issues can affect their physical and mental well-being. A total of seven (7) students participated in the project which also introduced them to career opportunities in mental health.

Highlights

Students planned and participated in a "Day of Hope" celebration held at the King Kennedy Neighborhood Center. The focus of the event was mental health recovery and reducing the stigma of mental illness. Students wrote and performed a Rap song with inspirational messages about wellness and mental health.

Students also planned and completed the "Positive Affirmation Pencils" project. They helped design and hand out pencils that included positive messages. The pencils were distributed at the "Day of Hope" celebration.

Students also participated in community activities at Josie's Place, an MHSA funded drop-in center for transition aged young adults in Modesto. The students met with staff and learned about the activities and resources offered at the center. For the second year, as a component of the program, students chose a community service project to give back. They prepared holiday cards and ornaments for residents of the Acacia Park Rehabilitation Center in Modesto.

Challenges

This is the only program in the Outreach and Career Academy. Strategic planning is now underway to look for ways to re-introduce the program into area high schools. The program originally began at Davis High School in Modesto in FY 11-12 but was discontinued due to staffing changes.

Program Results	
• Seven (7) scholarships were offered to Mark Twain Junior High School students enrolled in the wellness project. • Seven (7) junior high school students volunteered for the "Day of Hope" celebration at WMKKNC.	**How Much?**
• One mental health clinician provided information on careers in behavioral and mental health • 100% of seven (7) junior high school youth are from diverse/underserved community	**How Well?**
• Student gained valuable information about Josie's Place and learned about community resources.	**Is Anyone Better Off?**

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

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

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

Highlights

A Volunteer Liaison was contracted to oversee the BHRS volunteer program. Among the opportunities: volunteering for one-time special events. This allowed individuals interested in a day event or a special event to volunteer with no long-term obligations. The process was much simpler with a quicker turnaround time.

In all, there were 77 volunteers during FY13-14. Nine of those volunteers were Modesto Junior College (MJC) CASRA/Human Services students.

Challenges

Coordinating volunteer efforts through BHRS proved challenging because this was relatively a new process for the department. Up until FY 11-12, volunteer efforts were organized and directed through United Way of Stanislaus County. A newly hired part-time volunteer liaison had the challenge of learning all BHRS programs and their volunteer needs. In addition, the WE&T Manager was tasked with overseeing MHSA Policy and Planning. At the end of fiscal year 12-13, the WE&T Manager accepted a job out of the area leaving the position vacant. A full time Director of Volunteer Services has been hired for FY 14-15.

Program Results	
• A total of 77 volunteers participated in the program. • A total of 14,603 volunteer hours were accumulated.	**How Much?**
• The total dollar value to the department (at $21.79 an hour) equaled $318,202. • Ten sites participated in using volunteers.	**How Well?**
• A staff member from a BHRS program commented, "Volunteers are the backbone of this organization. We value their work and couldn't serve our community without them." • A Volunteer stated, "Volunteering for me is a chance to give back to the community. It is also a really fun way to spend my time. I enjoy everything that I have been shown how to do and because I have an open honest relationship with my director. I have very little stress. For me, it definitely beats isolating. I get a rush when I complete a project I have been assigned and I feel satisfied when I leave at the end of my shift having made a difference." • A volunteer commented, "I started out at BHRS volunteering to complete my hours for Alliance Worknet. Through this program I am gaining experience and getting my foot in the door towards the career that I eventually want to get into. I enjoy giving back to my community and helping others get into volunteering as well."	**Is Anyone Better Off?**

WE&T - Targeted Financial Incentives to Increase Workforce Diversity
Operated by Human Resources and Training Division of Behavioral Health and Recovery Service

This program provides educational stipends to students in Master's level Social Work and Psychology programs at CSU, Stanislaus. It also offers financial stipends for BHRS and community partner staff working on a Baccalaureate degree in Psychology. The scholarships are awarded to potential recruits who meet established criteria based on the ongoing assessment of "hard to fill or retain" positions. Such positions include those related to language, cultural requirements, and special skills. This year fewer stipends were awarded because the funding for this WET program has been mostly expended in FY 14/15.

In this 13-14 fiscal year, MS and MSW stipends were provided to students through an existing contract with CSU, Stanislaus. BHRS awarded 4 stipends this year and all 4 of the recipients met desirable classifications for hard to fill positions identified in the WE&T plan workforce needs assessment.

BHRS assisted in submission of loan repayment applications to the Statewide Loan Repayment Program. A total of 20 applications were awarded in Stanislaus County totaling $144,346.

Highlights

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

Challenges

The economy continues to be a challenge for workforce development. Consequently, the Workforce Development Council recommended a reduction in stipends for master's level students.

However, at the end of FY 13-14, some BHRS positions were added after stakeholders approved expansions of MHSA programs.

Program Results	
• Four (4) stipends; two (2) MSW and two (2) MS stipends were awarded, each to graduate students at CSU, Stanislaus • Stipend awards equaled a total of $37,000	**How Much?**
• 100% of stipend recipients are from diverse populations: 3 bilingual Spanish, 1 African American	**How Well?**
• Five (5) MSW/MS stipend recipients were hired as full-time mental health clinicians at the following agencies: Center for Human Services, Sierra Vista Child & Family Services, and AspiraNet	**Is Anyone Better Off?**

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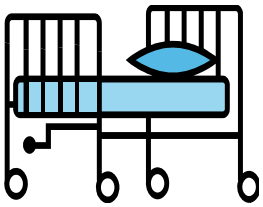
Capital Facilities (CF) Projects

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

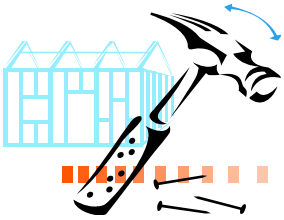
In FY 13-14, design and construction work continued on a countywide Crisis Stabilization Unit (CSU) to address a significant increase in the number of acute psychiatric inpatient hospitalizations. As highlighted in the June 2014 Annual Update, the project is the third piece of a strategic planning process by the Stanislaus County Chief Executive Office and BHRS to enhance Secure Mental Health Services.

In partnership with Doctors Medical Center (DMC), the local provider of acute psychiatric inpatient services, local hospital emergency rooms, MHSA Representative Stakeholders, law enforcement, and the Stanislaus County Mental Health Board, a Strategic Plan was developed that focused on recovery–centered care and creating an opportunity for each consumer to be treated in the least restrictive setting. Integral to this plan was the realization that a proper set of support services need to be available to sustain recovery after hospitalization.



The outcome was a plan with three main goals. One was expanded inpatient treatment capacity. This capacity building goal resulted in the creation of a 16 bed local Psychiatric Health Facility (PHF) in recognition that not all individuals required the level of an acute psychiatric inpatient service of a general acute hospital. Additionally, the PHF was located on the same campus as the BHRS Substance Use Treatment services. The PHF opened in March 2014. No MHSA funding was used for this goal.

A second goal was the development of aftercare strategies to enable follow-up after hospitalization. The Transition TRAC team connects consumers with needed outpatient services, including, but not limited to, follow up with primary care, assistance with getting medications, and a thorough assessment of their mental health needs. The Transition TRAC was included in the FY 2012-13 Annual Update and was approved by stakeholders in a CSS expansion reported in FY 2014-15. The one time funding augmentation allows the team to follow up with discharges from the PHF. The team has been very successful in reducing readmissions to the psychiatric hospital.



The third goal of the Strategic Plan is the Crisis Stabilization Unit (CSU). Its development has two components: capital facilities and ongoing operations. When BHRS began to plan for the stakeholder meetings, focused on the use of one-time funding, one idea was to access some of these funds for the capital facility portion of the project. BHRS has identified an unused wing of a Stanislaus County-owned facility that is being remodeled to accommodate a CSU. On April 1, 2014, stakeholders endorsed using some of the one-time funds to help design the facility. Under guidelines for CF proposals set forth on March 18, 2008, architectural services and costs are allowable pre-development costs.

In keeping with MHSA core values, collaboration with other agencies will be a focus to increase outreach and work towards the concept of well-rounded, integrated services to individuals suffering from mental illness. It is very important that this facility be welcoming for consumers and family members.

After discussions that this project would be in stages with additional parts to be considered in the second round of MHSA planning in late May of 2014, stakeholders endorsed proposing the use of $158,000 of Capital Facilities funding to begin the architectural design of this project During the community planning process in July of 2014, stakeholders approved a proposal to fund construction costs for the CSU at $944,000.

Capital Facilities (CF):

In the MHSA FY 2014-2015 Annual Update and Three Year Program and Expenditure Plan approved by community stakeholders and by the Board of Supervisors on June 17, 2014, the creation of a Crisis Stabilization Unit (CSU) represented the first Capital Facilities project to receive MHSA funding. Under guidelines for CF proposals set forth on March 18, 2008, architectural services are allowable pre-development costs. After discussions with community stakeholders indicating that this project would be accomplished in stages, they endorsed proposing the use of $158,000 of CF funding to begin architectural services for this project. An RFP was subsequently approved for issuance by the Board of Supervisors on August 20, 2014.

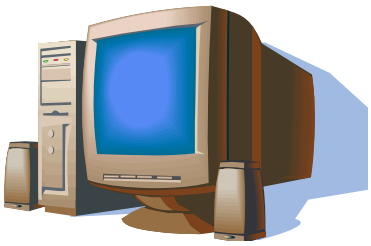
Capital Facilities (CF) Proposed Expansion for Crisis Stabilization Unit (CSU):

The second phase of the project, approved by stakeholders, on July 18, 2014, would provide for the construction in FY 2014-2015 for the CSU. This expansion covers the costs of construction of a Crisis Stabilization Unit (CSU) that was highlighted in the FY 2014-2015 Annual Update and Three-Year Program and Expenditure Plan. The estimated additional costs related to this CF expansion are approximately $758,000, bringing the total CSU Construction costs to $944,000. Upon approval by the Stanislaus County Board of Supervisors, plans are to issue an RFP through the GSA Purchasing Department for the construction of the CSU.

Technological Needs (TN) Projects

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

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



Electronic Health Record System (a.k.a. Anasazi and now Cerner) implementation is a massive endeavor that reaches every part of BHRS' service system. All support areas including the billing department are affected. And all face-to-face contacts between service recipients and providers are touched by this new method of keeping health records confidential and accessible. In the second quarter of FY 13-14, the Doctor's Home Page (DHP) got fully implemented, and various prescribing methods were available to all prescribers, one of them been e-Prescribing. In the fourth quarter of the same fiscal year, the initial Assessments, electronic clinical forms, were implemented. Managed Care Operations is the remaining component, and initial discussions with Cerner have taken place as part of the implementation phase. It is expected to have this component fully implemented during FY 14-15.

