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StanUp for Wellness!

Support Mental & Emotional Health

Stanislaus County
Behavioral Health and Recovery Services

Mental Health Services Act
Annual Update FY 2018-2019

May 2018

Stanislaus County
Striving to be the Best
Behavioral Health and Recovery Services

Mental Health Services Act Proposition 63 California

WELLNESS • RECOVERY • RESILIENCE

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Stanislaus County Behavioral Health and Recovery Services (BHRS)

MHSA Planning Office

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Modesto, CA 95350

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COUNTY COMPLIANCE CERTIFICATION

County: Stanislaus

County Mental Health Director	Project Lead
Name: Richard DeGette, MFT Telephone Number: 209-525-6225 E-mail: Rdegette@stanbhrs.org	Name: Leng Power Telephone Number: 209-525-5324 E-mail: lpower@stanbhrs.org
Mailing Address: 800 Scenic Drive, Modesto, CA 95350	

I hereby certify that I am the official responsible for the administration of county mental health services in and for said county and that the county has complied with all pertinent regulations, laws and statutes for this annual update/plan update. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

This plan update has been developed with the participation of stakeholders, in accordance with Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft FY2018-19 plan update was circulated to representatives of stakeholder interests and any interested party for 30 days for public review and comment. All input has been considered with adjustments made, as appropriate.

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

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

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

All documents in the attached Annual Update FY 18-19 are true and correct.

Richard DeGette, MFT
Mental Health Director/Designee (PRINT)

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: Richard DeGette, MFT	Name: Lauren Klein, CPA
Telephone Number: 209-525-6225	Telephone Number: 209-525-5673
E-mail: Rdegette@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 counties in future years.

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

Richard DeGette, MFT _____
Local Mental Health Director (PRINT) Signature Date

I hereby certify that for the fiscal year ended June 30, 2017, 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 2017 for the fiscal year ended June 30, 2017. I further certify that for the fiscal year ended June 30, 2017, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County/City MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County/City has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

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

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

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

Message from the Director

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

– Shannon L. Alder, Author

Stanislaus County Behavioral Health and Recovery Services (BHRS) has been spreading this message of hope and healing for decades. With the passage of Proposition 63 in 2004, the Mental Health Services Act (MHSA), that message has reached more people and addresses more unmet need for behavioral health services than ever before. MHSA has transformed how behavioral health services are delivered in California and here in Stanislaus County.

This year's Annual Update reports on all MHSA services and activities from FY 2016-2017 and reflects our ongoing commitment, we hold with our community partners, to offer integrated services that are client and family-driven, recovery oriented and easily accessible to diverse underserved populations.

I personally, want to thank members of the MHSA Representative Stakeholder Committee, BHRS Behavioral Health Board, Stanislaus County Board of Supervisors for their participation in planning processes to development this Annual Update. I want to acknowledge the work and enthusiasm of BHRS employees who fulfill the promise of a transformed behavioral health system in their daily work.

Lastly, special recognition and thank to the many consumers and family members who shared their remarkable stories of hope, recovery, and resiliency for this report.

Sincerely,

Richard DeGette,

EXECUTIVE SUMMARY

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

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

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

FY 16-17 Highlights

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

- A total of 6,575 individuals were served through CSS programs.
- A total of 708 individuals were active partners in Full Service Partnership (FSP) programs. Of that number, 529 partners were active in FY 16-17 and in the program at least one year.
- There was a 28% decrease in homelessness after one year in a Full Service Partnership.

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 37 programs that promote wellness, foster health, and prevent the suffering that results from untreated mental illness. Here are some of their outcomes:

- A total of 1,846 individuals (unduplicated) received brief counseling intervention services
- A total of 3,286 individuals (unduplicated) engaged in prevention services
- A total of 1,115 potential responders (includes families, employers, school personnel/teachers, leaders of faith based organizations) were trained to recognize and respond effectively to early signs of mental illness
- 26,000 PEI services were provided (includes screenings, support, peer and volunteer development, brief counseling groups, and other engagement)

Workforce Education and Training (WE&T) is designed to improve and build the capacity of the local, diverse mental health workforce to deliver culturally competent, client and family member directed services. BHRS has 6 programs that improve and build workforce capacity. Here are some of their outcomes:

- A total of 182 trainings were held in Stanislaus County with 3,432 BHRS, contractor staff, and community members in attendance.
- A total of 21 CASRA Based Stipend Program participants completed the academic requirements and volunteer/internship hours need to receive their Skills Recognition Certificate for the Modesto Junior College (MJC) 9-unit Psychosocial Rehabilitation Program.
- A total of 119 individuals participated in the Consumer and Family Member Volunteerism program and contributed 21,983 volunteer hours with a total dollar value to BHRS (@ $23.07 an hour) of $507,164.

Capital Facilities/Technological Needs (CF/TN) provides funding for building projects and increases technological capacity to improve mental illness service delivery. BHRS has four (4) projects to modernize information systems and increase consumer/family empowerment by providing tools for secure access to health and wellness information. Here are some of their outcomes:

- Piloted the Integrated Mental Health Documentation and Electronic Health Record Navigation Training which were previously separate. This change resulted in increasing the capacity to provide the appropriate level and length of training for individuals.
- There was an increase in electronic documents scanned and attached to client health charts. Mental Health Plan referrals made up 27% of the increase. The impact is significant because it allows for more complete access to chart information including assessment outcomes.

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. In FY16-17, BHRS had two (2) ongoing learning projects; two (2) projects completed in June 2017. INN focuses on learning and developing new and effective practices or approaches to mental health service delivery.

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

- INN-16 – Full Service Partnership (FSP) Co-Occurring Disorders
- INN-17 – Suicide Prevention Innovation Project

FY 18-19 Proposed New or Expanded Programs

Community Services and Supports (CSS) and CSS Housing:

- New - Assisted Outpatient Treatment Full Services Partnership
- New – Palm Valley Supportive Housing Project

Technological Needs (TN):

- Expanded funding for Access to Computing Resources for Consumers and Family Members Projects

Innovation (INN):

- New - Conduct community planning process in FY18-19 with intention to develop new Innovation projects that begin in FY19-20.

BHRS is dedicated to continuous process improvement efforts, with our partners, to identify opportunities to address unmet mental health need in our community. This Annual Update contains many details related to that existing effort and we invite stakeholder input on all aspects of the report.

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 has five (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)

Behavioral Health and Recovery Services (BHRS) is working continuously to expand and improve behavioral health services using a "help first" approach that enables community members to access services and supports before they are in crisis. MHSA funds are an investment in services, supports, prevention, and system infrastructure to support a full and robust continuum of behavioral health care in Stanislaus County.

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). The Annual Update summarizes Stanislaus County's progress in implementing all services and activities, including highlights and challenges from July 1, 2016 through June 30, 2017. In addition, the report provides an overview of all MHSA-funded programs, component funding and proposals for new or expanded programs, when they are developed, for each of the components.

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

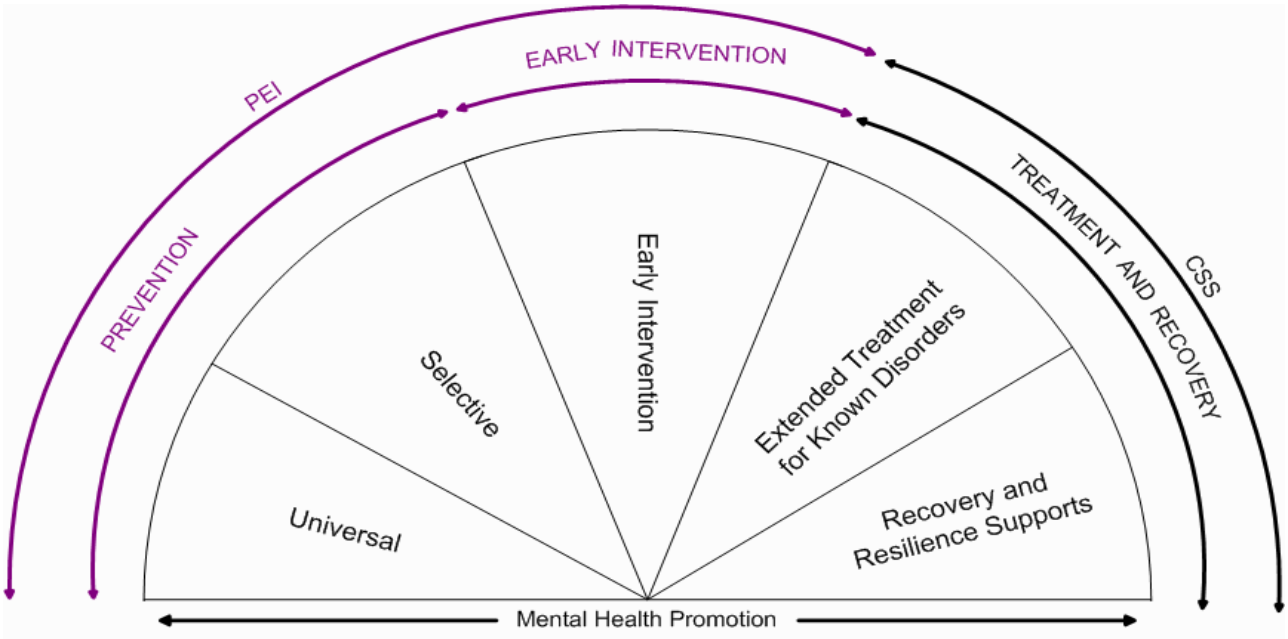
The Annual Update development process must also include a 30 day public review/comment period and a public hearing conducted by the Stanislaus County Behavioral Health Board (W&I code 5848).

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

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.



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

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 (CSS & PEI) 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 Controller's 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 the following FY 2018-2019 budget plans.

FY 2018-19 Annual Update Mental Health Services Act Expenditure Plan

Funding Summary

County: Stanislaus Date: 5/16/18

	MHSA Funding							
	A	B	C	D	E		F	G
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Housing (Returned from CalHFA)	Prudent Reserve	Total
Estimated FY2018/19 Funding								
1. Estimated Unspent Funds from Prior Fiscal Years	18,069,610	5,609,455	2,868,663	404,068	1,256,201	859,862	500,000	29,567,859
2. Estimated New FY2018/19 Funding	17,642,665	4,410,666	1,160,702					23,214,033
3. Transfer in FY2018/19[a/]	(300,000)			300,000				0
4. Access Local Prudent Reserve in FY2018/19							0	0
5. Estimated Available Funding for FY2018/19	35,412,275	10,020,121	4,029,365	704,068	1,256,201	859,862		52,281,892
Estimated FY2018/19 Expenditures	21,844,944	6,009,443	2,957,694	638,688	959,037	859,862		33,269,668
Estimated FY 2018/19 Unspent Fund Balance	13,567,331	4,010,678	1,071,671	65,380	297,164	0	500,000	19,512,224

FY 2018-19 Annual Update Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: Stanislaus Date: 5/16/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. FSP-01 Westside Stanislaus Homeless Outreach	5,357,201	3,572,201	1,785,000			
2. FSP-02 Juvenile Justice	864,371	684,371	180,000			
3. FSP-05 Integrated Forensic Team	2,434,768	2,007,768	427,000			
4. FSP-06 High Risk Health & Senior Access	2,187,637	1,625,637	552,000			10,000
5. FSP-07 Turning Point-ISA	751,274	751,274				
6. FSP-08 FSP for Children/Youth with SED	883,371	574,191	309,180			
7. Assisted Outpatient Treatment	427,540	315,347	112,193			
8.	0					
Non-FSP Programs						
1. O&E-02 Housing Program - Garden Gate Respite	3,324,972	2,938,471		45,847		340,654
2. O&E-02 Employment - Garden Gate Respite	710,104	559,463		65,218		85,423
3. O&E-03 Outreach and Engagement	140,000	140,000				
4. GSD-01 Transition Age Young Adult Drop in Cente	1,484,703	963,703	521,000			
5. GSD-02 CERT/Warmline	962,853	962,853				
6. GSD-04 Families Together	558,593	558,593				
7. GSD-05 Consumer Empowerment Center	509,365	509,365				
8. GSD-06 Crisis Stabilization Unit	1,764,604	1,088,450	584,871			91,283
9. GSD-07 Crisis Intervention Program for Children a	866,159	558,684	73,135			234,340
10. GSD Portion of Westside Stanislaus Homeless Ou	1,190,734	1,190,734				
11. GSD Portion of Integrated Forensic Team	278,000	278,000				
12. GSD Portion of High Risk Health & Senior Access	211,000	211,000				
13. Crisis Residential Unit - 4 Beds	550,786	275,393	275,393			
14. Youth Peer Navigators	44,660	44,660				
15.	0					
16.	0					
CSS Administration	2,701,986	2,034,786	500,000			167,200
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	28,204,681	21,844,944	5,319,772	111,065	0	928,900
FSP Programs as Percent of Total	57.1%					