Consumer Family Access to Computing Resources Project is in operation. Two technicians were assigned to manage the computer and internet resources at community sites throughout Stanislaus County.

Electronic Data Warehouse is an infrastructure project to extract, manage, and report data from the Electronic Health Record (EHR) system. During the fourth quarter of FY 13-14, after the implementation of the initial electronic assessments, functionality was added to extract assessment related data from the EHR via the Data Warehouse for reporting purposes, specifically for CANS (Children and Adolescent Needs and Strengths) assessments.

Electronic Document Imaging is aimed at transferring the existing warehouse of paper medical records to more readily accessible electronic files. Work continues on a document management system. The pilot project related to the replication of the legacy system "Insyst face sheets" as electronic documents was successful, and as time allows, Medical Records staff continue to attach those electronic documents to the electronic charts in the EHR.

In FY 1-14, stakeholders endorsed the expenditure of up to $200,000 for technological needs. Initial planning to purchase computers and accessories took place, and a significant order of new equipment took place in the last Quarter of FY 13-14.

Program Budget

FY 2013-14 Actual	FY 2014-2015 Budgeted
$ 1,125,586	**$ 2,205,981**

Highlights

Implementation, "Go-live" of selected Assessments, electronic clinical forms, was completed in May, 2014. This was a major milestone that took a great commitment on the part of the SuperUsers. During initial training by the vendor, SuperUsers were able to test some of the Assessments prior to training the rest of the clinical staff. Training included both BHRS staff and contract service providers.

Functionality was added to the Data Warehouse to complete the reporting phase of the CANS ("Children and Adolescent Needs and Strengths) assessment. As previously described, clinical staff complete assessments in the EHR and data is extracted via the Data Warehouse for reporting and analysis.

Challenges

Due to on-going changes in Federal and State requirements, the EHR vendor has released several system upgrades. Upgrades include changes that must be tested prior to installation and may require notification and training of staff. This type of changes will always present a challenge because they could be very time consuming.

System changes are taking place in preparation for DSM 5 (Diagnostic and Statistical Manual of Mental Disorders) and ICD 10 (International Classification of Diseases) implementation which is mandated to start on Oct 1, 2015. This is a major change that requires careful planning, department decisions and staff training prior to go-live. It involves Assessment reviews and billing setup changes in the EHR. The department continues to experience staff turnover, due to retirements, promotions and departures that have had direct and indirect impacts to the project staffing.

Program Results	
• 386 staff were trained in the initial Clinical Assessments. This included all systems of care, and 46% of those trained were contract providers, while the rest were BHRS staff. • 16 new Assessments, clinical forms, were installed ranging from 1 page to more than 20 pages	**How Much?**
• 93% of clinical staff that needed to be trained were trained before the go-live date in May, 2014	**How Well?**
• The Data Warehouse is instrumental in the process of data analysis and outcomes reporting for decision making. It gets updated on a daily basis so the different departments can benefit from access to summary and detail data.	**Is Anyone Better Off?**

Technological Needs-Evaluation Outcomes Funding Proposal

On February 27, 2015, the MHSA Representative Stakeholder Steering Committee (RSSC) endorsed a proposal to fund $400,000 for Technological Needs and Evaluation Outcomes.

The additional funding will build infrastructure for new and expanded MHSA programs. It includes three additional staff: one (1) Systems Engineer, one (Software Developer), and one (1) Staff Services Coordinator. BHRS has 64 MHSA programs and needs the staffing to adequately maintain and develop data systems to track, retrieve, and analyze program data.

Using the Gradients of Agreement matrix, 94% of stakeholders present voted to move forward with the Tech proposal. One stakeholder endorsed the block of proposals with a minor point of contention.

Innovation (INN)

The main goal of MHSA innovation projects is to learn from a new practice and see if it increases access and/or improves community services or collaboration to help transform communities.

A total of 11 projects were funded for this component in FY13-14. They were developed through community planning input and reflect unmet needs. The following projects were in operation during FY 2013-2014:

- INN-02 - Arts for Freedom
- INN-03 - Beth and Joanna-Friends in Recovery
- INN-04 - Building Connections for Troubled Youth
- INN-05 - Choose Civility Learning Project
- INN-06 - Connecting Youth to Social Supports
- INN-07 - Families in the Park
- INN-08 - Integration Innovations
- INN-09 - Promoting Community Wellness through Nature
- INN-10 - Revolution Project
- INN-11 - Wisdom Transformation Initiative
- INN-12 – Garden Gate Innovative Respite Project

INN Budget

FY 2013-14 Actual	FY 2014-2015 Budgeted
$1,465,545	**$1,244,701**

Background

The eleven Innovation projects provided a wide variety of activities to make life better for those suffering from mental illness and to help their families. Six of the projects included in Stanislaus County's second round of Innovation planning ended in FY 13-14. A detailed Final Learning Report on those projects was completed and sent to the MHSOAC on June 26, 2014. The projects are as follows: Building Connections for Troubled Youth; Choose Civility Learning Project; Revolution Project; Promoting Community Wellness through Nature; Connecting Youth to Social Supports; and Integration Innovations. Peer to Peer mentoring and community empowerment were common threads to the programs along with important life changing linkages to mental health services and support.

Three additional projects will be completed in FY 14-15. They are Families in the Park; Arts for Freedom; and Beth and Joanna – Friends in Recovery. Two other projects, Wisdom Transformation Initiative and Garden Gate Innovative Respite Project, conclude their learning in FY 15-16.

Challenges

Because of their newness and the urgency to move quickly on these short term demonstration projects, some projects faced challenges such as building community trust, hiring staff quickly, and establishing needed infrastructure to conduct evaluation processes.

Innovation - Request For Proposals from September 2014 Plan Update

On July 18, 2014, the MHSA Representative Stakeholder Steering Committee (RSSC) approved a funding proposal to issue a Request for Proposal (RFP) for Innovation. The estimated funding amount was $1.3 million. (Details about the RFP and the RFP process were included in the MHSA Plan Update 2014-15, pages 33 -34, approved by the RSSC and the Stanislaus County Board of Supervisors on September 30, 2014.)

The following Innovation projects were awarded and approved by the Stanislaus County Board of Supervisors on February 10, 2015: Center for Human Services/Father Involvement Project and Sierra Vista Child and Family Services/Quiet Time Project. Additionally, the BHRS Juvenile Justice program requested to expand its services to children, Transition Aged Youth (TAY), and Transition Aged Young Adults (TAYA) in the Children's System of Care (CSOC) through a Youth Peer Navigator project. The

expansion request was reviewed by the Evaluation Committee and the BHRS Senior Leadership Team and recommended for approval.

The three proposals must still be approved by the Mental Health Services Oversight and Accountability Commission. Descriptions of the Innovation projects can be found on page 102.

Innovation - FSP Co-Occurring Disorders Project Funding Proposal

On February 27, 2015, the MHSA Representative Stakeholder Steering Committee (RSSC) endorsed moving forward with an Innovation Full Service Partnership (FSP) Co-Occurring Disorders Project at a cost of $800,000. The FSP project is aimed at co-occurring disorders among the seriously mentally ill. The focus is on adults who have both serious mental illness and co-occurring substance use disorder. The project will insure that treatment and primary care is provided to address potential risks to reduce homelessness, criminal justice involvement, acute psychiatric hospitalizations, and institutionalization.

This is a three (3) year project with a total budgeted amount of $1,098,979 of which $800,000 will be MHSA Innovation funds. The funding will be for the first year of operation. Federal Financial Participation (FFP) funds generated by medically necessary Medi-Cal services provided by this FSP program will offset a portion of the full program cost and allow for some Innovation money to be used in year two (2) of the operation. Years two (2) and three (3) would be sustained by FFP and MHSA CSS FSP funding. A total of six (6) positons are needed for this project: three (3) Behavioral Health Specialists II, one (1) Mental Health Clinician, one (1) Mental Health Coordinator, and one (1) Administrative Clerk III.

Using a Gradients of Agreement Matrix, all but two stakeholders voted to endorse the project. One stakeholder endorsed the Innovation proposal with a minor point of contention citing the size of the project and the need for clearer learning goals. Citing a concern with the Innovation RFP process, one other stakeholder disagreed with moving forward with the project but will support the majority.

This Innovation proposal must still be approved by the Stanislaus County Board of Supervisors and the Mental Health Services Oversight and Accountability Commission. The proposal in its entirety can be found on page 104.

Arts for Freedom (INN - 02)
Operated by Peer Recovery Arts Project

Summary

The primary purpose of this 3-year project is to increase quality of services, including better outcomes for individuals of all ages by offering a free public art gallery, art consignment shop, classroom, meeting space and a clearinghouse for participants to volunteer and gather for support and arts expression.

Arts for Freedom is part of the Peer Recovery Art Project, a non-profit gallery in downtown Modesto. It's a collaborative that empowers mental health consumers, including seriously mentally ill consumers, to take part in the arts and other activities to improve wellness and connect people to the community. The goal is to demolish old attitudes and ensure that those with mental health life experiences are not blocked from finding their rightful place in the community. The emphasis is on what people can do rather than what they cannot do. The Innovation project is one of nine community-based projects begun in FY 11-12.

- Promote a free public art gallery and special events that offer community-based awareness and support
- Develop an art collaborative for some contributing artists with lived experience as mental health consumers
- Support people in recovery and network to end stigma
- Connect isolated individuals to each other so they become a community

The project concluded in January of FY 14-15. A detailed Final Learning Report for this project will be sent to the MHSOAC in a separate document.

Learning Proposed:

Would building a welcoming and inclusive community that provides opportunity for those with a mental illness to step away from and not be their illness while working and learning side by side with others increase self-esteem, promote recovery, and reduce stigma? And can it contribute to healthier and more productive members of the community who are therefore less dependent on the mental health system?

Stigma Reduction Survey Findings:
"Peer Recovery Art Project's example helped improve my opinion of persons with mental health diagnoses."

Has helped to improve	70.54%
Neutral	28.29%
Has not helped to improve	1.16%

Beth & Joanna - Friends in Recovery (INN - 03)
Operated by National Alliance for Mental Illness

Summary

This Innovative project proposed to increase quality of services including better outcomes for consumers of mental health services. Operated by the National Alliance for mental Illness (NAMI Stanislaus), the project used a model borrowed from other disciplines in which two individuals are pared in a mentor/mentee relationship. Mentees are individuals who have mental illness and/or co-occurring substance issues, are isolated and need/seek support. Mentors are someone who is successfully utilizing recovery practices related to their mental illness and/or co-occurring substance issues.

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

Beth and Joanna Friends in Recovery is a three year project that ended in February of FY 14-15. A detailed Final Learning Report for this project was sent to the MHSOAC in a separate document.

Learning Proposed

Does making connections to community-based peer supports improve the experience of recovery and decrease the length of time and intensity of needed treatment?

Highlights

The mentoring project was contracted and funded to begin November 15, 2011 and had a total of 32 consistently active participants during its three years of operation. It initially began with two mentors and by the end of the third year there were eight consistently active mentors trained. These eight people made the decision to accept the responsibility of mentoring others after they themselves were mentored in the program. Mentor activities included meeting in public places such as libraries and coffee houses and check-in phone calls.

- The program had a total of 32 consistently active participants and eight mentors were trained
- Program coordinator facilitated *friendship* activities planned and implemented by mentors and mentees
- Follow up surveys were completed by 29 consumers that participated in the program for six months or more. Questions and results include the following:

Has Friends in Recovery been helpful in improving your recovery experience and/or your quality of life?

24 Persons chose “Very helpful”
5 Persons chose “Helpful”
0 Persons chose “Somewhat helpful”
0 Persons chose “Not at all helpful”

To what degree has/has not Friends in Recovery contributed to relapse prevention?

26 Persons chose “Very helpful”
3 Persons chose “Helpful”
0 Persons chose “Somewhat helpful”
0 Persons chose “Not at all helpful”

Has Friends in Recovery connected (or tried to connect) you to at least one service in the community?

29 Persons chose “Yes”
0 Persons chose “No”

If yes, tell us how? Check all that apply.

22 Persons chose “Helped you make an appointment”
16 Persons chose “Gave you a ride”
20 Persons chose “Provided a bus pass”

19 Persons chose “Gave you a phone number to call”
27 Persons chose “Helped you fill out paperwork”
29 Persons chose “Gave you encouragement”

Challenges

Some people were fearful of providing their personal information to complete the project intake forms. Three individuals with dual diagnosis have joined the program. But it was only after three weeks of participation in activities that they completed the forms .Only after trust and friendships were established did mentors and mentees visit each other’s home. Another challenge was serving home bound individuals with severe mental illness. This challenge was met by keeping program criteria simple and activities flexible.

Building Connections for Troubled Youth (INN - 04)
Operated by Ceres Partnership for Health Children/Center for Human Services

Summary

The project's primary purpose was to increase quality of service and better outcomes by increasing developmental assets and community supports for troubled children ages 7-11 years. Individual mentoring services were provided to children who have demonstrated aggressive or inappropriate behaviors at school.

Operated by the Ceres Partnership for Healthy Children and the Center for Human Services, the project offered educational curriculum that addressed anger control and development of pro-social skills. Parents, teachers, and others were included in the innovative effort.

The two year project ended in January of FY13-14. A detailed Final Report about the project was submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on June 26, 2014.

Learning Proposed

Change existing mental health mentoring practice and integrate community support, services for parents, and involve all adults in the child's life who can provide meaningful support to work together and build internal and external developmental assets for identified youth.

Highlights

This unique project was implemented by the Ceres Partnership for Healthy Children, a Family Resource Center (FRC), that is a widely known and deeply trusted resource in the Ceres community. Among the learning results:

Integration of support services - The most frequent services provided to families were mentoring visits with students and education/support visits with parents. Analysis of a small group of children who entered the program with poorly developed assets suggests that increased parent support enhances the effect of mentoring. Parents whose children showed the most improvement by the end of the program spent more time with the mentor.

Length of time for improvement - Improvement in internal assets was gradual, with increases evident at each 30-day check-in with students. This suggests that mentoring and parent support have an immediate impact on student personal well-being.

- A total of 30 students, 26 boys and 4 girls, participated in the mentoring program. Students that participated ranged from 7 through 11 years of age (n=30)
- 75% of families surveyed through the Stanislaus Comprehensive Family Assessment (SCFA) identified conflict resolution as a frequent family concern. (n=28)

Challenges

- Room availability at school sites was limited
- Scheduling of sessions was challenging for participants and program mentor
- Parents in the program wanted a "quick fix" to solve their child's behavior problems/focus was on taking small steps toward positive progress

INN – Choose Civility Learning Project (INN - 05)
Operated by Center for Human Services in partnership with Keyes Unified School District

Summary

In collaboration with a small, rural school district, the primary purpose of this learning project was to increase quality of services, including better outcomes for children, school staff, and parents. The project introduced a promising approach that could be replicated in other schools in Stanislaus County.

Operated by the Center for Human Services (CHS), the focus was to build capacity to promote school culture towards civility and positive interactions that impact mental, behavioral and emotional wellness for students, teachers, and school staff.

The program was implemented in the Keyes Union School District on the campuses of Keyes Elementary and Barbara Spratling Middle School. Among the activities were school assemblies, staff trainings, and student "challenges" where acts of kindness were creatively represented using a paper chain.

The two year project ended in January of FY 13-14. A detailed Final Report about the project was submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on June 26, 2014.

Learning Proposed

Does creating a "culture of civility" have an impact on emotional wellness outcomes and improve developmental assets for children in a school environment?

Highlights

Students participated in interactive assemblies to help teach kindness and civility. Among them was the "Civility Chain Reaction" project where acts of kindness were displayed using a paper chain that stretched a mile long.

CHS staff facilitated a civility kick-off day for district staff that consisted of teambuilding exercises and other training activities designed to change the school culture. More than 80 district staff members attended the event. Students participated in interactive assemblies to teach help kindness and civility.

The superintendent initiated a district-wide study of the book, "Mindset - The New Psychology of Success". The book focused on how to approach conflict. Concepts of the book were taught in class and students created posters to reinforce the concepts.

- A total of 85 district staff attended a CHS facilitated "Back to School Kick-Off" day that included civility teambuilding and other training exercises
- Six (6) district staff members attended a "Turn Around Schools" conference
- School staff was provided with curriculum to teach civility concepts.
- School staff learned strategies to implement civility in classrooms
- Changes were evident on four of seven indicators with gains of 15 – 20%.
- Staff rated civility as more important for the school at the end of the first semester and those gains were maintained.

Challenges

The program experienced some staff turnover.

INN - Connecting Youth to Social Supports (INN – 06)
Operated by Sierra Vista Child and Family Services

Summary

The project proposed to increase quality of services including better outcomes. A secondary focus was to promote interagency collaboration and increase access to services for youth by connecting them to community based activities to help reduce the length of time and intensity of their treatment.

Mental health clinicians would assist youth in identifying activities that are of interest to them. A Community Support Specialist, based at a Family Resource Center or partner agency, would receive an activity referral, connect the youth, and monitor their participation in the activity and their progress toward recovery.

The two year project by Sierra Vista Child and Family Services (SVCFS) ended in February of FY 13-14. A detailed Final Report about the project was submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on June 26, 2014.

Learning Proposed

Is it beneficial to include community based youth development activities as a formal part of the treatment plan and would including these activities significantly transform the way a clinician performs and provides mental health services to youth?

Highlights

A total of 115 active youth clients participated in the program. It was learned that connecting children to community activities in effect increased time and intensity of services. Parents and children reported ancillary benefits to participation in community activities. Clinicians reported that children fully participating in the project developed improved social skills. Children from both outpatient settings and more intensive programs, such as non-public school, benefited from participation in community activities.

The project also found that the community at large is ready and willing to assist children in getting connected to activities. Over the two years of the project, donors contributed more than $14,000 to help fund activities for needy children. In addition, there were 42 organizations that connected youth to activities.

- A total of 155 youth were screened and connected with community activities
- The project received a total of 155 referrals
- A total of 87 youth engaged in community activities for a minimum of four (4) months
- 93% (69/74) of participants surveyed reported satisfaction with the program
- The average length of treatment for all programs was 18 months
- 78% (58/74) of surveyed caregivers indicated improvement in child's presenting symptoms as related to their participation in community activities

Challenges

Among the challenges identified during the evaluation and learning process:

- Identifying no cost or low cost activities
- Subsidized activities that impacted length of stay
- Staff turnover

INN - Families in the Park (INN - 07)
Operated by West Modesto King Kennedy Neighborhood Collaborative

Summary

The project proposed to provide outreach to pre-school aged children and their caregivers who spend their days in Mellis Park in West Modesto. The focus was to provide support and increase school readiness for 15 to 25 families with young children.

Operated by the West Modesto King Kennedy Neighborhood Collaborative (WMKKNC), the project provided socialization activities for children and families to encourage sharing and relationship building. Mental health problems that contribute to lack of success, and later in life, can be linked to lack of preparation for school, lack of effective parental support to attend school, and the lack of internal resources (developmental assets) during the school years. This program connected families to mental health services and school readiness preparation.

The project ends in March of FY 14-15. A detailed Final Learning Report for this project was sent to the MHSOAC in a separate document.

Learning Proposed

Increase access to underserved groups through an innovative approach in a culturally specific way of outreaching to young African-American families (predominantly mothers with pre-school age children) who spend their days from April to November in the 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.

Highlights

This project was one of nine community-based innovation projects begun in Stanislaus County in FY11-12. The program uses the 40 Developmental Assets curriculum approach to create a foundation for success. Among the 40 key areas are family support, positive family communication, self-regulation, safety, and self-esteem. A total of 19 families and 21 children participated in the program in FY 12-13. The project was fully operational during FY12-13.

- A total of 24 program sessions were held in FY 12-13.
- Staff members attended a two day training on the 40 Developmental Assets

Challenges

The program first started with an initial group of six (6) families and ten children. It expanded to nine (9) families by mid-summer of 2012. But then the group size dropped as children enrolled in either kindergarten or pre-school. The program was then modified with a focus on enrolling 2 to 4 years olds ensuring that children would be in the program a minimum of eight (8) months even if they entered kindergarten at age 5. Incentives were introduced to encourage enrollment and regular ongoing participation.

INN - Integration Innovations (INN - 08)
Operated by Stanislaus County Health Services Agency in partnership with NAMI and WMKKNC

Summary

The primary purpose of this project was to increase the quality of services including better outcomes for adult and older adults of all cultures and ethnicities who receive medical and psychiatric care in a primary care clinic setting. Participants included adults (18-54) and older adults (55+). The population is considered "medically high risk" and included uninsured and underinsured individuals.

The program provided peer support to participants who struggle with mental illness and/or substance abuse with community based supports and wellness activities.

Integration Innovations ended in August of FY 13-14. A detailed Final Report about the project was submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on June 26, 2014.

Learning Proposed

To learn if an integrated behavioral health service with peer support available to patients can be effective in a medical primary care setting. By combining non-medical case coordination, peer support, group/individual interactive learning, and chronic disease management, can the approach effectively contribute to reducing psychiatric and chronic disease symptoms? Could it also build resiliency in a population of patients dually-diagnosed with one or more mental health conditions, substance use/abuse issues and chronic medical conditions?