FY 2018-19 Annual Update Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: Stanislaus Date: 5/29/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Prevention	1,694,440	1,694,440				
2. Outreach for Increasing Recognition	164,631	164,631				
3. of Early Signs of Mental Illness	0					
4. Stigma Discrimination Reduction	78,540	78,540				
5. Suicide Prevention	215,403	215,403				
6. Outcomes and Evaluation	132,357	132,357				
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Early Intervention	2,974,627	2,894,627	80,000			
12. Access and Linkage	150,000	150,000				
13. Statewide Initiative	4500	4500				
PEI Administration	676,245	634,445				41,800
PEI Assigned Funds	0					
Total PEI Program Estimated Expenditures	6,131,243	6,009,443	80,000	0	0	41,800

FY 2018-19 Annual Update Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: Stanislaus Date: 4/5/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Innovations Planning	198,593	198,593				
2. INN-16 - Co-Occurring Disorders Project	1,210,115	890,115	320,000			
3. INN-17 - Suicide Prevention	216,228	216,228				
4. RFPs	1,500,000	1,500,000				
5.	0					
INN Administration	163,758	152,758				11,000
Total INN Program Estimated Expenditures	3,288,694	2,957,694	320,000	0	0	11,000

FY 2018-19 Annual Update Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: Stanislaus Date: 4/5/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Workforce, Education and Training	558,688	558,688				
2.	0					
3.	0					
4.	0					
5.	0					
WET Administration	80,000	80,000				
Total WET Program Estimated Expenditures	638,688	638,688	0	0	0	0

FY 2018-19 Annual Update Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: Stanislaus Date: 4/5/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1.	0					
2.	0					
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
CFTN Programs - Technological Needs Projects						
11. SU-01 Electronic Health Record	575,907	575,907				
12. SU-02 Consumer Family Access	218,811	218,811				
13. SU-03 EH Data Warehouse	116,674	116,674				
14. SU-04 Document Imaging	47,645	47,645				
15.	0					
16.	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	959,037	959,037	0	0	0	0

Housing Component Worksheet (Returned from CalHFA)

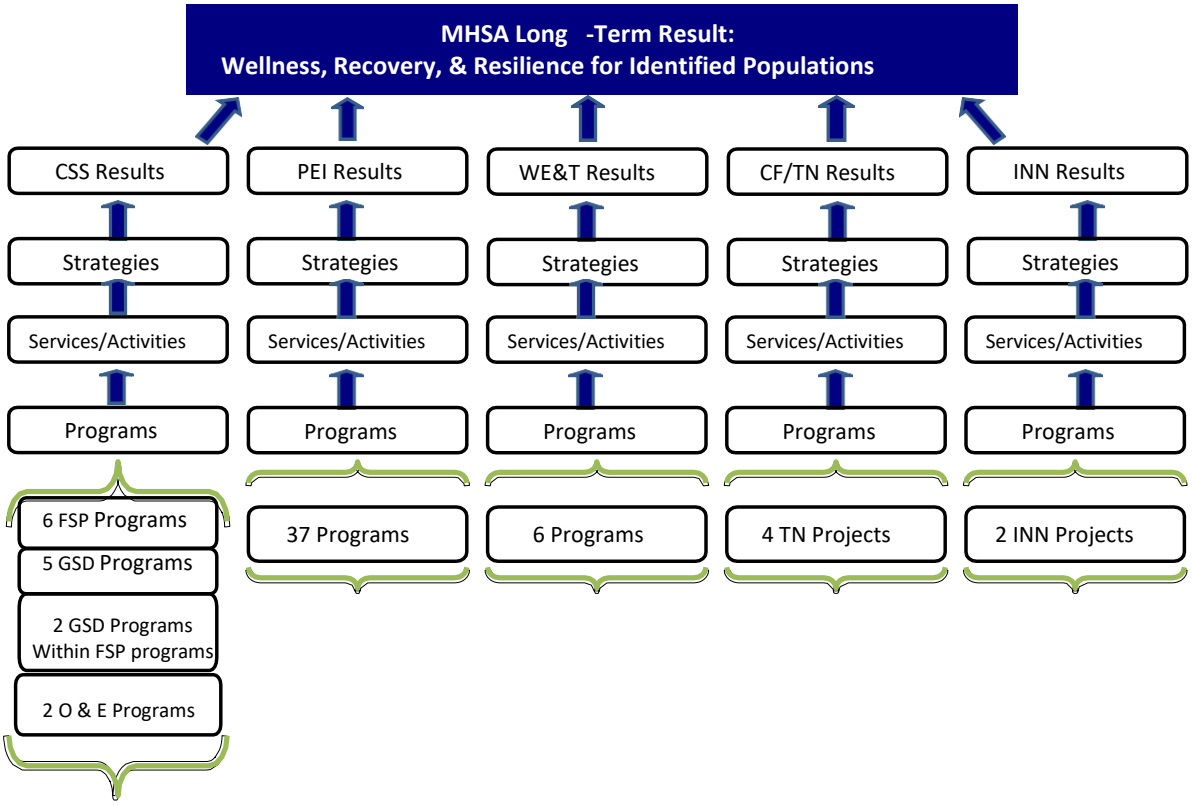
County: Stanislaus Date: 4/5/18

	Fiscal Year 2018/19					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated Housing Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Housing Programs						
1. Housing Project	859,862	859,862				
2.	0					
3.	0					
4.	0					
5.	0					
Housing Administration	0					
Total Housing Program Estimated Expenditures	859,862	859,862	0	0	0	0

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

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

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



COMMUNITY STAKEHOLDER PLANNING ACTIVITIES AND LOCAL REVIEW

Stanislaus County Behavioral Health and Recovery Services (BHRS) conducted community program planning and local review processes for this Annual Update for Mental Health Services Act (MHSA) programs and expenditures in accordance with Title 9 of the California Code of Regulations, sections 3300 and 3315, and WIC 5848. BHRS is dedicated to continuous efforts to engage diverse stakeholder input with the overarching goal of creating transparency, facilitating an understanding of outcomes progress and accomplishments, and promoting a dialogue about present and future opportunities.

The Representative Stakeholder Steering Committee (RSSC) is a vital part of the local MHSA planning process. This committee's role is to provide key input on all proposed plan updates and annual updates as well as share information about MHSA activities with members of their represented sector or group.
The RSSC is made up of dedicated community members and agency partners from diverse backgrounds that care about mental health and wellness in Stanislaus County. RSSC stakeholder groups represented:

- Adults and seniors with serious mental illness
- Families of children, adults, and seniors with serious mental illness
- Providers of behavioral health services
- Law enforcement agencies
- Social services agencies
- Veterans community
- Providers of alcohol and drug services
- County behavioral health staff
- Health Care organizations – private and public
- Representatives of diverse unserved and/or underserved populations and family members of unserved/underserved populations

BHRS and its partner agencies in MHSA implementation are continuously seeking input from individuals with diverse cultural experience and lived experience perspectives. Meetings are open and members of the community are invited to attend stakeholder meetings.

In FY2017-18 the RSSC was convened one time and received an update letter from the Behavioral Health Director.

MHSA Planning Manager staffing changes resulted in delays to developing the Annual Update and related community planning meetings in calendar year 2017. An interim manager was contracted, in November 2017, to begin work on the Annual Update, Innovation planning and other requirements for the 2018 stakeholder meetings. In February 2018 a permanent, full-time MHSA Planning Manager was hired and preparation for the Annual Update accelerated.

March 23, 2018 - The RSSC was convened with 14 members, 12 alternates in attendance and 30 other participants (e.g. Stanislaus County Chief Executive, BHRS staff, RSSC alternates, and community observers.) BHRS Leadership viewed this as the opportunity to re-engage stakeholders, revitalize the committee's role and describe the considerable amount of work to be done in FY2018-19. The three hour meeting included a detailed description of the agenda items with background information and sharing of diverse points of view with facilitated discussion of key aspects. This opportunity provided clarification on past planning processes and outcomes related to Innovation project ideas. The discussion achieved consensus and allowed the committee to move forward in the planning process.

Topics covered on March 23, 2018

- BHRS staffing introductions and changes.
- Local impact of AB114 which clarifies and defines the MHSA reversion process for funds that have been unspent for over three years by counties. In this agenda item, BHRS clarified the purpose and content of an upcoming document posting for 30 day public review and comment from 4/2/18 – 5/3/18 and next steps. In brief, the purpose of the document is to comply with AB114 changes and subsequent DHCS Information Notice 17-059. BHRS had 1.6 million of Innovation funds subject to reversion due to AB114 and the change in the calculation. Prior to AB114, BHRS was completely in compliance with existing regulation and had no funds subject to reversion. Next steps: Board of Supervisor approval and submission to DHCS.
- Proposed and recommended new programs and funding changes (see details below),
- Next steps with proposed timeline for Innovation funds planning (see details below).

Proposed and recommended new programs and funding changes:

Transfer CSS funds to Technology Needs (TN) Project

- This is an allowable funding contribution for an already approved TN project.
- TN Project to be funded: Access to Computing Resources for Consumers and Family Members.
- Project strategy to be funded: ongoing funding for two (2) MHSA Technicians
- Population to be served: adults, transition aged youth and older adults with serious mental illness and family members of youth with serious emotional disturbance.
- Activities: placement of computers, technical support and training in easily accessible areas of service locations and behavioral health drop-in centers
- Intended Outcomes: provide an opportunity for consumers and family members to be providers of training and technical support. Provide access to on-line resources and technical support intended to enhance a service recipient's ability to be a knowledgeable partner in making treatment decisions and in maintaining personal recovery and resiliency goals.
- Estimated Funding Amount: $49,000 per year

Background supporting transfer of funds

Capital Facilities/Technological Needs (CF/TN) Component Proposal was developed, and submitted for approved in July 2009. (To view the CFTN Component Proposal as submitted, go to www.stanislausmhsa.com.) Following approval of the Component Proposal, BHRS developed, with input from stakeholders, two (2) Technological Needs (TN) Project Proposals: Electronic Health Record and Consumer Family Access to Computing Resources. Initial CF/TN component funding was limited and may be funded continuously with CSS funds. Per statute, 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 (W&I 5892(b)).

CSS funds proposed to be utilized for a new Assisted Outpatient Treatment (AOT) Pilot Full Service Partnership (FSP) Program

- Population to be served: adults, older adults and transition aged young adults (TAYA) with SMI and Co-Occurring SMI/SUD who have not voluntarily engaged in treatment services and who are at significant risk due to mental illness,
- Activities: Full Service Partnership using evidenced-based Assertive Community Treatment (ACT) Approach including, but not limited to, the following features: 24 hour, 7 day per week access and support for individual enrolled in the FSP, low client to staff caseload ratio, access to supportive services funds to assist with housing and other basic

needs, a multi-disciplinary team approach, services delivered in the places and situations where they are needed; integrated services for clients that includes active facilitation connecting to outside resources, including case management, crisis response, family support, housing and employment assistance, mental health rehabilitation, medication support, and peer support. An Assisted Outpatient Treatment (AOT) referral process may be initiated based on the unique needs and risk assessment of the each individual. When individuals are not voluntarily engaging in services, a determination will be made to initiate the AOT court referral process.

- Expected Outcomes: Three (3) year pilot FSP to assess effectiveness in achieving the following: increase voluntary participation and engagement in behavioral health services with ACT approach, decrease homelessness, incarceration, psychiatric hospitalization, emergency room visits. Reduce need, when possible, for more extensive and expensive services.
- Staffing: The AOT treatment team will be comprised of three individuals with unique roles. These positions are based on existing BHRS job classifications; Behavioral Health Clinician (1 FTE), Behavioral Health Advocate (1 FTE), Behavioral Health Specialist (1 FTE) and Behavioral Health Program Coordinator (.3 FTE) Three new positions and leveraging of one existing position will comprise the team.
- Performance Measures: BHRS has a well-developed system for collecting data used in performance measures analysis including: BHRS' Electronic Health Record and the Mental Health Services Act Data Collecting and Reporting (DCR) systems. Use of the existing data collection systems are most cost effective and will address the necessary AOT performance outcomes.
- Estimated MHSA Funding*: up to $1,053,415 over 3 years:

FY18-19	FY19-20	FY20-21	Total 3 year pilot
$336,580	$350.231	$366,604	$1,053,415

*Additional revenue will be generated through Medi-Cal Federal Financial Participation (FFP)

Background supporting use of funds

Assembly Bill (AB 1421) introduced and enacted Laura's Law, also referred to as Assisted Outpatient Treatment (AOT), as a means to provide court-ordered, intensive outpatient treatment for people with serious and persistent mental illnesses (SPMI) who refuse treatment and medication because mental illness impairs their ability to make decisions to seek help. AB 1421 set forth regulations related to AOT implementation including the provision that implementation is optional, thus allowing California counties the choice of whether or not to implement using local funding. AB 1421 did not make available any new or additional funding for counties to implement AOT. The use of MHSA funds for AOT is allowable.

In recent years, the Stanislaus County Board of Supervisors has received a significant amount of public comments and input regarding the implementation of AOT locally. The Board and BHRS staff have received and reviewed numerous materials on the subject, including petitions, documents, books, letters, and email communications from local advocacy groups and other interested parties. Consideration of local implementation had generated public interest and participation to the extent that a wider education and fact-finding process was deemed necessary by the Board of Supervisors in spring of 2017.

A report on the education and fact finding community process was given on August 15, 2017 to the Board of Supervisors. The Board authorized the BHRS Behavioral Health Director to develop a plan, in collaboration with a community work group, for a three-year AOT pilot program in Stanislaus County. The plan would include performance measure criteria to appropriately gauge the success of the program at the end of the pilot period; cost estimates based on anticipated staffing levels and operating expenses for the entire pilot period, by fiscal year; an outline of related court procedures required to implement the program; and definitions of relevant California Welfare and Institutions Codes (W&I 5892). Once developed, the proposed plan would then be presented for approval to the Stanislaus County Board of Supervisors by the BHRS Behavioral Health Director.

The work group was comprised of stakeholders from the community who have been directly impacted by mental illness (e.g. family members and consumers) and/or will have a role in implementation of AOT (e.g. Courts). Diverse perspectives on the issue were critical to a successful outcome and included representatives from the following organizations; National Alliance for Mental Illness (NAMI), Stanislaus County Courts, Stanislaus County Probation Department, Stanislaus County Public Defender, Stanislaus County Sheriff's Office, Stanislaus County Adult Protective Services, consumers of mental health services, and BHRS providers. The work group was directed by co-facilitators Debra Buckles, Public Guardian and Forensic System of Care Chief at BHRS, and Karen Hurley, MFT, Mental Health Service Act Planning Coordinator (retired). With the intent of having community work group members contribute meaningfully to a pilot project proposal, full participation was encouraged.

A majority of the workgroup members were also MHSA RSSC Committee members. The work group was convened on November 3, 2017 and completed its work on March 2, 2018. Subsequently on March 23, 2018 the community work group's proposed AOT pilot program was endorsed by the MHSA RSSC Committee with an understanding that BOS approval and other steps were necessary prior to implementation.

The new program would be included in the MHSA Annual Update FY18-19 and next steps prior to implementation include thirty (30) day public review and comment; a public hearing conducted by the BHRS Behavioral Health Board; approval by the Board of Supervisors and submission to Department of Health Care Services (DHCS) and Mental Health Services Oversight and Accountability Commission (MHSOAC) within 30 days of BOS approval.

Stanislaus County has had eight (8) FSP programs over the years, six (6) are currently operating. The Assisted Outpatient Treatment Pilot Full Service Partnership (AOT-FSP) Program, if approved by the Board of Supervisors, is proposed to be FSP-09.

Community Services and Supports Housing (CSS-Housing) – new project

Palm Valley Permanent Supportive Housing Complex located at 201 E. Coolidge Avenue, Modesto

- Population: Adults/Older Adults/TAY with severe mental illness (SMI)
- Strategy: Use housing funds in partnership with City of Modesto and Stanislaus County Housing Authority to refurbish Palm Valley complex and increase housing units for target population.
- Partnerships: Execute necessary loan agreements with project partners including signing related promissory note.
- Activities: Provide 10 additional 1 and 2 bedroom units of supportive housing for individuals with SMI within a larger complex that has a wide variety of tenants
- Intended Outcomes: Reduce homelessness for persons with SMI; Improve the well-being of individuals with SMI
- Estimated Funding Amount: $550,000 one-time plus up to 25% rental subsidies.

Background

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

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

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

BHRS has three years to spend the Housing funds. Kestrel Ridge Project was approved for funding in FY17-18. Palm Valley is the second project proposed to be considered since the local Master Plan was developed.

Innovation project planning

On March 23, BHRS proposed to begin project planning in FY18-19 and include all INN funds available, through FY20-21, for community-based projects. This will be a significant effort to develop new projects in Stanislaus County.

Contributing elements to the next innovation projects will include, but not be limited to: 1) estimated funds available; 2) emergence of new opportunities to advance learning identified through community input; 3) BHRS capacity to conduct a timely planning and RFP process; and 4) MHSOAC capacity to complete timely approvals on new proposals.

BHRS <u>estimates</u> the following funds will be available for new projects and BHRS administrative/planning costs

FY17-18	FY18-19	FY19-20	FY20-21
$800,000	$1,241,333	$1,268,675	$1,268,675
To be spent or obligated by June 30, 2020	To be spent or obligated by June 30, 2021	To be spent or obligated by June 30, 2022	To be spent or obligated by June 30, 2023

BHRS proposed the following tentative timeline for INN planning processes, which includes the issuance of a Request of Proposal for the provision of community based innovation projects*:

March 2018	July 2018	August - September	October-January 2019	January – June	July-August
RSSC endorsement for proposal	Stakeholder input to INN project opportunities	Pre-RFP release Potential Contractor Outreach Workshops	RFP posted, projects reviewed and selected for award	New projects to 30 day public review>BOS approval> OAC approval	Project(s) begin
* This chart represents, in brief, a complex process with many steps and may be subject to change.					

This approach to Innovation project planning gives the widest opportunity for community and agency partners to participate and propose strategies that advance learning and practice to resolve some of our communities most difficult issues and unmet needs.

By statute and prior to implementation, proposed new programs, funding changes and RFP processes proposed in this Annual Update must be approved by the Stanislaus County Board of Supervisors following a 30 day public review and comment process and public hearing by the Behavioral Health Board.

LOCAL REVIEW PROCESS

This Annual Update will be posted for 30-day public review and comment May 30, 2018 – June 28, 2018. Notification of the public review dates and access to copies of the Annual Update has been made available through the following methods:

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

An additional opportunity to understand and comment is offered through an informal information meeting as follows:

- June 20, 2018, 1-2:30 p.m. in the Redwood Room at 800 Scenic Drive, Modesto, CA (contact Juanita Solis to RSVP jsolis@stanbhrs.org)

Comments are solicited through a comment form attached to the back of this document and may be faxed to (209) 558-4326 or U.S. mail to Leng Power, MHSA Planning Manager 800 Scenic Drive, Modesto, CA 95354. Contact may be made through the website www.stanislausmhsa.com and e-mail (lpower@stanbhrs.org)

The public comment period will conclude with a public hearing conducted by the Stanislaus County Behavioral Health Board meeting on June 28, 2018 at 5pm at 800 Scenic Drive. All community stakeholders are invited to participate.

All public comments are considered and substantial comments included in the final and submitted version of the Annual Update.

****Substantive Comments and Response**

***To be completed following 30 day review and comment period.*

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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 funds direct services to individuals with severe mental illness and children with serious emotional problems. The culturally competent services are focused on wellness, recovery, and resiliency while integrating the service experience for clients and families. Long term supported housing is also part of CSS funding. Stanislaus County has twelve CSS programs including six (6) FSP programs, five (5) GSD programs, and two (2) O&E programs.

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

FY 16-17 Programs

- FSP-01 - Stanislaus Homeless Outreach Program (SHOP)
- FSP-02 - Juvenile Justice (JJ)
- FSP-05 - Integrated Forensic Team (IFT)
- FSP-06 - High Risk Health & Senior Access (HRHSA)
- FSP-07 - Turning Point Integrated Services Agency (ISA)
- FSP-08 – Central Star Youth with SED

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 16-17 Programs

- GSD-01 - Josie's Place Transitional Age Young Adult Drop-in Center
- GSD-02 - Community Emergency Response Team/Warm Line
- GSD-04 - Families Together at the Family Partnership Center
- GSD-05 - Consumer Empowerment Center
- GSD-06 - Crisis Stabilization Unit (CSU)/Operational Costs

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

FY 16-17 Programs

- O&E-02 – Supportive Housing Services (Includes Garden Gate Respite, Intensive Transitional Housing, Vine Street Emergency Housing, and Supportive Housing Services/Transitional Board and Care)
- O&E-03 – Outreach and Engagement/Underserved Rural Communities

In addition, all CSS programs are committed to providing services that embrace the MHSA general standards:

- Community Collaboration
- Cultural Competence
- Client Driven
- Family Driven
- Wellness, Recovery, and Resilience Focused
- Integrated Service Experiences for clients and their families

CSS Budget

FY 2016-17

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$20,064,065	***$15,785,150***	***6,575***	***$2,401***

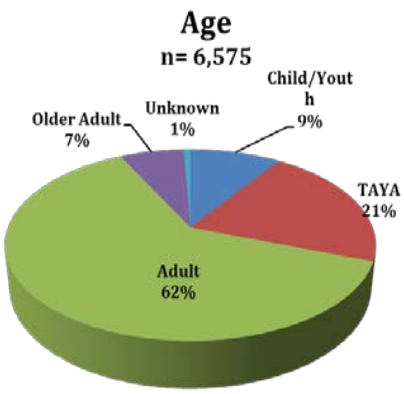
FY 17-18 Budget	*FY 17-18 Projected*	*FY 18-19 Projected*
$21,082,988	***$18,557,599***	***$21,844,944***

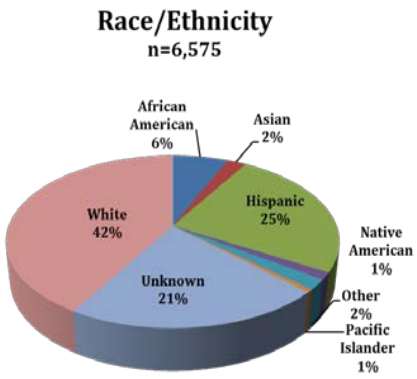
CSS Demographics

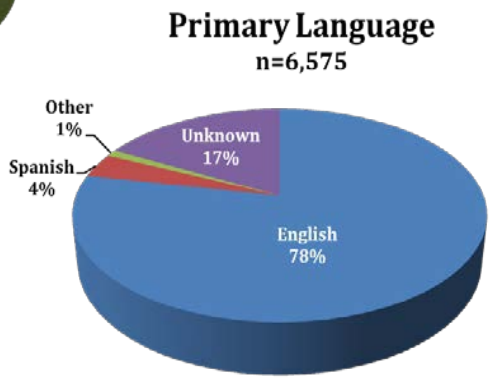
MHSA data collection and reports focus on how many individuals were served and whether programs were meeting service targets. Data collected provides an indication of how programs are doing in reaching unserved/underserved and diverse populations.