Highlights

The "Savvy Self Care" program evolved into a 12-week psycho-educational approach to diabetes self-management for people who also suffer from a mental illness. One of two cycles of the program was conducted in Spring 2013. A total of 39 patients from the Health Services Agency (HSA) Paradise Medical Office in West Modesto were screened and met criteria for the program.

Among the findings: Depression scores were reduced from a mean of 45.08 at pre-test to a mean of 34.74 at post-test, a statically significant finding; anxiety scores were reduced from a mean of 34.81 at pre-test to a mean of 27.09 at post-test.

- The project had 39 participants - 17 Male, 22 female (n=39)
- 50% of the participants were ethnic minorities.
- A1c (blood glucose) levels were reduced from a mean of 8.91 at pre-test to a mean of 8.19 at post-test
- Depression scores were reduced from a mean of 45.08 at pre-test to a mean of 34.74 at post-test
- Anxiety scores were reduced from a mean of 34.81 at pre-test to a mean of 27.09 at post-test
- 97% of participants responded in a survey that they were eating healthier as a result of the program (n=36)

Challenges

Recruitment and retention of potential program participants was a challenge.

INN – Promoting Community Wellness through Nature (INN - 09)
Operated by Tuolumne River Trust

Summary

The Tuolumne River Trust (TRT) innovative project provided a unique community-based approach to address wellness issues in Modesto's Airport Neighborhood. A series of community-driven and resident led activities were used to bring children and families outdoors in nature.

The activities addressed environmental and social barriers to mental wellness in the neighborhood on 3 levels:

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

The project proposed to increase access to underserved groups through family-oriented outdoor programming with resident-led neighborhood improvement and community capacity building. It incorporated nature "therapies" to address wellness issues and tested the theory that a community's attitude towards and connection with its natural and urban environment plays an important role in the overall health and vitality of its residents.

The two year project ended February of FY 13-14. A detailed Final Report about the project was submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on June 26, 2014.

Learning Proposed

Do combining family-oriented outdoor experiences with community-driven neighborhood development and capacity building lead to strengthened developmental assets in children? Does it help increase leadership and competency in adults and create a more connected community?

Highlights

The Community program known as Charlas Communitarias (Community Chats) helped solidify a core group of 15 community leaders to take action in their neighborhood. They were primarily Hispanic women between the ages of 25-35 who were either stay at home moms or seasonal workers. The group met with city and county leaders to address key issues related to neighborhood safety and community wellness.

The youth program included outdoor activities to engage young people to visit parks and family summer camps to increase their comfort level, skills and interest in the outdoors.

- A total of 5 special family events were held with more than 500 people participating
- 35 youth participated in Family Summer Camp
- 30 youth participated in the afterschool program
- Leadership groups gained confidence in their ability to address issues of concern
- Staff and volunteers report observing improvements in youth behavior

Challenges

While all the learning activities were completed, affecting change with multiple groups at multiple levels in a short period of time was difficult. Safety in the Airport neighborhood was also an issue for some residents.

INN - Revolution Project (INN - 10)
Operated by Center for Human Services

Summary

This project promotes interagency and community collaboration. The aim was to engage business and community leaders in the rural, underserved Westside community of Patterson to learn what it takes to resolve conflicts with youth from nearby schools and build partnerships to improve emotional health and mental well-being.

Through strengthened relationships with community members, the youth leadership project was expected to help lower the incidence of substance abuse and other risk behaviors as well as increase youths' resilience, mental and emotional wellness, and academic success.

The two year project by the center for Human Services (CHS) ended January of FY 13-14. A detailed Final Report about the project was submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC) on June 26, 2014.

Learning Proposed

Using a unique approach of "Asset Learning Circles" and other methods not typical of standard mental health practice, what changes will occur as adults are engaged in learning about positive youth development? How do out-of-school activities help youth experience positive mental health, social experiences, academic success, and well-developed life skills?

Highlights

This project was one of nine community-based innovation projects begun in Stanislaus County in FY11-12. Parents, spiritual leaders, and youth participated in Community Youth Café, a community group to learn about positive youth development and the role of the community in supporting them.

A Patterson Teen Center was established to provide youth access to mental health prevention, intervention, and treatment services. Teen center staff created a volunteer recruitment list for outreach events and recruited 100 community members to participate in youth activities.

- A total of 370 youth (unduplicated count) participated at the Teen Center
- A total of 107 youth participated in "Tuesday Teen Talks"
- 39 youth received tutoring and homework assistance
- 96% (27) of parents reported that participating in this program is good for their child

Challenges

Staffing changes were a challenge. Another transpired as the Center for Human Services began to transition the Patterson Teen Center to the city of Patterson. This created uncertainty among some young people since they were unsure how the new transition would affect them directly.

INN – Wisdom Transformation Initiative (INN -11)
Operated by Center for Collective Wisdom

Summary

The purpose of this three-year project—called the Wisdom Transformation Initiative—is to promote interagency and community collaboration by supporting transformation and learning among many of the largest non-profit and community-based organizations in Stanislaus County.

In 2010, Behavioral Health Recovery Services (BHRS) began an on-going process of transformation, focused on four commitments: a commitment to results, a commitment to community capacity-building, a commitment to fiscal sustainability, and a commitment to leadership. The focus of the Wisdom Transformation Initiative is to learn how to help non-profit and community-based organizations embody this transformation framework, so they can better collaborate with each other and with BHRS.

Participating organizations—Center for Human Services, Sierra Vista Child and Family Services, Turning Point Community Programs, and West Modesto King Kennedy Neighborhood Collaborative—contract with Behavioral Health Recovery Services (BHRS) to serve some of the county's most vulnerable individuals and families who are at risk of, and affected by, serious mental illness.

The ultimate goal of this project is to improve outcomes for people receiving services and supports through the behavioral health system by helping participating organizations improve their programs and their capacity for collaboration. This Innovation project is currently funded through FY 15-16.

Learning Proposed

The project will assess whether and how the adoption of the Wisdom Transformation framework by participating organizations increases their capacity to do the following:

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

Highlights

One of the first insights emerging through this effort is that the commitment to leadership provides the foundation for the adoption and embodiment of the three other transformation commitments. To this end, we have provided intensive training and support to hundreds of staff and volunteers across the participating organizations in the Leadership for Collective Wisdom framework, the framework that defines the commitment to leadership.

The training and support that staff and volunteers have received includes off-site and on-site trainings; facilitation of learning dialogues; facilitation of and program design and strategic planning sessions; and intensive 1:1 and small group coaching and support. Through these efforts, senior leaders, mid-level managers, line staff, and volunteers are learning to embody the commitments and practices of self- and collective leadership in support of their work to improve their programs, including applying aspects of the other three transformation commitments.

Staff and volunteers are regularly reporting:

- Experiencing higher levels of creativity and less debilitating stress;
- Discovering new solutions to challenges previously seen as intractable;
- Increased capacity to hold and engage productively with difficult conversations;
- Fewer experiences of the opposite of collective wisdom—collective folly, marked by unproductive conflict, stress, and incoherence—and an increased ability to name and address moments of collective folly when they arise.

Examples of how programs are applying the Wisdom Transformation framework include:

- **CHS Pathways** is a transitional housing program that provides critical support to young adults 18-21 years old who are homeless. Staff members are using the Wisdom Transformation framework to strengthen their intake and assessment processes, and the ways they engage young people who join the program. The purpose of this work is to improve the program's capacity to help young people develop more permanent supportive relationships, housing, and employment.

- **TPCP Warm Line** is a mental health consumer-run program providing non-crisis intervention, offering peer support, referrals, and shared experiences of hope and recovery. One challenge that Warm Line staff members are addressing is the issue of repeat callers. Repeat callers call Warm Line sometimes every day, multiple times a day. Staff members are working to increase their capacity to engage in meaningful dialogue with these callers, and exploring ways to connect them to more appropriate and sustainable sources of care.
- **The West Modesto King Kennedy Neighborhood Collaborative** (WMKK) is one of the leading community-based organizations addressing the behavioral health care needs of West Modesto residents in Stanislaus County. WMKK leaders—including board members, staff, volunteers—have been focusing on developing a long-term sustainability plan for the organization that will increase their impact across the neighborhood.
- **CHS Family Resource Center** staff and volunteers are engaging in a series of learning dialogues to help transform their work to more intentionally focus on building and strengthening the experience of community among all who come to the Centers— family members who receive support, other families who may interact with the Center, volunteers, and staff. *Community* in this means a group of people who act together and support each other. This work has required FRC staff and volunteers to rethink their understanding of their roles, and to explore strategies for creating relationships of mutual support among families, volunteers, and staff.

- Over 300 individuals from three organizations have participated in the Innovation project to date. *(estimate through December 2014)*
- The organizations have received over 1500 hours of consultation support to date. *(through December 2014)*
- 68% of participants are individuals who have received mental health services *(through June 2014)*
- 71% of participants have family members who have received mental health services *(through June 2014)*
- Participants are ethnically diverse (44% Hispanic/Latino, 44% White, 6% African American) *(through June 2014)*

Challenges

In working with organizations over a period a time, there have been some newly discovered patterns and complexities. They include the following:

- The need to translate and re-frame the framework to make it more relevant and appropriate to non-profit community-based organizations.
- The need to understand each organization's level of readiness, organizational capacity, and engagement to ensure that the framework can meet each organization and program where it is.
- The need to understand sub-cultures within organizations, and to translate and adopt the framework accordingly.

INN – Garden Gate Innovative Respite Project (INN - 12)
Operated by Turning Point Community Programs

Summary

The aim of this three year Innovation project is to increase the quality of services, including better outcomes, by developing and testing a consumer and family centered approach to short-term crisis respite housing and peer support for individuals and their families who are at risk for psychiatric hospitalization.

The Innovation project is funded through FY 15-16.

Learning Proposed

The project will explore the following overarching questions:

1. Can a "culture" shift occur in the community that creates better alignment between the need and support available? Can we create a more effective way of supporting individuals and families that experience the negative consequences of mental illness?
2. Can this project approach allow individuals to step away from their illness, increase self-esteem, promote recovery, reduce stigma and contribute to healthier, happier and more productive members of the community who are less dependent on the behavioral health service system in a crisis?
3. Can we assist people to avoid the trauma of psychiatric hospitalization by offering community-based peer support paired with short-term respite care?
4. Can we learn a new cost effective approach to significantly reduce psychiatric hospital admits and possibly other related costs to the behavioral health and related systems; such as emergency rooms and jails?

Highlights

The program had a total of 229 referrals during the fiscal year. The majority of them came from the Modesto Police Department. Linking clients to community resources is an important part of this program. During the year, the program had a total of 540 community resource linkages. The majority of the clients were linked with Turning Point's Empowerment Center. Of those 540 linkages, 72% were recorded as having been successful.