Note: The data collected across all CSS programs is reported in this section with client duplications as some clients may receive services in multiple programs. Within each CSS program and across individual program levels of care, the data reported is unduplicated.

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







CSS-FSP Highlights

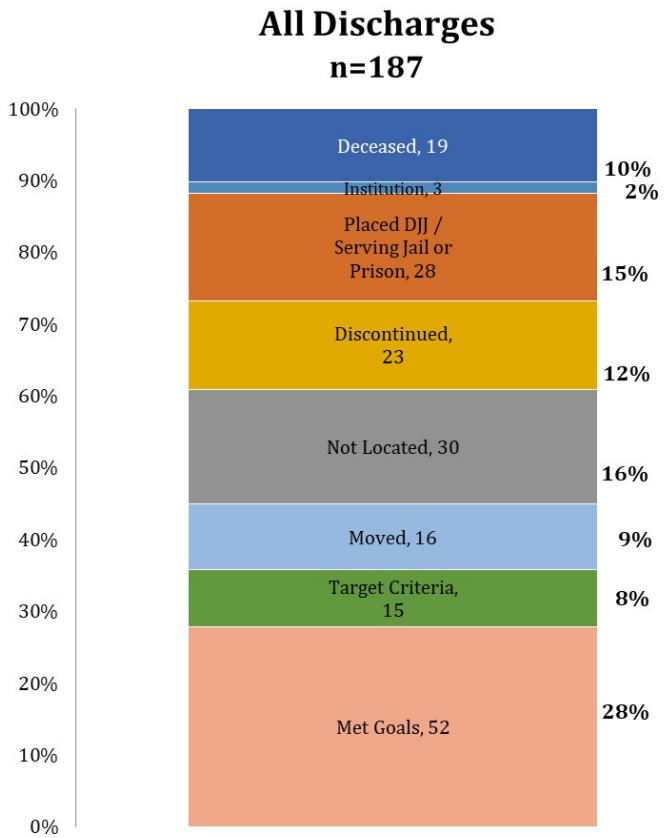
All FSPs
7/1/2016 – 6/30/2017

- 529 active FSP partners in FY16-17
- All outcomes in the following table based on the 529 partners who were active in FY16-17 and in the program at least one year.

Outcomes for Partners After One Year in an FSP
n=529

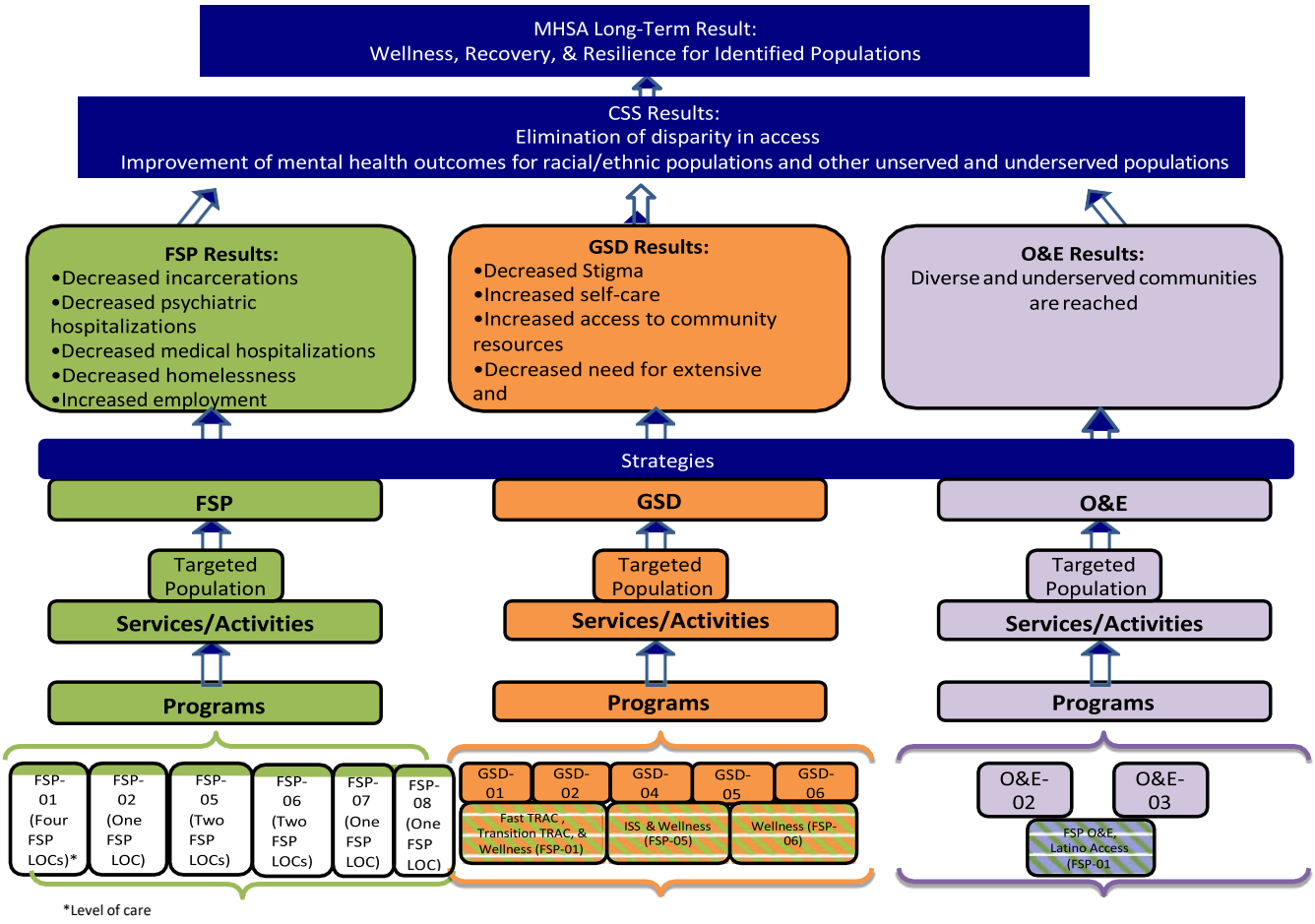
	Partners	*Days*
Homelessness	↓ 27.6% (from 98 to 71)	↓ 69.7% (from 15,430 to 4,668)
Incarceration	↓ 28.7% (from 129 to 92)	↓ 55.3% (from 8,928 to 3,995)
Acute Medical Hospitalizations	↓ 1.6% (from 63 to 62)	↓ 10.1% (from 1,342 to 1,207)
Acute Psych Hospitalizations	↓ 23.1% (from 286 to 220)	↑ 28.1% (from 8,158 to 10,447)
State Psychiatric	↓ 70% (from 30 to 9)	↓ 81.5% (from 6,605 to 1,225)

This table represents the total number of discharges from an FSP and provides a breakdown of reasons for discharge.



Theory of Change

The Community Services and Support (CSS) component plays an important role in reaching the desired MHSA long-term results of wellness, recovery, and resilience for identified populations. Below is the CSS component for FY16-17 displayed in the Theory of Change Framework.



Stanislaus Homeless Outreach Program (FSP- 01)
Operated by Telecare Corporation in the BHRS Adult/Older Adult System of Care

Program Description

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

Target Population

Transitional Aged Young Adults (TAYA) 16-25, Adults 26-59, and Older Adults 60+ with a serious mental Illness or co-occurring substance abuse.

Services and Activities

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

Under the name "FSP-01 SHOP" there are five (5) FSP teams serving different populations

- Westside SHOP,
- Partnership Telecare Recovery Access Center (Partnership TRAC),
- Josie's Telecare Recovery Access Center (Josie's TRAC),
- Modesto Recovery Services TRAC (MRS TRAC) - FSP Access and Supports
- Turlock Recovery Services TRAC (TRS TRAC) – FSP Access and Supports

All FSP teams utilize ACT strategies including, but not limited to, integrated intensive community-based services and supports with 24/7 availability with a known service provider, a "housing first" approach alongside a wellness and recovery focus with client/family centered services that inspires hope.

SHOP offers 3 levels of care within the Full Service Partnerships

- Full Service Partnership (FSP) – ACT Model
- Intensive Support Services – Less frequent contact and more peer support
- Wellness/Recovery – Primarily peer support with service contact as needed

This level of care approach within an FSP allows an individual to enter the program at the level they need and then move to a lesser or greater level of care as their needs change.

SHOP also includes services funded by General System Development (GSD) dollars that expand capacity to support individuals to receive group and peer support in achieving and maintaining recovery and wellness goals.

GSD Funded levels

- Intensive Support Services (ISS) TRAC/Fast TRAC
- Wellness/Recovery
- Transition TRAC

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

Transition TRAC is an effort to assist individuals who are being discharged from the acute psychiatric inpatient hospital in Stanislaus County. The Transition TRAC team also contacts individuals who are not receiving behavioral health services prior to hospitalization and attempts to engage them following hospitalization. The goal is to prevent re-admissions to inpatient psychiatric services.

The estimated number of individuals to be served in FY17-18 is 615; 456 in the Full Service Partnership and 159 in Intensive Support Services and Wellness/Recovery.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2016-17

Total Budget	*Actual*	*Total Number Served*	*Estimated Cost Per Participant*
$ 4,278,545	***$3,864,886***	***2,839***	***$1,361***

FY 17-18 Total Budget	*FY 17-18 Total Projected*	*FY 18-19 Total Projected*
$4,188,836	***$4,499,692***	***$4,762,935***

Highlights

- Proficient in English and Spanish, Latino Access teams connected with Latino communities to talk about mental health issues and reduce the stigma of receiving mental health services.
- Successful community agency partnerships include the following: Center for Human Services, BHRS, Sutter Health, Golden Valley Health Centers, Catholic Charities, Riverbank Community Collaborative and the Modesto and Turlock Police departments.
- Telecare was granted a three-year accreditation from the Commission on Accreditation of Rehabilitation Facilities (CARF) renewal in September 2017.
- Each team participates in monthly internal chart audits ensuring that every chart will be reviewed within a year. These audits are triggered by treatment episode opening dates and review dates of treatment plan.
- The Telecare Member's Handbook, available in Spanish and English language, was revamped to include client's artwork.
- Program brochures were updated and improved.
- A new system was implemented to bring new staff onboard quicker and with more timely trainings in an effort to better serve our clients.
- Increased community involvement was achieved through participation in the Out of the Darkness Walk; a suicide prevention event and an information booth at the Amgen bicycle race event.

(The following SHOP activities/highlights were supported with General System Development funds)

- Transition TRAC Team engaged and provided referral information to all individuals (on the psychiatric units) who were evaluated by Community Emergency Response Team (CERT) and determined to meet criteria for involuntary inpatient care and who were not already connected to treatment service providers.
- Transition TRAC Team responded to individuals for crisis contact evaluations to determine whether they could benefit from other alternatives to another psychiatric admit.