- The program had 229 referrals, the majority of which came from the Modesto Police Department (20%, n=45)
- 171 (76%) of the total referrals were made when the client was at risk of arrest
- 203 (90%) of the total referrals were made for those at risk of homelessness
- The program had 540 linkages to other community resources. The majority of clients were linked with Turning's Point's Empowerment center (14%, n=77)
- Of the 540 community linkages, 387 (72%) were recorded as having been successful.
- Participants completing a program survey reported they were Very Satisfied (93%) or Satisfied (7%) with the services they received

Challenges

Transportation is a barrier for some clients. Collaboration with the Peer Navigation program is one of the strategies to address this issue.

Innovation - Request For Proposals from September 2014 Plan Update Project Descriptions

Quiet Time Project

Community Agency Implementing: Sierra Vista Child and Family Services

Summary:
Quiet Time is a stress reduction and wellness program that enhances the holistic development of children with Severe Emotional Disturbance (SED) and children on the Autism spectrum. Implemented in school districts by the Center for Wellness and Achievement in Education (CWAE) in San Francisco, the program incorporates the practice of an extensively researched stress reduction technique known as Transcendental Meditation to reduce stress, balance lives, and increase a child's readiness to learn. Up to 63 students between the ages of 8-14 will be trained in the Quiet Time project at two of Sierra Vista's Non-Public School campuses, Kirk Baucher School and Sierra Vista Learning Center.

Learning proposed:
Quiet Time in public school populations has shown to complement existing educational strategies by improving the physiological underpinnings of learning and behavior. It not been offered in a non-public school setting with SED children. The goal is to learn if this Innovation project can produce similar outcomes in two non-public schools serving children with SED and children with SED on the autism spectrum. t whether or not Quiet Time complements other school efforts, including the support of teachers, in creating changes and enabling SED students to improve their behavior, wellness, and academic performance.

Here are some of the learning questions this project will explore:

- Will SED students and SED students on the autism spectrum be able to effectively participate in Quiet Time for the allotted time period, without disrupting the rest of the class?
- Will Quiet Time effectively impact SED student's behavior and their ability to focus, stay on task, and interact positively with their peers and teachers?
- Will there be a difference in results between Kirk Baucher (SED) students and Sierra Vista Learning Center (SED students on the Autism spectrum)?
- Will the Quiet Time implementation strategies used for traditional school settings work for the SED school setting?

Strategy:
Introduce a new application to the mental health system of a promising community driving practice/approach or a practice/approach that has been successful in a non-mental health context or setting.

Adaptive Dilemma:
Improving the well-being of children/2nd Tier- Honoring and Identifying More Holistic Approaches to Well-Being

Father Involvement Project

Community Agency Implementing: Center for Human Services

Summary:
The Father Involvement Project will create a collaborative learning network that brings organizations and community groups together to achieve positive mental health results and build protective factors against mental health problems for fathers in Stanislaus County. This is a new concept in promoting interagency collaboration to reach fathers with mental illness or those at risk of mental illness and their families.

Learning proposed:
Through interagency collaboration, this project introduces to the mental health system a community defined approach that has been successful in a non-mental health context. It utilizes the development of a collaborative learning network as the key strategy to achieving positive results for fathers.

Here are some of the learning questions this project will explore:

- How will participation in a learning network impact the growth and development of its members?
- How will the learning network impact the quality (e.g. best practices) and quantity of father involvement activities?
- Will participation in father involvement activities increase as a result of this project?
- How will fathers and their families benefit from participating in the project activities, in particular increased protective factors.

Strategy:
We expect to learn a great deal on how to increase interagency and community collaboration for mental health services or supports.

Adaptive Dilemma:
Improving parental competency and social support for fathers

Youth Peer Navigators

Community Agency Implementing: Behavioral Health and Recovery Services (BHRS)/Juvenile Justice

Summary:
The Youth Peer Navigator Project is an integrated youth-centered approach to help young people with mental illness or Serious Emotional Disturbance (SED) navigate through the Stanislaus County mental Health services system and improve mental health outcomes and their well-being. This project will explore making a change to an existing mental health system practice/approach by engaging youth and their families in a manner that has proven promising in other areas, as well as less extensively for youth in mental health systems. The expectation is that by making this change, the project will increase the quality of services, including better outcomes. Navigators will provide mental health education, linkages, and peer support to youth in the BHRS Children's System of Care (CSOC) including Child Welfare, Juvenile Justice, and School Based Services.

Learning proposed:
The project seeks to adapt the current best practice model of Peer Navigation and pattern an Innovative approach to impact the lives of children, Transition Age Youth (TAY), and Transition Age Young Adults (TAYA), ages 6-19 within the Stanislaus County CSOC. Many youth served in CSOC have not successfully been engaged by traditional methods of treatment. As a result, they can become more seriously ill, have more aggressive behavior, and have higher rates of re-incarceration or re-institutionalization. This project is designed to increase the quality of services, including better outcomes through youth peer support in multiple areas of SCOC.

Here are some of the learning questions this project will explore:

- Are Youth Peer Navigators effective within various mental health settings in engaging youth and their families in navigating the mental health system? Are the navigators more effective in specific settings?
- Do Youth Peer Navigators help youth connect to natural and community supports?
- Do Youth Peer Navigators contribute to increased protective factors? If so, which protective factors?
- Do Youth Peer Navigators contribute to the reduction of criminal recidivism?

Strategy:
Consistent with Innovation guidelines, given by past and present state agencies, this project explores making a change to an existing practice in the field of mental health and improving the well-being of children.
The Youth Peer Navigator project seeks to incorporate an adaption from current known best practices of existing Peer Navigator programs. These programs have not been used in a Juvenile Justice setting with youth.

Adaptive Dilemma:
Improving the well-being of children, Transitional Aged Youth (TAY) and Transition Aged Young Adults (TAYA).

Innovation - FSP Co-Occurring Disorders Project Funding Proposal

Below please find the funding proposal endorsed by the RSSC on February 27, 2015. The proposal still needs approval from the Stanislaus County Board of Supervisors and the Mental Health Services Oversight and Accountability Commission.

County: Stanislaus

Program Name: FSP Co-Occurring Disorders Project

Date:

☒ **Completely New Program**

☐ **Revised Previously Approved Program**

Complete this form for each new INN Program. For existing INN programs with changes to the primary[1] purpose and/or learning goal, please complete the sections of this form that are applicable to the proposed changes. If there are no changes in the applicable section, please state "No Changes."

Select **one** of the following purposes that most closely corresponds to the Innovation's learning goal.

- ☒ Increase access to underserved groups
- ☒ Increase the quality of services, including better outcomes
- ☐ Promote interagency collaboration
- ☐ Increase access to services

1. Describe why your selected primary purpose for Innovation is most relevant to your learning goal and why this primary purpose is a priority for your county.

It is common knowledge among mental health treatment providers that a great proportion, or even the majority, of people with severe mental illness that are not benefiting from mental health treatment efforts have co-occurring substance use disorders (SUD). These co-occurring SUDs are substantially interfering with the effectiveness of their mental health treatment. While it is also known that a great proportion of all adults with severe mental illness have co-occurring substance use disorders and that all adult FSPs should have the capability to diagnose and treat SUDs (e.g. IDDT), there are some individuals for whom the extent of the interference of the SUD behavior makes these FSPs' efforts ineffective. It is this group of individuals that this innovation project hopes to impact by providing services intended to produce better outcomes. Since the options for co-occurring treatment are few in our county, this project will also increase access to a potentially unserved/underserved group.

Mental health (MH) treatment and substance use disorder (SUD) treatment are very similar and have great overlap. There are however some areas that are significantly different in approach, training and philosophy. These areas include, but are not limited to: engagement versus enabling, abstinence versus meeting the client where they are at, hopefulness for recovery versus desire to drink or use drugs without consequence, empowerment of the individual versus acceptance of the individual's powerlessness over controlled drugs and alcohol use. It is our belief that a client-centered, stage-based approach to MH and SUD treatment and treatment planning would create a theoretical framework that allows for both approaches to be fully utilized.

Many of these individuals are also involved with the criminal justice system, often directly related to their mental health and substance use disorder symptoms and behaviors. Many of these individuals are homeless or at risk of homelessness. In addition, many are at risk of institutionalization and may be frequent users of emergency services. Therefore, there is some overlap with other adult FSPs in our county. However, all of the other adult FSPs perceive a gap in our continuum of FSP programs that this proposed Innovation Project would address. Coordination with these other FSPs will be a key component of this program.

[1] The term "essential purpose" has been replaced with the term "primary purpose" for INN.

2. Describe the INN Program, the issue and learning goal it addresses, and the expected learning outcomes. State specifically how the Innovation meets the definition of Innovation to create positive change; introduces a new mental health practice; integrates practices/approaches that are developed within communities through a process that is inclusive and representative of unserved and underserved individuals; makes a specific change to an existing mental health practice; or introduces to the mental health system a community defined approach that has been successful in a non-mental health context.

This INN program will be a Full Service Partnership that focuses on adult individuals who have both a serious mental illness as well as a co-occurring substance use disorder. Though Behavioral Health and Recovery Services currently has a small Co-occurring Treatment Program (COT), this program focuses mainly on treatment and not the broader issues surrounding many individuals with co-occurring conditions. This FSP will ensure that treatment is provided, but in addition, the FSP model will also address potential risks that all FSPs are designed to reduce, i.e., homelessness, involvement with the criminal justice system, acute psychiatric hospitalizations, and institutionalization.

In addition, given the focus on integration of behavioral health and primary care, this INN project will include primary care as an integrated component of this FSP. Broadening the focus beyond behavioral health to encompass physical health is becoming an expected standard of care in the health industry and is designed to reduce the silos that have often characterized behavioral and physical healthcare. Well-documented research has indicated that untreated behavioral health conditions lead to early death in individuals with mental health and/or substance abuse conditions. Also, it is believed that the inclusion of physical health care in this INN project is a way to engage individuals that are resistant to behavioral health treatment. The experience of our outreach teams supports this assumption given that many individuals want assistance with health issues about which there is less stigma. However they are engaged, many individuals are then more receptive to dealing with the root causes of their physical health issues.

A 'housing first' approach is also critical in engaging this population and beginning the treatment process. Experience in our other FSPs has demonstrated that clients often continue harmful substance use behaviors despite efforts to eliminate this. Consequently, they appear at the temporary housing under the influence and, ultimately, lose the housing because the continued substance use has put the other clients in the housing at risk of relapse and using substances themselves. This FSP will develop housing engagement strategies that deal with continued substance use without resulting in the client losing their housing, while still protecting the other clients from this behavior. It has been shown in other states that offering housing that does not require sobriety to begin with has resulted in the client actually working toward sobriety, i.e., engaging in treatment.