- Transition TRAC Team provided clients with short-term case management service which included accompanying individuals as they accessed community resources.
- Telecare partnered with BHRS to create a Performance Improvement Project (PIP) that resulted in a pre-post tool used to increase engagement, follow-up and linkage to community resources.
- Groups throughout the year including but are not limited to:
  - SUD Co-Occurring Education
  - Depression (Spanish)
  - Women's Group
  - Stress Reduction
  - Men's Group
  - Life Skills
  - Peer Support
  - Triggers and Cravings
  - Parenting Skills
  - Art Therapy
  - Spirituality

Challenges for FSP and GSD Levels of Care

- There is a scarcity of mental health services/resources for uninsured and uninsured undocumented individuals, specifically for the Spanish speaking population.
- There are limited free resources available for Spanish speakers with mild to moderate mental health needs including individual counseling and support groups.
- Lack of available child care and transportation are barriers identified by individuals who are engaged in treatment.
- A challenge exists for the homeless population in having a safe place to store their belongings or pets when entering residential treatment.
- There exists a shortage in housing and emergency shelters for all homeless individuals and more significantly for homeless individuals needing a link to mental health treatment.
- Hiring and retention of staff is a challenge due a small pool of potential individuals who are qualified and there is competition for those individuals among agencies.
- An increased number of individuals on temporary and permanent conservatorship were served by Telecare in FY16-17. A central challenge with individuals on conservatorship is that placement opportunities (treatment and/or housing) are limited due to the high demand throughout Stanislaus County and neighboring counties. As a result, individuals on conservatorship may be housed in residential facilities outside the county (e.g. Bakersfield, Sacramento, and Novato) which necessitates long distance travel for family members and treatment staff.
- Successful engagement into treatment of individuals with co-occurring SMI and SUD is very challenging. These issues can, and regularly do, significantly hamper an individual's efforts to seek recovery, be motivated to obtain and maintain in treatment.

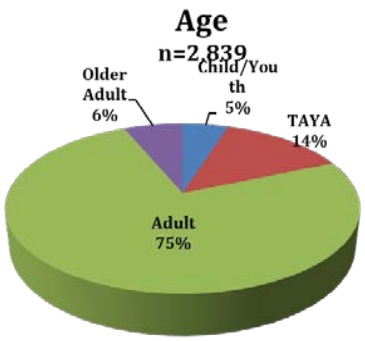
Outcomes for Partners After One Year in FSP 01
n=192

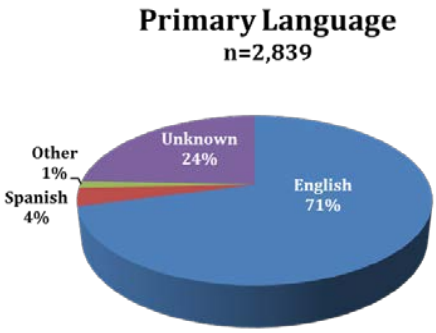
	Partners	*Days*
Homelessness	↓ 26.9% (from 52 to 38)	↓ 76.0% (from 8,210 to 1,969)
Incarcerations	↓ 24.4% (from 45 to 34)	↓ 40.6% (from 2,020 to 1,199)
Acute Medical Hospitalizations	↓ 25.9% (from 27 to 20)	↓ 17.8% (from 259 to 213)
Acute Psych Hospitalizations	↓ 25.5% (from 137 to 102)	↑ 4.8% (from 3,356 to 3,518)
State Psychiatric	↓ 100% (from 7 to 0)	↓ 100% (from 1,156 to 0)

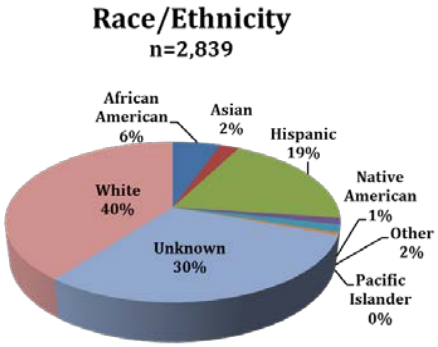
Stanislaus Homeless Outreach Program

FY 2016-17

2,839 Individuals Served







Program Results for FSP Level of Care

How Much?

- 247 individuals were served *
- 39 is the average number of clinical services per individual
- 14 is the average number of support services per individual

How Well?

- 124% (247/200) of annual target of individuals served was met (Target: 200)
- 614 days –average length of FSP services
- 95% (82/86) of surveyed individuals were satisfied with services
- 92% (76/83) of surveyed individuals said that “Staff believed I could change”

Better Off?

- 80% (60/75) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems
- 69% (51/74) of surveyed individuals indicated that as a results of services, they feel they belong to their community
- 85% (429/504) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, and decreased need for extensive and expensive services

Program Results for GSD Level of Care

How Much?

- 1317 individuals served *
- 2 is the average number of clinical services per individual
- 1 is the average number of support services per individual

How Well?

- 100% (35/35) of surveyed individuals reported being satisfied with services
- 86% (31/36) of surveyed individuals indicated that “Staff believed I could change”

Better Off?

- 83% (30/36) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems
- 61% (22/36) of surveyed individuals indicated that they feel they belong to their community as a result of services
- 90% (194/216) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, or decreased need for extensive and expensive services**

** Individuals served in both FSP and GSD levels of care are counted in each category.*
***The number of individuals served is an unduplicated count between all levels of care.*

Juvenile Justice (FSP- 02)
Operated by Behavioral Health and Recovery Services in the Children's System of Care

Program Description

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

Target Population

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

Many youth are from racially and ethnically diverse communities. Often there is a history of domestic violence, gang involvement, and multi-generational incarceration. Due to the severity of the serious emotion disturbance, the levels of aggression involved in the crimes committed and continued recidivism, these youth are frequently made formal wards of the court and are at persistent risk of out-of-home and/or out-of-town placement.

Services and Activities

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

Juvenile Justice also includes services and support funded by General System Development (GSD). These funds expand capacity to support individuals with group and peer support activities achieve and maintain recovery and wellness goals, and give young people access to supports that encourage the development of leadership skills and support for parents. The following activities support those goals:

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

- Billiards
- Ping Pong
- Youth Recovery Groups
- Life Skills Education and Coaching
- Volunteer Program
- Opportunities to serve community
- Youth Leadership and Peer Support Groups
- Speakers Bureau Training
- Computer Lab
- Housing Information
- Healthcare information
- Help with Resumes
- Assistance in applying for employment

Youth Leadership and Stanislaus Youth in Mind
A program supporting youth to participate in leadership and advocacy, including attend leadership summits, mental health conferences, and local advocacy activities to promote positive change through authentic youth engagement. Goals and activities include the following:

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

Stanislaus County Youth Leadership Network (SCYLN)

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

Youth Peer Navigator "YPN" Project

An integrated youth-centered approach to help young people in need of mental health services navigate through Stanislaus County's mental health services system and to help youth improve their mental health and well-being. YPN activities include the following:

- Navigators provide mental health education, peer support, and mentoring to youth in the Behavioral Health and Recovery Service's (BHRS) Children's Systems of Care (CSOC) and to those youth that need help connecting to mental health services.
- Project goals include increasing youth's developmental assets, reducing psychiatric hospitalization and reduce the Juvenile criminal recidivism rate.

Parent Support Services

Parent support groups offered to families who wish to receive support in navigating the juvenile justice system or improving parenting skills.

- Groups are coordinated by a Parent Support Specialist to give parents/grandparents an opportunity to gain better understanding of the Juvenile Justice System. It's also a place for parents to support each other and share their experience.

In FY 18-19, there are no proposed changes in the population to be served. The estimated number of individuals to be served is 25 at any given time; 13 Children/Youth and 12 Transition Age Young Adults.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2016-17

Total Budget	*Actual*	*Total Number Served*	*Estimated Cost Per Participant*
$386,316	***$372,221***	***202***	***$1,843***

FY 17-18 Total Budgeted	*FY 17-18 Total Projected*	*FY 18-19 Total Projected*
$539,070	***$480,428***	***$684,371***

Highlights

- "The Spot" exceeded its goal of attracting 75 youth within the first year. There were 82 additional participants this fiscal year.
- "The Spot" has, on average, 154 youth visits per month.
- Youth have shared their life experiences with students at Modesto Junior College and CSU Stanislaus, to help decrease mental health stigma and discrimination.
- "The Spot" provided a venue to allow "Stanislaus Youth in Mind" to provide mental health education, wellness techniques, leadership development and advocacy opportunities.
- Thirty (30) youth have obtained assistance with job applications, resumes, and homework. Additionally, those youth pursuing employment, have gained interviewing practice through mock interviews.
- Youth were provided with a safe environment to engage with peers, and learn pro social skills.

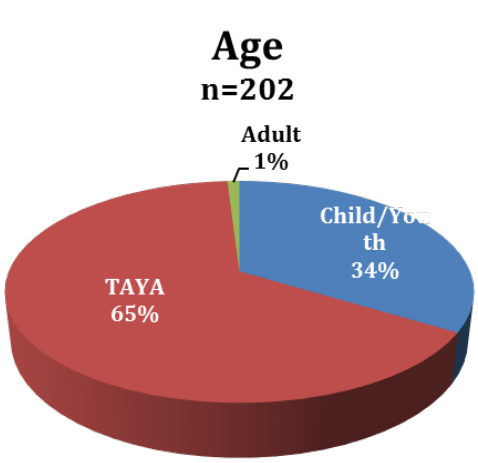
Challenges

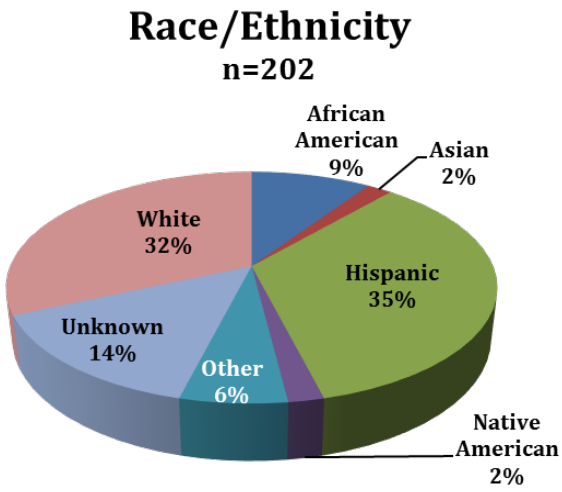
- Co-location with Probation/Juvenile Hall can make it difficult to engage youth in activities when some have distrust of the justice system.
- Getting to "The Spot" can be challenging for some youth who take the bus to the center.
- The program is experiencing growing pains with leadership activities, mentoring, and treatment groups all held in a small triple-wide trailer.
- Raising awareness of "The Spot" in high schools has been a goal this year. However, due to the location of the program, it has proven challenging for clients to travel to the site for services.
- Youth state they would like to see more outings, and they would like for "The Spot" to have extended hours, and they would like to see more youth run groups.

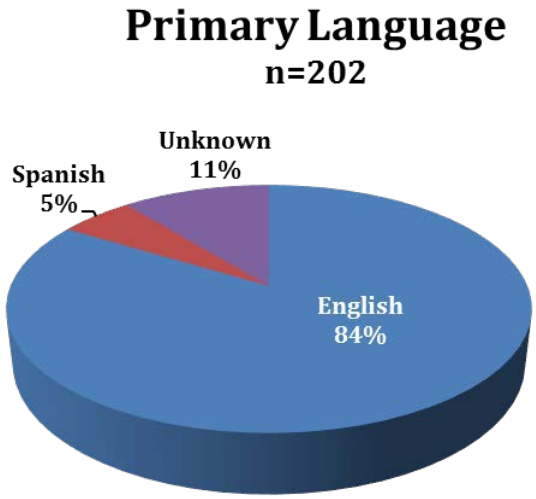
Outcomes for Partners After One Year in FSP 02
n=26

	Partners	*Days*
Homelessness	0% (from 0 to 0)	0% (from 0 to 0)
Incarcerations	↓ 13.3% (from 15 to 13)	↓ 51.1% (from 542 to 265)
Acute Medical Hospitalizations	↑ 100% (from 1 to 2)	0% (from 7 to 7)
Acute Psych Hospitalizations	↓ 60% (from 5 to 2)	↓ 28.9% (from 83 to 59)
State Psychiatric	0% (from 0 to 0)	0% (from 0 to 0)

Juvenile Justice
FY 2016-17
202 Individuals Served







Program Results for FSP Level of Care

How Much?