It is believed that once engaged into treatment, this population would benefit from stage-based mental health treatment and stage-based substance use disorder treatment concurrently and integrated. Too often, mental health treatment and substance use disorder treatment are provided sequentially, allowing progress to be undermined by issues stemming from the untreated aspect. Beginning where the client is in their recovery process, whether that is more mental health related, or more substance use related, treatment will be guided by data that reflects that specific client's readiness for treatment in both areas. Using peers who are in recovery as well as the SUD recovery environment and group-based treatment is expected to be particularly effective with this population. Staff will be trained in the Integrated Dual Diagnosis Treatment protocol. Ultimately, this approach should create positive change.

The learning goals will be that these difficult to engage, and therefore underserved, individuals will be successfully engaged in treatment that will address both physical and behavioral health needs. In addition, it is expected that this innovative combination of services will yield better health and behavioral health outcomes in this population that is at risk of disabling conditions affecting the quality of their lives as well as the length of their lives.

2a. Include a description of how the project supports and is consistent with the applicable General Standards as set forth in CCR, Title 9, Section 3320.

This project will be a collaboration with primary care with the shared vision of overall health and recovery. Services will be provided in a culturally competent manner using individuals with lived experience to provide outreach and engagement to the target population. Since research has demonstrated that primary care is often a more acceptable resource to turn to for help for many ethnically diverse populations, it is expected that this component will overcome some of the stigma that is associated with behavioral health treatment. Having the "housing first" component is a component of the client-driven aspect of the project. Service provision will be integrated in that physical health and behavioral health are integrated and mental health and substance use treatment are integrated. Ultimately, the outcomes should demonstrate that this approach leads to wellness and recovery in a very at risk population. in an Integrated Dual Disorder Treatment (IDDT) trained Full Service Partnership (FSP) program,

2b. If applicable, describe the population to be served, number of clients to be served annually, and demographic information including age, gender, race, ethnicity, and language spoken.

The population to be served will be adult individuals with co-occurring substance use and mental health disorders. Fifty (50) individuals are expected to be served at any one time.

3. Describe the total timeframe of the program. In your description include key actions and milestones related to assessing your Innovation and communicating results and lessons learned. Provide a brief explanation of why this timeline will allow sufficient time for the desired learning to occur and to demonstrate the feasibility of replicating the Innovation. Please note that the timeline for your Innovation Program can be longer than the period for which you are currently requesting Innovation Component funds.

This project is expected to be completed in three years. DCR data will be monitored as will California Outcomes Measurement System (CalOMS) results on a quarterly basis. Engagement data, Level of Care data, service utilization data, and other client outcome data will be gathered at least quarterly. At 3 months the program should be fully operational and at least at 70% client capacity, engagement activities should be fully operational. At 6 months the program should be at 90% client capacity, data gathering fully in place. At 1 year initial data analysis of trends and outcomes will be reviewed. At 2 years full data analysis on years 1 and 2 of operation will be reviewed. At 2 ½ years data gathering for project study will be completed. At year 3 the full analysis of data and client outcomes will be completed.

4. Describe how you plan to measure the results, impacts, and lessons learned from your Innovation, with a focus on what is new or changed. Include in your description the expected outcomes of the Innovation program, how you will measure these outcomes, and how you will determine which elements of the Innovation Program contributed to successful outcomes. Include in your description how the perspectives of stakeholders will be included in assessing and communicating results.

1) With the ongoing measurement of clients' levels of engagement in their mental health treatment and their substance use disorder treatment, as two **independent** variables, as a guide for stage-based treatment processes for **both** their mental health treatment and their substance use disorder treatment, treatment outcomes for those individuals with Severe Mental Illness (SMI) that are un/underserved due to the extent of their SUD behavior interfering with their mental health treatment will be monitored using DCR data and CalOMS data. It is expected that outcomes will mirror, if not exceed, the success rate of the other FSPs currently available in our Community Services and Supports continuum.

2) Co-locating this FSP on an SUD/Co-occurring treatment site, with SUD recovering peers and supports and other SUD specific treatment, will also improve client outcomes as measured by DCR and CalOMS.

3) Integration with physical health care and the promotion of health interventions, used as an early engagement strategy, will improve the engagement rate for very hard to engage SMI/SUD clients. Rate of engagement prior to the implementation of this strategy will provide the baseline.

4) A list of engagement strategies and interventions useful with this population will be provided at the conclusion of the INN project. Evaluate the effectiveness of these various engagement strategies with this population in terms of engagement in treatment, retention in treatment and treatment outcomes.

5. If applicable, provide a list of resources to be leveraged.

6. Please provide a budget narrative for total projected costs for the entire duration of the Innovation Program, and also provide projected expenditures by each fiscal year during the program time frame, including both the current and future funding years. (For Example, Program 01- XXXX, the entire project is $1,000,000. The first year projected amount will be $250,000, the second year projected amount is $250,000, the third year is $250,000 and the fourth year is $250,000.) Please also describe briefly the logic for this budget: how your proposed expenditures will allow you to test your model and meet your learning and communication goals.

The total budgeted amount is $1,098,979, of which $800,000 is Mental Health Services Act INN funds. The funding will be for the first year of operation. Federal Financial Participation (FFP) funds generated by medically necessary Medi-Cal services provided by this Full Service Partnership program will offset a portion of the full program cost and allow for some innovation money to be used in year 2 of operation. Years 2 and 3 would be sustained by FFP and MHSA CSS FSP funding. Funding for outcome data gathering and analysis for this program is being built into the overall MHSA plan.

7. Provide an estimated annual program budget, utilizing the following line items.

NEW ANNUAL PROGRAM BUDGET

A. EXPENDITURES

	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/CBO's	Total
1.	Personnel	$735,545	$151,800	$0	$887,346
2.	Operating Expenditures	$92,433	$0	$0	$92,433
3.	Non-recurring Expenditures	$49,200	$0	$0	$49,200
4.	Contracts (Training Consultant Contracts)	$0	$0	$30,000	$30,000
5.	Work Plan Management				
6.	Other Expenditures		$40,000		$40,000
	Total Proposed Expenditures	**$877,178**	**$191,800**	**$30,000**	**$1,098,979**
B. REVENUES					
1.	New Revenues				
	a. Medi-Cal (FFP only)	$298,979			$298,979
	b. State General Funds (MHSA-INN)	$578,200	$191,800	$30,000	$800,000
	c. Other Revenues				
	Total Revenues				
C. TOTAL FUNDING REQUESTED		**$877,178**	**$191,800**	**$30,000**	**$1,098,979**

D. Budget Narrative

1. Provide a detailed budget narrative explaining the proposed annual program expenditures for each line item.

1 PERSONNEL

All personnel costs are estimated at Step V of the Classification range x 2080 working hours.

Annual benefit costs are approximately 40%.
Estimated overhead is calculated at 30%
Mental Health Clinician II – Coordinator (MHC II) includes 10% supervision differential

Classification	FTE	Annual S/B Costs	Project Costs
County Mental Health Personnel:			
Behavioral Health Specialist II	3	$96,338	$289,013
Mental Health Clinician II	1	$118,831	$118,831
MHC II – Coordinator	1	$130,714	$130,714
Psychiatrist	0.15	$370,007	$55,501
Administrative Clerk III	1	$77,687	$77,687
Peer/Volunteer Organizer	0.5	$78,220	$39,110
Manager III	0.15	$164,601	$24,690
Sub Total - County MHD Personnel			$735,545
Other Government Personnel:			
RN/Public Health Nurse II contracted from County Public Health Department	1	$151,800	$151,800
1 Total Salary Costs			**$887,346**

2	OPERATING EXPENDITURES	
	Mileage - estimated mileage at $ .565/per mile	$2,800
	Office Supplies	$5,000
	Wraparound - includes support services to individuals such as housing and basic needs that are directly related to the client care plan.	$50,000
	SRC Rent/Utilities - approximately 2,170 square feet @ $1.33/sq	$34,633
2	**Total Operating Costs**	**$92,433**
3	NON-RECURRING COSTS	
	Desks – 8 @$1,500 each	$12,000
	Chairs – 8 @ $500 each	$4,000
	Desktop Computers, monitors, mouse, licenses – 8 @ $1000	$8,000
	Miscellaneous Office Equipment	$1,600
	Laptops – 2 @$1,800	$3,600
	Vehicle - sedan or small van for outreach purposes	$20,000
3	**Total Non-Recurring Costs**	**$49,200**
4	CONTRACTS	
	Consultation time from local Primary Care Physician	**$30,000**
5	Work Plan Management	**$ - 0 -**
6	Other Expenditures	
	Treatment for substance use disorders purchased from county or community based providers	**$40,000**
	Total Expenditures	**$1,098,979**
	ESTIMATED REVENUE	
	MHSA Innovations. Approximate 71% of program cost, including match for FFP	$800,000
	Estimated Federal Financial Participation (FFP)	$298,979
	Total Revenue	**$1,098,979**

MHSA ANNUAL UPDATE 2015-2016

SUMMARY OF PROJECTS

Prevention and Early Intervention (PEI) - Statewide PEI Initiative - $90,000

Workforce Education & Training (WE&T) - Training Costs - $150,000

Innovation (INN) - Full Service Partnership (FSP) Co-Occurring Disorders Project - $800,000

Technological Needs (TN) – Evaluation Outcomes Funding - $400,000

MHSA AND HOW LIVES ARE CHANGING

From direct services to prevention and early intervention to peer support, MHSA funded programs have impacted thousands of people in Stanislaus County. Here are some personal individual stories of **hope and recovery.**

Community Services and Supports (CSS)

"Gregory's" story:

I want to start by telling you that I am a homeless man and I thought resources for me were few and far between. I was told about the Empowerment Center from some peers at the Modesto Gospel Mission. The moment I stepped into the Center I was treated like a human being again. Through the center, I was able to apply for general assistance, apply for unemployment, and jobs. The staff was more helpful then other agencies combined. The staff worked twice as hard as I provided the leg work. They gave me hope and a sense of purpose again when it seemed like all the lights had been turned out.

I am happy to say now that through their help and understanding I now have a job and my homelessness will soon be over. My situation would have been very bleak and dismal had it not been for the Center and its excellent staff. I would like to close by saying the Center for me is one of the best if not the best resources in the city of Modesto. Thanks to the powers that be for making this place a light at the end of the tunnel.

"Gregory's story" from the Empowerment Center:

Gregory utilized our services including support groups. It was within one of the support groups he met with staff to further share the struggles he was having with his mental health and court commitments. He was clean and sober, but he was stressed out and in crisis. He utilized Garden Gate Respite services to give him a safe place to stay when his shelter ran out. While he was at respite, he connected with service providers and was able to get an assessment for services. CEC assisted him with these fees. He completed his court commitments, including having his record expunged of this charge due to completing all his commitments and paying his restitution in record time. He has completed several BHRS trainings to increase his skills to provide support to other consumers. He is looking to enroll in school at Modesto Junior College for human services classes. He has been hired into permanent employment with a community service provider where he will be able to share his lived experience with others that are also struggling. He still continues to co-facilitate at the Center and provide support to his fellow members.