- 202 Individuals were served

How Well?

- 245% (184/75) of annual target of individuals served was met (Target:25)
- 286 days is the average length of GSD services
- 100% (9/9) of surveyed individuals were satisfied with services

Better Off?

- 88% (7/8) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problem.
- 97% (29/30) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.

Integrated Forensics Team (FSP- 05)
Operated by Behavioral Health and Recovery Services in the Forensic System of Care

Program Description

The Integrated Forensic Team (IFT) works in partnership with the Stanislaus County Criminal Justice System to serve individuals with serious mental illness or co-occurring substance abuse issues who are also at risk for more serious consequences in the criminal justice system. The program goals are to reduce the risk for emergency room use, contact with law enforcement, homelessness, and psychiatric hospitalization.

Target Population

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

Services and Activities

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

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

General System Development (GSD) activities in the program expand capacity to provide crisis services to known clients, peer and family support, and access to community resources for achieving and maintaining recovery and wellness goals (As previously reported, the funding formula for this FSP now is 100% FSP funding without change to services.)

In FY 18-19, there are no proposed changes in the population to be served. The estimated number of individuals to be served is 92; 52 Full Service Partnership level and 40 in Intensive Support Services or Wellness/Recovery Levels.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2016-17

Total Budget	Actual	Total Number Served	Estimated Cost Per Participant
$1,882,710	$1,780,908	126	$14,134

FY 17-18 Total Budgeted	FY 17-18 Total Projected	FY 18-19 Total Projected
$2,158,688	$2,037,577	$2,285,768

Highlights

- IFT implemented a new group which focused on prevention and wellness. This group utilizes the evidenced based practice known as W.R.A.P. (Wellness Recovery Action Plan).
- IFT continued to increase outreach and engagement efforts by teaming up with other partners (e.g. homeless outreach team, MPD, probation) in an attempt to engage some of the most disenfranchised individuals in the community.
- IFT continued to focus on accurate, timely documentation by requiring that all staff participate in monthly internal chart audits.

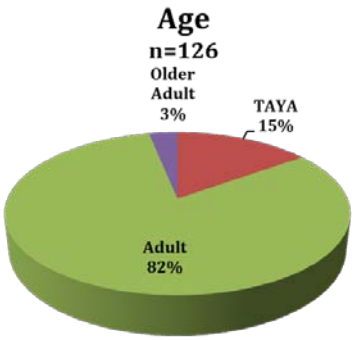
Challenges

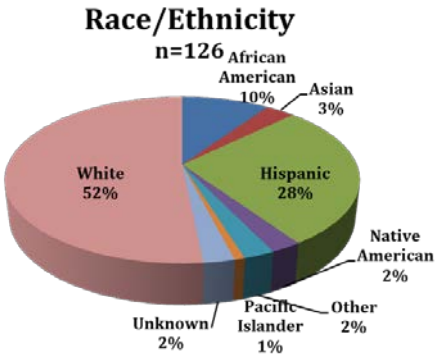
- A large number of individuals who have been placed on temporary or permanent conservatorship have been referred to the program over the past year. Serving these individuals poses a unique challenge due to the scarcity of and high demand for supportive housing and locked treatment facilities.
- Recruitment and retention of Psychiatrists is a pervasive challenge. Use of tele- psychiatry has mitigated the issue but there are still challenges.

Outcomes for Partners After One Year in FSP 05
n=58

	Partners	Days
Homelessness	0% (from 14 to 14)	↓ 49.1% (from 2,477 to 1,261)
Incarcerations	↓ 39.6% (from 48 to 29)	↓ 66.7% (from 4,624 to 1,541)
Acute Medical Hospitalizations	↓ 100% (from 1 to 0)	↓ 100%(from 4 to 0)
Acute Psych Hospitalizations	0% (from 20 to 20)	↑ 64.1% (from 309 to 507)
State Psychiatric	↓ 91.7% (from 12 to 1)	↓ 94.4% (from 2,126 to 120)

Integrated Forensic Team
FY 2016-17
126 Individuals served





Program Results for FSP Level of Care

How Much?

- 126 Individuals were served
- 13 is the average number of clinical services per individual
- 15 is the average number of support services per individual

How Well?

- 137% (126/92) of annual target of individuals served was met
- 444 days is the average length of FSP services
- 96% (22/23) of surveyed individuals were satisfied with services
- 83% (19/23) of surveyed individuals said that “staff believed that I could change”

Better Off?

- 71% (15/21) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems.
- 81% (17/21) of surveyed individuals indicated that they feel they belong to their community as a result of services
- 90% (127/141) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, and decreased need for extensive and expensive services

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

Program Description

This program is a Full Service Partnership (FSP) that provides mental health services to adults with co-occurring health and mental health disorders. The program offers two levels of care: FSP and Intensive Support Services. This allows individuals to enter the program at an appropriate level of service for their need and then move to lesser or greater intensities of service if necessary. A graduated level of care allows more individuals to access the FSP level of service when needed.

Target Population

Transition Aged Young Adults (TAYA) 18-25, Adults 26-59, and Older Adults 60+ with significant ongoing and potentially chronic health conditions are co-occurring with serious mental illness. Individuals served are also at risk for homelessness, institutionalization, hospitalization, nursing home care or are frequent users of emergency rooms.

Services and Activities

Strategies include 24/7 access to a known service provider, individualized service plans, a multidisciplinary treatment approach, access to wellness and recovery focused groups and peer support, and linkage to existing community support groups. Both service recipients and family members receive education regarding the management of both health and mental health issues as well as benefits advocacy support and housing support. Outreach and engagement services are focused on engaging diverse ethnic/cultural populations and individuals who have or are at risk for mental illness and homelessness.

In FY 18-19, there are no changes in the population to be served and strategies to be used. The estimated number of individuals projected to be served is 125.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2016-17

Total Budget	*Actual*	*Total Number Served*	*Estimated Cost Per Participant*
$1,694,361	***$1,483,785***	***133***	***$11,156***

FY 17/18 Total Budgeted	*FY 17-18 Total Projected*	*FY 18-19 Total Projected*
$1,933,164	***$1,802,356***	***$1,836,637***

Highlights

- HRHSA is an ethnically and culturally diverse team that provides outreach to underserved communities through community events, such as; National Depression Screening Day, BHRS Peer Support/Volunteer programs, local community fairs, educational summits, and a countywide homeless vigil.
- HRHSA Peer Support/Volunteer program has grown to approximately 30 individuals.
- Volunteers continued to meet with clients in the community to promote and support peer advocacy.
- HRHSA continues to align with Behavioral Health and Recovery Services (BHRS) Cultural Plan Requirements through trainings, hiring practices and use of interpreters.
- The LGBT Committee conducted training for staff and volunteers at HRHSA offices.
- HRHSA has an ongoing LGBT support group for older adults on site.
- HRHSA now has two drivers to assist with outreach to underserved population.
- Social support between clients increased within the Peer Support/Volunteer program.
- HRHSA continued to participate as a mental health rotation site for RN students/programs at Modesto Junior College and CSU Stanislaus.

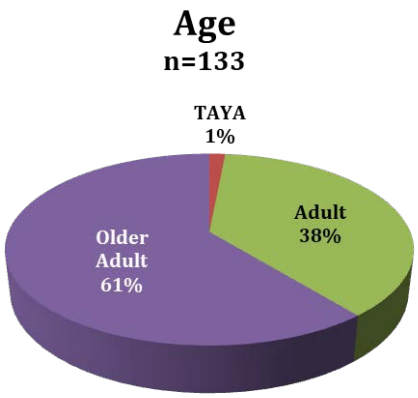
Challenges

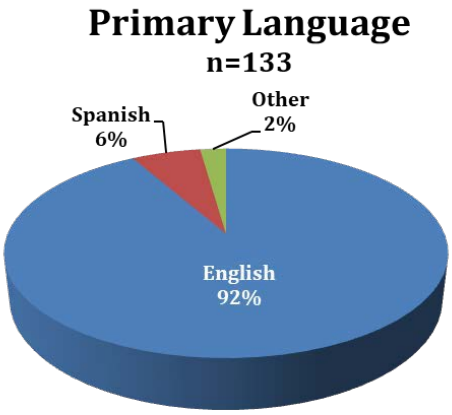
- The physical space of HRHSA is challenging and plans are in development to relocate program in FY17-18
- Hiring and retention of staff is an ongoing challenge

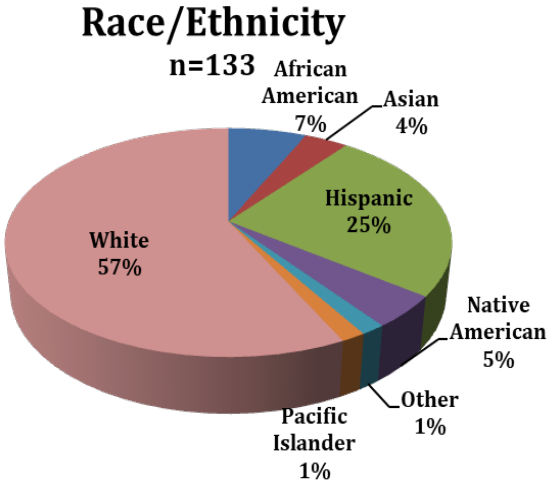
Outcomes for Partners After One Year in FSP 06
n=93

	Partners	*Days*
Homelessness	↓ 42.9% (from 14 to 8)	↓ 64.2% (from 2,996 to 1,065)
Incarcerations	↓ 25% (from 8 to 6)	↓ 62.4% (from 388 to 146)
Acute Medical Hospitalizations	↓ 6.7% (from 15 to 14)	↓ 37.3% (from 400 to 251)
Acute Psych Hospitalizations	↓ 43.1% (from 58 to 33)	↑ 58.2% (from 1,643 to 2,600)
State Psychiatric	= 0% (from 1 to 1)	↓ 99.7% (from 291 to 1)

High Risk Health and Senior Access
FY 2016-17
133 Individuals Served







Program Results for FSP Level of Care

How Much?

- 133 Individuals were served
- 25 is the average number of clinical services per individual
- 20 is the average number of support services per individual

How Well?

- 106% (133/125) of annual target of individuals served was met (Target:125)
- 479 days is the average length of FSP services
- 92% (43/47) of surveyed individuals were satisfied with services
- 90% (43/48) of surveyed individuals said that “staff believed I could change”

Better Off?

- 78% (36/46) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems.
- 86% (38/44) of surveyed individuals indicated that as a result of services, they feel they belong to their community
- 91% (258/283) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.

Turning Point Integrated Services Agency (FSP- 07)
Operated by Turning Point Community Programs in the Adult/Older Adult System of Care

Program Description

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

Target Population

Transitional aged young adults 18 - 25, Adults 26 - 59, and Older Adults 60+ with a serious mental Illness

Services and Activities

Relationship building with service recipients is central to successful services that assist them on the path of wellness and recovery. This FSP includes a continuum of care, crisis intervention, and wraparound funds, in alignment with the severity of the mental health challenges experienced by these service recipients. This FSP offers services 24 hours a day including crisis response, seven days a week to clients, supportive services including wraparound funds to help client's immediate and temporary needs such as food, clothing, and shelter. The FSP works collaboratively with Doctor's Behavioral Health Center, the Psychiatric Health Facility (PHF), the Public Guardian's Office, and the Community Emergency Response Team (CERT) and Warm Line to ensure client's needs are appropriately served.