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The staff and patients and the whole environment made me feel welcome and safe. If I ever need a safe environment again, I will come back. It is places like this that make me feel okay and safe reaching out for help. Thank you for being so accommodating and helping me feel better.

-Warm Line/CIP Client

*** Note: Some personal stories have been edited for content and length.**
Client names have been changed for confidentiality reasons.

Working at the Warm Line has taught me a lot on how to help manage my mental health, and that of my friends and family. I now find myself able to do more for them thanks to the resources I have access to and the general peer support skills that are taught to us through great training both in and out of the workplace. I had always considered myself to be a good listener before working here, but this job has taken that and redefined it into something greater. Being able to pick up that phone and know I can provide the best service to the caller that I can is an amazing feeling, one I never grow tired of. I had never once considered working in the mental health field before starting this job, but after working here for over a year, I now want to devote myself to this field and to helping others.

Warm Line Staff member

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I was 10 years old when my pediatrician finally diagnosed me with depression and put me on Prozac because I was going through a tough time as a pre-teen. When I got into high school, things got worse. I ended up in the psychiatric hospital at least 3 times every year up until I turned 21 years old. I felt like I was going to live this life forever. I had no hope for the future. I didn't know there was any help out there for me and it seemed like no one wanted to help or give me any advice. When I turned 18, I got kicked out into the streets on my birthday and my physician diagnosed me with bi-polar disorder. Even though I knew he was right, I didn't want to admit it. I didn't want to admit that I was different and that I had a mental illness.

When I was 19 years old, I was at the psychiatric hospital and a man came into to tell me about Josie's Place. But my mind was so distorted that I thought he was trying to sell me something. I couldn't believe that they actually wanted to help me…for free. So I never went there. Then about 2 years later, while I was in the psychiatric hospital, a man from Josie's TRAC came to see me,

He said he wanted to help me, help me stay out of the hospital, off drugs and booze, get off the streets and into a board and care home, and help me reach my goals of going back to school and finally obtaining a job that I would be able to hold on to. He said he had "tools" to help me recover from drugs, alcohol, and my mental illness and not let this illness control me. I thought to myself, "What is he trying to sell? I have no money." Then I thought, "What do I have to lose that I have not already lost from my downward spiraling life?"

I was going down a dark path in life. I was living on the streets. All my friends were drug addicts so that's what I was doing. My family gave up on me and I had no support system. So I gave in and admitted I had a mental illness and I needed help because I didn't want to live like this anymore. I finally said yes to a case manager. It was the first step into my recovery and the second best decision I ever made. I am crying at this point because I think of where I would be without the unconditional support from the Josie's Drop-In Center and their wonderful staff.

My case manager would come to the board and care home that he checked me into almost every day and pick me up and drive me to the drop-in center, drop me off, and then come get me. Even though I did not want to be there…but then again I had nothing else to do. I was around positive people. I sat at the arts and crafts table every day, silently staring at the table for hours a day. Most times I was depressed and crying. Some of the staff would come up to me and try to engage with me but I would not engage back or talk to them because I was so depressed. I talked to no one…for about 6 months.

Finally, they broke me and I started to slowly talk to people. I don't know how they did it but they did. They never gave up on and still to this day they keep believing in me. I started to doodle with their art supplies. They would tell me that I was very talented and a great artist. They encouraged me to doodle more. They gave me a canvas and some paint. I started painting for them. It made me feel good. They made me start feeling good about myself. They got me to start showing my art at art shows with the Peer Recovery Art Project and eventually they encourage me to show my art on my own at downtown art walks in Modesto. They helped me and encouraged me to go back to school.

I come and do my homework on their computers. I wanted to take the next step forward and get a part time job. They helped me do a resume. I got the job I wanted but I would constantly get bad anxiety. Every time I would get anxiety I would go to the Drop-In Center and they were always there for me. They would comfort me, give me encouraging advice and build my self-esteem. I lost the job because it became too hard for me and the stress brought back bad symptoms from my mental illness. They didn't look down on me for it. They just reassured me that they were still they for me and that in my journey to wellness I might take two steps forward and one step back but least I made progress into my recovery.

I didn't see it before but I see what they meant now that they were right. I am not where I want to be in life yet but I am not where I used to be and I am proud to say I have not been back to the hospital in 7 years which I owe to the Drop-In Center their staff and TRAC team. They got me housing, stable financially, and headed in the right direction. I am proud I am clean and sober. I see the light at the end of the tunnel. I see hope for the future for my son and me. I became pregnant and they didn't tell me I should have it because I am bi-polar. They just reassured me that will here for me and they support my decision to have my son. They directed me to parenting classes at the Parent Resource Center which help me a lot. I can say now that I have a lot more self-esteem than I did 7 years ago. It has been a slow process for me but I'm getting there.

Josie's Drop-In Center gave me an opportunity to volunteer which I thank them for because I would really like to help give back what they have given me to other struggling young adults. I feel like if I can just make a difference in at least one person's life like they did for me that would make it worth it. They eventually hired me which has given me this great opportunity to serve others and work on my next goal in life to obtain a full time job and be a part of the working society. I don't have to be on SSI for the rest of my life. My main hope is that when my son gets older he will be able to take me to his school career day and say his mommy has a career. And it's all because, even though I aged out a long time ago, they still encourage me and believe in me and gave me a chance to work on my next goal in life.

From the bottom of my heart, thank you Josie's Drop-in Center.

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"Bill" suffers from bi-polar disorder and substance abuse. He has a history of homelessness and abusing crack cocaine. The SHOP Intervention team worked with Bill and helped him get admitted to Stanislaus Recovery Center (SRC). He progressed from SRC to an outpatient program and was able to re-establish a relationship with his wife and begin attending NA/AA groups including the Matrix (AOD) group at Telecare. He also received individual therapy. Bill has maintained good relations with his ex-wife and now has a stable home. He's clean and sober and maintains a steady job.

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"David" was diagnosed with bi-polar, MRE severe with psychotic features. He was referred from Josie's Place after having been living on the streets and not taking his medications. He was in transitional housing for two years while he worked with Telecare staff to control his voices and anxiety. Currently, David is receiving SSI benefits and Medi-Cal. He has effectively controlled his symptoms through the help of medications and learned skills. He has reached his goal to have stable housing. He is now calm and more focused. He's been making friends in the community and is currently applying to Culinary Arts School.

Prevention and Early Intervention (PEI)

Last year I received a call from a staff member at the Veterans Medical Facility in Modesto asking if I could come and talk to some veterans who were getting ready to graduate from a Post- Traumatic Stress Syndrome (PTSD) management session. The veterans had grown to like each other during the sessions and were curious to see if I would know of any way they could still meet and be of support to each other.

I told them about peer support and in my opinion I thought a peer support group would be exactly what they made need. Four of the Veterans then signed up for my Group Facilitator Training and they attended each class without fail. The Veterans Administration in the meantime informed the group they could no longer have them at their facility due to space limitations. I was able to secure a meeting place in our facility at 800 Scenic and the group started meeting every Tuesday afternoon at 1:30 in the Main Conference Room. The group has grown steadily and I can see big improvements in the demeanor of the participants. And the leaders that took the training are now reaching out in the community to help other veterans still in tremendous need.

I was told a story about a homeless veteran who came into the meeting in an old broken down borrowed wheelchair. He told the group that he was living in an abandon shack in Salida. The group appointed some of the guys to help the veteran to get to future meetings and appointed others to help him find suitable housing. Some of the leaders then contacted some connections they had at the Veterans Administration and found out that the man was a Vietnam Era Veteran and had benefits available to him such as medical, housing, and a monthly income of about $800.00. The guys found him a nice place in Modesto. They were also instrumental in getting the Veterans Administration to hire an in-home caretaker for their fellow veteran.

This is what peer support and groups are all about - peers helping themselves by helping others. With minimal support from the county, the veterans were able to organize and help a fellow Veteran. This in turn has raised the hopes of the veterans and now you can see that the focus is switching from a “what happened to us back then” to what can we do to help those that are now walking the road.

Tim White, Behavioral Health Advocate, Coordinator
BHRS Friends are Good Medicine Program

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“Mary” began attending a promotore group Morning Coffee. She was very depressed and had low self-esteem. At first, she wouldn’t engage in conversation and appeared withdrawn. Over time, she began to participate more in the support groups and later began to speak more. She helped organized events and completed a promotore mental health training. Mary is more positive and says she enjoys life more than ever including spending time with her family. And her family is happy to see her cheerful again. Mary is now the first one to raise her hand and volunteer for community events. She looks forward to becoming a certified Bailoterpia instructor and start leading her own dance group. Participation in the promotore group has ignited her passion to help others in the community.

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“Sarah” said her life was to take care of her family and to sleep. She would get her children ready for school and her husband ready for work. Once they were gone, she would go back to bed. She said her life was depressing. One day a friend invited her to come to a Spanish support group and she thought, “How is this going to help me?” After the first visit, she has returned every week since. Sarah has learned so much and joined an English as a Second Language (ESL) group. She is now in an advanced class. Her goal is to one day attend classes at Modesto Junior College.

“Paula” said her life has changed since she joined her promotore support group. She says she’s been living with depression for the past year and she was skeptical about joining a support group. But as time went on, she began to see things in a new way. She learned things about herself and began to make changes. She now wants to help others with similar mental health problems and make a difference in the community.

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“Esther” has been attending promotore support groups since they began in 2011. She shares her struggles with stress, anxiety, and depression. She is the mother of four children. She is now sharing with others her journey to use Yoga as a way to not only lose weight but to de-stress her life. She says it has made her feel calmer and that she is not at peace with herself.

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A promotore couple began facilitating an art exhibit group at a local park. Before they began training, both stated that they would not have felt comfortable facilitating a group. Now they outreach to neighbors in the community with information about the group and other programs to enhance community well-being. During the summer break, students participate as well. Some parents who were reluctant to participate are becoming more comfortable and joining in with their children. The promotores are excited about their personal growth and the success of the art group.

Workforce Education and Training (WET)

I started out at BHRS volunteering to complete my hours for Alliance Worknet. Through this program I am gaining experience and getting my foot in the door towards the career that I eventually want to get into. I enjoy giving back to my community and helping others get into volunteering as well.

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Volunteering for me is a chance to give back to the community. It is also a really fun way to spend my time. I enjoy everything that I have been shown how to do and because I have an open honest relationship with my director, I have very little stress. For me it definitely beats isolating. I get a rush when I complete a project I have been assigned and I feel satisfied when I leave at the end of my shift having made a difference.”

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Being a volunteer for the county has been very rewarding, but, hard work and dedication has put me right now at this point to think about when I first arrived in Modesto. I was homeless, staying at the Salvation Army. I left behind an apartment, but now I can say that I have met some really caring people that gave me information on resources on how to restore my life back in order and I have executed all of the opportunities that were given to me through the people that were once volunteers and now employed by Stanislaus County.

I have overcome a lot of barriers and volunteering at Wellness Recovery Center, the Peer Recovery Gallery (ART) and being one of the most dominate person in our new adventure; the good neighbor squad, that we practice clean-up recycles, and art events in Modesto and other cities around Stanislaus County. Now at this time I just want to give thanks to my head mentor who helped made it possible for me to be able to have this opportunity of living a healthy clean life again, & God Bless us all!

The CASRA program is a life savior, I don't know about anyone else but I was homeless at one point and had to drop out of school because I couldn't afford to pay for books, bus passes or even just one way to school. Thanks to CASRA I know am doing well in all of my classes and have a 3.0 GPA that has not just help my school situation, but was a real confidence boost for me.

Without this program I would have never came back to school or had the chance to prove to not just others, but myself how smart I really am. Today I am more confident in my abilities at school and without the CASRA program and Meme pushing me and giving me the encouragement to keep moving forward I would be a failing student.

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“John”: Volunteering for me is a chance to give back to the community. It is also a really fun way to spend my time. I enjoy everything that I have been shown how to do and because I have an open honest relationship with my director, I have very little stress. For me it definitely beats isolating. I get a rush when I complete a project I have been assigned and I feel satisfied when I leave at the end of my shift having made a difference.”

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An appreciation for services rendered from the CASRA Stipend Program, is I am delighted to announce that with this program I have been able to set goals in my life that I would have not been able to make otherwise. I am a B student putting all my efforts toward an Associate Degree for Human Service/Sociology pursuing my BA in Social Work. I have been working in the mental health field for 11 years and now I can be proud of the services this programs offers to help me become the qualified person to help those in need and provide "on the spot" counseling.

Without the CASRA program, I would not have achieved these goals. I would not been able to afford the books needed for the classes and surely the enthusiasm would have died along with that thought. If only I could afford the books I know I can go forth, not to mention that I too suffer from depression and anger issues. I am also thankful for "NAMI" National Alliance Mental Illness the support groups have also made it possible for me to step out of depression with a can- do attitude.

Therefore, I am so thankful for those little blessings that turn out to be big blessings. I am so grateful for the CASRA Stipend Program and for great people to run this program run smoothly using their knowledge accordingly helping those in need.

I am an African American single mother who has thrived to achieve higher success within my education as well as the workforce while all together raising my 7 year old daughter and my 4 year old son...on a fixed, very low income. It had been difficult paying for the books required for my classes due to the fact that the price of the books and my income conflicted.

My income would not compensate for the book's prices, and the CASRA Stipend Program has blessed me with not only my books to pass my classes but with bus fare and college parking passes. I can truly say that I will be forever grateful for this program. Had this program not helped us in not one, not two, but In MANY, MANY ways, I may not be getting my college degree in the near future. Thank You!

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First let me say that the CASRA Stipend Program has been such a relief to us students. So many times students such as myself stress over books and simply attending classes. Stress is no joke. See stress affects your study habits plus your home life. As you can see, the CASRA Stipend Program helps us tremendously. Then you have the CASRA team. My, you, and the students can't lose. I would just like to share a personal experience that I had with the CASRA Stipend Program this fall session, I needed a book I was kind of stressing, but I was told to hang in there so I did. I received that book.

Thank You!

Innovation (INN)

"William": When William first volunteered, he was quiet and not very good at communicating with others. During his time at the Peer Recovery Art Gallery, he has learned to be more comfortable in social situations as well as to speak in front of others. This has helped him achieve goals such as being in several plays at Modesto High School and being cast in several plays at Gallo Center for the Arts. He was awarded a scholarship with the Mayor's Top Teen program.

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"Marty": "Before finding Peer Recovery Art Project, I felt that my art did not fit in anywhere and would not be good enough for anyone. I was referred to the gallery by a friend and reluctantly came down. When I met the staff, they were very welcoming and accepted my art. I was so happy to see it put in the first edition of the gallery flyer. It was amazing to know that my work was so valued. Since coming here and being in this positive environment, I've been able to improve my art skills and have also decided to improve my life. I am attending school and plan on getting my high school diploma soon!"

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"John": "My life has taken a 360 degree turn. I meet other artists, influential people, my art work has improved and my general outlook on life is better. I have come to a place when I know there is a lot more out there to learn. I went from being in a place that was depressing but I have grown from there since joining the gallery."

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"Tom": Tom was diagnosed with ADHD when he was three years old. His school career has been plagued with teachers labeling him because of this. In coming to the gallery, Lucas has been able to find

an outlet for his energy by learning to do set up, help hang art tags and greet those who come into the gallery. He has discovered that he is very social and intelligent and this has helped him and his ADHD work for him in the gallery environment.

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"Albert": Albert sees the gallery as a place where he can come and be himself without worrying about being judged. As a 5th grader who has unique interests such as cryptozoology, he is subject to bullying at school. He uses the gallery as a safe place to express himself because he can.

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"Irma" lives in the Airport Neighborhood and is a single mother of four sons. Participating in a community wellness project through the Tuolumne River Trust has allowed her to make more friends and feel less isolated and depressed. She says participating in the outdoor activities has empowered her to help improve her neighborhood, increased her feeling of self-worth, and made her feel better about her future.

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"Billy" signed up for Summer Fun Camp through the Tuolumne River Trust program because he suffers from anxiety and lack of socialization skills. The 9-year-old was afraid to go outside and play with others in the neighborhood. By the second week, he was participating more in camp activities and was able to come out of his shell. He became more self-confident and social. His mom says she is totally amazed to see his transformation.

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"Nate" has had sporadic access to a psychologist/psychiatrist for counseling. Over the past five years or so his only access to professional help has been through DBHC. He has been diagnosed as bipolar and then as having PTSD. Currently he lives at the Gospel Mission and then when he is on his '15 days out' he sleeps at his 'camp site.'

In what way has FIR been helpful? He described Beth and Joanna Friends in Recovery (FIR) activities as a "pleasant distraction" from hardships. His mentor has acted as a friend and an advocate. One thing he noted as being helpful is that he now has a cell phone. His mentor assisted him in signing up for Life-Line a low income phone service. He told me, "It's nice being able to call and the phone is answered by someone that wants to talk." He went on to note the good feeling of talking to his friend/mentor as opposed to making a business related call. Before having a mentor, all his phone calls were business related such as making appointments.

Nate went on to explain another way FIR has been helpful is that it gave him the opportunity to help others. During one of the Graceada Park picnics Nate participated in several of the planning and preparation activities. He expressed appreciation for the trust and responsibility given to him. He was given ten dollars and asked to help shop for picnic items.

Nate's recovery goals are to continue attending group therapy, taking a class at MJC, and pursuing housing. He currently attends NAMI Connection groups (peer support groups) and recently finished the NAMI Peer to Peer classes (10-week class on mindfulness and other topics). He explained that he has lots of depression and anger. He said that he is sometimes "too sensitive and internalizes" what people say. He recognizes that it interferes with his recovery goals. Nate explained that his mentor has been helping him to recognize symptoms and their affect.

“David” was diagnosed with post-acute withdrawal syndrome with the symptoms of mood swings, anxiety with panic attacks, depression, and general cognitive impairment. About three years ago Jim was evaluated at DBHC. After having several panic attacks he disparately wanted to understand what was happening to him. DBHC determined he was not suicidal so he could not receive treatment that night. They did refer him to a psychiatrist and his family paid for treatment. David was pleased with the referral because the psychiatrist was able to diagnose him and prescribe medication.

David has been participating in the Friends in Recovery program for 8 months. He has embraced his recovery efforts and meets with his mentor twice a week. In the year 2012 Jim attended AA meetings and was also in his second year of narcotics replacement therapy at the Aegis Clinic. Now he attends a dual diagnosis group instead of an AA meeting. David made this decision to change to a group that addresses mental health and substance abuse so he could learn more about mental health. His mentor facilitates this group.

As a result of mentoring, he has been able to take on empowering responsibilities as part of his recovery. He commented, "I want to do good. I hurt so many people in the past and I can only apologize for what I have done. This is why I want to do good by helping people." His mentor trained him and guided him through the process of becoming a volunteer Patient Advocate. He has been doing his advocacy work for two months now. In addition to advocacy work, David also assists in support group activities such as making coffee, arranging chairs, and passing out materials.

His recovery goals are to quit smoking, taper down on his methadone dosage, and take his mental health medications. David and his mentor are supporting each other’s effort to quit smoking. They both use smokeless electronic cigarettes and are feeling the benefits. David has decided to taper down his methadone after he quits smoking. He doesn't want to suffer the adverse effects of reducing/quitting both substances at the same time.

Technological Needs/Capital Facilities (TN/CF)

A technician working on the MHSA funded Consumer and Family member Access Project shared the following story:

“While being able to provide technological resources, computers, software, printers, internet, and trainings are one component of this project. Another is to assist program consumers and their families at public locations in the community while utilizing those resources. As a technician, my job is to ensure that consumers and family members are able to effectively use technological resources to move toward independence and self-sufficiency that would also support and maintain overall recovery.

As a technician, I’ve had the opportunity to work with individuals who were resistant, disinterested, or unfamiliar with using a computer and its many functions. With doing so, I have been successful in introducing technological resources and getting consumers to feel comfortable and sufficient with using them. A good example of this would be of the time I worked with a consumer from the High Risk Health/Senior Access Program. This particular consumer had never used the computer; nor had ever used the internet before. After working with me on a weekly basis for 3-4 months; she was able to independently use a computer and navigate the internet for e-mailing, facebooking, basic web browsing, and utilizing ancenstry.com. In addition, she eventually felt comfortable and ready to purchase her own computer for home use.

She ended up purchasing a laptop in which I was able to provide her training and assistance in utilizing. Besides assisting her with learning to use her new laptop, I was also able to assist her with finding a reliable and affordable internet service for home-use.

Currently, from time to time, I would run into her at the High Risk Health/Senior Access Program and she would always tell me how thankful she is for the training and the support I was able to provide her. And because of that training, she continues to use her laptop to connect with close family and friends through Facebook, e-mail, and other social media. She also uses the internet for occasional on-line shopping and ancestry.com to connect with family and build her family tress as a hobby or project."

For more information about BHRS/MHSA funded programs, please visit our website at http:///www.stanislausmhsa.com/