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

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2016-17

Total Budget	*Actual*	*Total Number Served*	*Estimated Cost Per Participant*
$751,274	***$344,802***	***156***	***$2,210***

FY 17-18 Total Budget	*FY 17-18 Total Projected*	*FY 18-19 Total Projected*
$751,274	***$406,274***	***$751,274***

Highlights

- The majority of the individuals served (N=153) did not accrue new hospital, homeless, incarceration days, or emergency interventions.
  - 79.7% (n=122) of the population served did not accrue any psychiatric hospital days,
  - 98.7% (n=151) did not accrue incarceration days,
  - 98.0% (n=150) did not accrue any homeless days,
  - 89.5% (n=137) did not accrue any emergency interventions.
- Total number of psychiatric hospital days accrued within the fiscal year decreased 6.3% (n=128) from the previous fiscal year.
- The Social Connectiveness domain within the MHSIP Consumer Satisfaction Survey scored above 80% (83.2%) suggesting that individuals served generally felt more connected to the community and their peers.
- Of the total 84 IMD admissions, 28 (33.3%) transitions to a lower level of care occurred at some point within FY16/17
- Supportive Services "Wrap around" funds have been successfully utilized to help individuals with their basic needs of food, clothing, and shelter, and avoid becoming homeless or in an emergency situation with law enforcement.

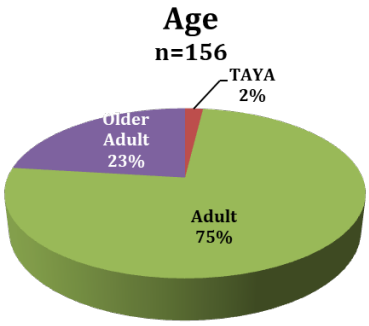
Challenges

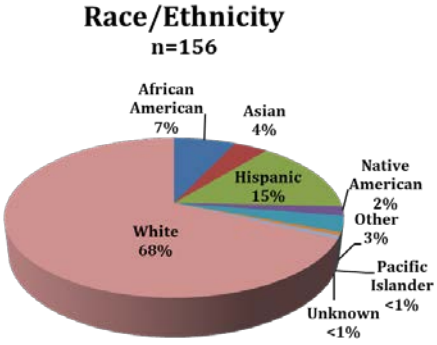
- There is an ongoing and persistent issue with limited placement opportunities for clients in Transition Board and Care home placements and general Board and Care homes.
- Clients in locked settings spend longer periods of time in acute hospitals due to the scarcity of community housing placements.
- There has been an increase in the acuity level of clients. This FSP serves many of the most severely ill and behaviorally challenging clients in the community.
- There has been an increase of average age of individuals served. An increase in the number of co-occurring medical disorders seems to correlate with the older individuals being served. Additionally, the medical challenges are diverse, and discernment of dementia related illness is particularly difficult.

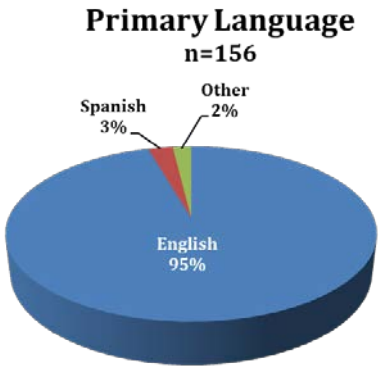
Outcomes for Partners After One Year in FSP 07
n=157

	Partners	*Days*
Homelessness	↓ 35.3% (from 17 to 11)	↓ 78.6% (from 1,761 to 377)
Incarcerations	↓ 23.1% (from 13 to 10)	↓ 77.7% (from 1,354 to 302)
Acute Medical Hospitalizations	↑ 33.3% (from 18 to 24)	↑ 81.5% (from 357 to 648)
Acute Psych Hospitalizations	↓ 6.1% (from 66 to 62)	↑ 35.9% (from 2,767 to 3,761)
State Psychiatric	↓ 30% (from 10 to 7)	↓ 63.6% (from 3,029 to 1,104)

Turning Point Integrated Services Agency
FY 2016-17
156 Individuals Served







Program Results for FSP Level of Care

How Much?
- 156 Individuals were served
- 34 is the average number of clinical services per individual
- 25 is the average number of support services per individual

How Well?
- 101% (156/155) of annual target of individuals served was met (Target:155)
- 2631 days is the average length of FSP services
- 93% (78/84) of surveyed individuals were satisfied with services
- 86% (66/77) of surveyed individuals said that “staff believed I could change”

Better Off?
- 89% (64/72) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems.
- 83% (55/66) of surveyed individuals indicated that as a result of services, they feel they belong to their community
- 82% (392/478) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.

Central Star Child Youth with SED (FSP-08)
Operated by Stars Behavioral Health Group within the BHRS Children's System of Care

Program Description

This program is a Full Service Partnership (FSP) that provides behavioral health services, including outreach and engagement, to high-risk children and youth with serious emotional disturbances (SED) and their families.

Target Population

Children and youth with serious mental health issues and at risk for suicide, violence, residential instability, co-occurring issues of substance use and mental health, criminal justice involvement, involuntary hospitalization and maybe part of unserved or underserved cultural/ethnic populations

Services and Activities

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

This FSP team of 3 Care Coordinators, 3 Family Specialists, 1 Peer Specialist, 1 Parent Partner, 1 Administrative Clerk, and 1 Program Manager was assembled in January 2017 to begin training. Located in NW Modesto the program opened officially in March 2017.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2016-17

Total Budget	*Actual*	*Total Number Served*	*Estimated Cost Per Participant*
$676,743	***$342,649***	***23***	***$14,898***

FY 17-18 Total Budget	*FY 17-18 Total Projected*	*FY 18-19 Total Projected*
$574,191	***$557,485***	***$574,191***

Highlights

- FSP program staff received training in the FSP approach including; wraparound principles and service processes, focus on service delivery in homes, schools, and other community locations.
- Additional training included an emphasis on staff, client and family member safety applying the Stars Behavioral Health Group (SBHG) Community Safety Interventions (CSI) training along with other foci during New Employee Orientation (NEO). CSI builds on the foundation of Professional Assault Crisis Training (Pro-ACT™), tailored for intensive outpatient service contexts where environmental awareness and de-escalation skills are used, never hands-on interventions. Another key SBHG safety emphasis pertains to client risk for suicidal behavior, an elevated risk in FSP populations, and the team learned the Columbia Suicide Severity Rating Scale (CSSRS) protocols for early detection and active preventative interventions.

- **Mandated Trainings completed**
  - All 10 FSP staff completed General Compliance, Specific Compliance and HIPAA trainings, achieving passing scores within their NEO context, and are on track with annual renewal updates starting over the fall period.
  - 6 FSP staff completed Safety, Emergencies and Infection Control Training; the rest are scheduled to obtain this before the end of the calendar year.
  - 6 FSP Peer staffs participated in the first rung of SBHG's Peer Staff Development Training Ladder, which is Orientation to Peer Support Services.
- The FSP team's first client enrolled in early February. To date, there were 29 enrollments of 29 unduplicated individuals. Most of these enrollments (N=22) occurred prior to the close of the FY. As of the end of the FY, there were 2 discharges, served over a period of 21 days, and 60 days, respectively. Since, there were 5 additional discharges and the combined average length of stay among all those discharged to date is 95 days. Other central tendencies related to enrollments and discharges across the 22 unduplicated children/youth served during the FY are as follows, reflective of a start-up period:

Start-Up Period

Avg. Enrollments Per Month	Avg. Discharges Per Month	Avg. Unduplicated Clients Served Per Month
4.4	.4	11

- The referral process culminates in enrollments of the intended service population and the team is now over-pacing to make up for the initial slow start of referrals, as seen in the BHRS report snippet, below (program started Q3):

Program Detail, FY 16-17 Target/Actual Population Served

FSP Client Count	Qtr 1			Qtr 2			Qtr 3			Qtr 4			Total Undup. Clients		
Age Group	Target	Actual*	%	Target	Actual*	%	Target	Actual*	%	Target	Actual*	%	Annual Target	YTD Actual*	YTD %
Child/Youth		0					10	4	40.0%	10	17	170.0%	10	17	170.0%
Transition Age Youth		0					5	2	40.0%	5	7	140.0%	5	7	140.0%
TOTAL		0					15	6	40.0%	15	24	160.0%	15	24	160.0%

- Seven (7) youth met most or all of their treatment goals and were discharged from the FSP between February – June 2017; three of them met most or all their treatment goals and graduated to lower levels of care, no longer requiring hospitalizations; one turned 18, was discharged from the Child FSP and referred to other services and supports; the remaining three went out of contact with the program with one moving out of the state with family.
- When youth and their families go out of contact, the team applies a standard of attempting contact multiple times over at least one month from last service, while also providing advance written notification of the pending closure with an invitation to the family to reconnect and a list of alternative resources and aftercare suggestions to consider for their child and the family should they elect to not return.
- The program began to access reports available based on service data from the Child and Adolescent Needs & Strengths (CANS) and MHSA DCR data forms; as well as from the SBHG Child COR in the Electronic Medical Record (EMR).

Cultural Competency Activities

- The FSP program is currently authoring their first ever *SBHG Bi-Annual Cultural Attunement Plan* which will be available and shared with the county. In the plan, all team members will participate in SBHG's Cultural Attunement Trainings, which include a basic orientation using the *Health Equities and Multi-Cultural Diversity Training* (HEMCDT) curricula and at least one additional special population focus training each year, geared to the needs of the service population.
- The plan also involves systematic review and training as needed regarding cultural-attunement related policies, procedures and practices, including client/family access to culturally specific service providers upon request, translations of consumer documents, ADA accommodations, Language Line use, and assessing and acting upon differential outcomes from a cultural lens. Finally, each team is asked to identify and act upon at least one significant elective cultural attunement initiative in the two-year cycle, often related to community integration and/or fine- tuning programming and practice models for a specific population need.

Challenges

New to Stanislaus County, challenges during the program's initial implementation center around learning county systems regarding referral processing, as well as documentation and data tracking.

- Referrals began slowly but the program approached a full census by September 2017. The referral and engagement process is deeply collaborative, which is a good thing, and the team embraces it! Still, the process takes time, as there are typically multiple contacts and communications involved with the family, and the referring providers, including coordinating around the timing of hospital discharges, important to success with enrollments.
- Information regarding enrollments, discharges and unduplicated clients served is based on data capture in the SBHG EMR. There are discrepancies between the SBHG EMR and data reported in an active Client Roster Report from Stanislaus's BHRS EMR (Cerner) system, primarily related to different enrollment dates. The discrepancies appear to be related to the time between the county's Weekly Referral Meeting (and the BHRS opening date) after which there is a process of active engagement culminating in a warm hand-off and the client's FSP enrollment as registered in the SBHG EMR. The lag time between the BHRS and SBHG EMR enrollment dates ranges from 0 to 107 days, with an average of 13 days and a median (50th%tile) of 8 days.
- One key indicator of the team's challenge regarding documentation was their initial inadequate performance in the timeliness of service entries (days between services delivered vs. entered in county BHRS): 8% over 16 days late; 27% 11 to 15 days late; 58% 4 to 10 days late; and, only 7% under 3 days late. There has been continued work and progress on this front and our quality management and performance outcomes systems are getting much better buttoned down in their interface with county databases, with improvements in documentation-related performance indicators and reporting summaries to the county.

Central Star Child Youth with SED

FY 2016-17

23 Individuals Served

Program Results for FSP Level of Care

How Much?

- 23 individuals were served

How Well?

- 153% (23/15) of annual target of individuals served was met (Target:15)
- 74 days is the average length of FSP services
- 83% (5/6) of discharged individuals met goals or transitioned to a lower level of care

Better Off?

- Data to be supplied from EPLD reports 1/2018

Josie's Place Drop-In Center (GSD-01)
Operated by BHRS in the Children's System of Care

Program Description

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

Target Population

Transition age young adults (TAYA); Drop in Center 16-25 years; Service Team and Josie's TRAC serves 18-25 years of age.

Services and Activities

Service Team and TRAC provide

- Therapy, intensive case management, Psychiatrist and medication services, psychiatric RN support.
- Work collaboratively with client and programs to reduce mental health symptoms.
- Work to help stabilize housing, reduce hospitalizations, reduce incarcerations, and reduce substance use.
- Work to increase healthy coping skills, socialization and community supports.
- Work towards independence and recovery on TAY terms.

Drop in Center

- Provide social skills and activities including independent living skills.
- Provide groups including Anger Management, LGBTQ and Transgendered support groups, SUD Peer support, Gender specific Peer Support Groups.
- Linkage and advocacy for Independent Living skills including: housing, eligibility, California IDs, SSI, vocational and education support.
- Outreach and Engagement with TAY population in all settings to provide resource and referral.

Josie's Place is also home to the Young Adult Advisory Council (YAAC), a consumer-based group that provides leadership opportunities for youth to get involved in daily activities and have the voice of programming at Josie's Place. Services can be provided in English, Spanish, and Cambodian currently but all cultures and ethnicities are accommodated for all members/clients.

In FY 17-18, there are no changes in the population to be served and strategies to be used. The estimated number of individuals projected to be served is 250+ in Drop in Center; approximately 175 with service team and 60+ at the TRAC level.

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2016-17

Total Budget	*Actual*	*Total Number Served*	*Estimated Cost Per Participant*
$757,091	***$694,668***	***401***	***$1,732***

FY 17-18 Total Budget	*FY 17-18 Total Projected*	*FY 18-19 Total Projected*
$966,780	***$826,321***	***$963,703***

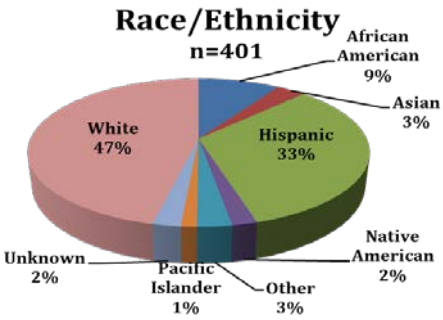
Highlights

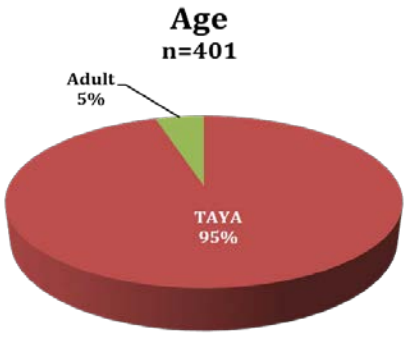
- Collaborations with Stanislaus County Health Services Agency (HSA) to provide health and sex education as well as testing and prevention measures for youth on-site at Josie's Place.
- Outreach and engagement to youth clients at the Psychiatric Health Facility (PHF), hospitals, children's crisis center and AB12 Child Welfare program. Outreach efforts include homeless youth to support the community as well as housing/pathways for the youth.
- Continued collaborations with Stanislaus Recovery Center (SRC), First Step Program, Probation and Child Welfare
- Individual peer support to help with coping and social skills as well as referrals and resource in community
- Ongoing use of out-of-the-box ideas and programming to support the needs of TAY in the community.

Challenges

- There is a lack of housing available in the community for homeless TAY population
- There is a lack of adequate resources in the community for transgender and LGBTQ youth
- Because of limited mass transit, transportation to the center continues to be a barrier for some youth
- The increased level of services has caused Josie's Place to outgrow the office space and location.

Josie's Place Drop-In Center
FY 2016-17
401 Individuals Served





Program Results for GSD Level of Care

How Much?

- 401 Individuals were served
- 10 is the average number of clinical services per individual
- 5 is the average number of support services per individual

How Well?

- 160% (401/250) of annual target of individuals served was met (Target:250)
- 271 days is the average length of GSD services
- 94% (63/67) of surveyed individuals were satisfied with services
- 92% (60/65) of surveyed individuals said that "staff believed I could change"

Better Off?

- 82% (50/61) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems.
- 69% (42/61) of surveyed individuals indicated that as a result of services, they feel they belong to their community
- 84% (319/380) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources or decreased need for extensive and expensive services.

Community Emergency Response Team (CERT) and Warm Line (GSD-02) Operated by BHRS and Turning Point Community Programs

Program Description

The CERT program provides the community with a team of licensed clinical staff who provide interventions in crisis situations. The Warm Line is a telephone assistance program that provides non-crisis peer support, referrals, and follow-up contacts. In 2015, Warm Line expanded services to provide Peer Navigators to help support CERT to connect individuals to specialty mental health services and avoid hospitalization.

Target Population

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

Services and Activities

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

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

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

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

FY 2016-17

Total Budget	*Actual*	*Total Number Served*	*Estimated Cost Per Participant*
$974,884	***$917,443***	***2,895***	***$317***

FY 17-18 Total Budget	*FY 17-18 Total Projected*	*FY 18-19 Total Projected*
$979,706	***$979,706***	***$962,853***

Highlights

Mobile CERT

- Provides Modesto Police officers with additional information and strategies for helping individuals with mental illness
- Can reduce the need for hospitalizations by providing community members with immediate access to a mental health clinician while in crisis
- CERT staff give information and refer individuals who may not be in crisis but are in need of behavioral health services to community resources
- CERT staff assists Modesto Police officers with screening clients to better determine the course of action and disposition for a person in crisis. This can reduce the number of transitions/transports for clients who are in crisis.

CERT

- Primary focus is on acute and sub-acute situations of children and youth with serious emotional disturbances (SED) and adults and older adult individuals with serious mental illness (SMI). Emphasis with each age group is placed on provision of age-appropriate outreach, engagement in the recovery process, and crisis intervention that include family and natural systems of support when available.
- Collaboration is central to the success of emergency mental health assessment and referral and occurs on a daily basis with families, consumers, law enforcement, and medical hospital emergency room personnel. Referrals are available for individuals who need ongoing agency- based mental health services or hospitalization as well as services and supports that are available in the community.
- CERT is responsible for evaluation and placement of individuals who are determined to need inpatient treatment including; ensuring a complete referral packet is prepared, consultation with other programs who are assessing individuals and ensure completion of needed documentation, working with hospitals to ensure needed information is available prior to placement, 24 hours re-assessments if a client has not been placed, and ensure, after placement has occurred, that necessary parties are notified.
- CERT is responsible for answering crisis calls referred by the Warm Line. If an individual, family members, or community program call regarding an individual in crisis, CERT assists in attempting to de-escalate the situation, create a safety plan, access emergency transportation to get clients to a safe assessment site, and provide community resource information when immediate crisis services are not needed.
- CERT maintains a log of all individuals assessed and this log is then made available to the county programs and appropriate contract agencies for coordination of care purposes.
- In February 2016, CERT expanded its services to include a Crisis Stabilization Unit (operated by Telecare). The purpose of this voluntary twenty-three (23) hour program is to expand how BHRS serves the community through CERT. Key features of the CSU include:
    - Offer immediate supportive counseling services to individuals in crisis who do not need hospitalization.
    - Provide meals and safe shelter for up to 23 hours.
    - Provide constant monitoring to ensure client's safety and stability.
    - Provide information regarding community resources (housing, support groups, AOD options, etc.).
    - Connect individuals to contracted provider to explore the option of continued mental health services.
    - Assist clients in establishing medication services (e.g. Golden Valley, Aspen Medical) if needed.

Peer Navigators

- This program offers supportive services to help individuals with mental illness and family members get connected to specialty mental health services.

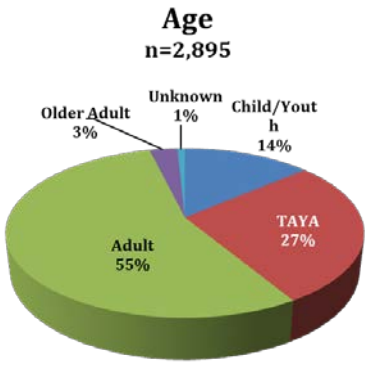
Challenges

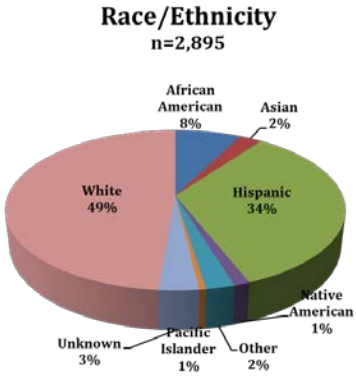
- The need for mental health crisis services has increased rapidly due to a variety of factors across all counties in California. CERT/Warm Line services are stretched to the limits of time and budget to provide 24/7 coverage that includes an immediate response to all who need crisis interventions and the needs of law enforcement.
- Staff turnover: although there is a core team of experienced Clinicians working at the CERT program retention of staff is a significant issue. In part, this can be attributed to the nature of the 24 hour service; (e.g. some people find it very difficult to balance life while working 24 hour shifts). Another factor in retention of staff is competition for a small pool of qualified clinicians.
- When new staff are identified and hired, significant time is needed to train staff and that includes multiple shifts for new staff to "shadow" experienced staff. CERT staff must be well trained, knowledgeable and capable of completing a crisis assessment that will result in an individual going to the hospital or back to the community.

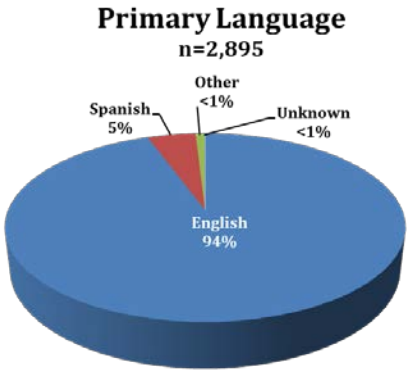
Community Response Team and Warmline

FY 2016-17

2,895 Individuals Served







Program Results for GSD Level of Care

How Much?

- 2,895 individuals were served (combined)
- 1 is the average number of clinical services per individual (CERT)

How Well?

- 97 % (2,895/3,000) of annual target of individuals served was met (Target:3,000)
- 1 day is the average length of GSD services (CERT)
- 100% (1/1) of surveyed individuals were satisfied with services (CERT)
- 100% (1/1) of surveyed individuals said that “Staff believed I could change (CERT)

Better Off?

- 80% (4/5) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, or decreased need for extensive and expensive services

Community Families Together (GSD-04)
Operated by Behavioral Health Recovery Services in the Children's System of Care

Program Description

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

Target Population

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

Services and Activities

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

In FY 17-18, there are no proposed changes in the population to be served. The estimated number of individuals projected to be served is 100.

FY 2016-17

Total Budget	*Actual*	*Total Number Served*	*Estimated Cost Per Participant*
$587,895	***$497,305***	***71+***	***$7,004++***

FY 17-18 Total Budget	*FY 17-18 Total Projected*	*FY 18-19 Total Projected*
$627,380	***$472,726***	***$558,593***

+ late in development of this draft Annual Update, it was discovered that the numbers for individuals served were grossly underrepresented due to confusion from staff and changes in staffing. Current efforts are underway to obtain true numbers served.

++ cost per participants will adjust once true number of individuals served is known.

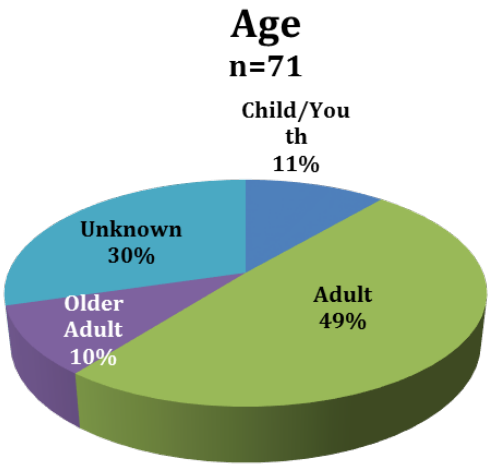
Highlights

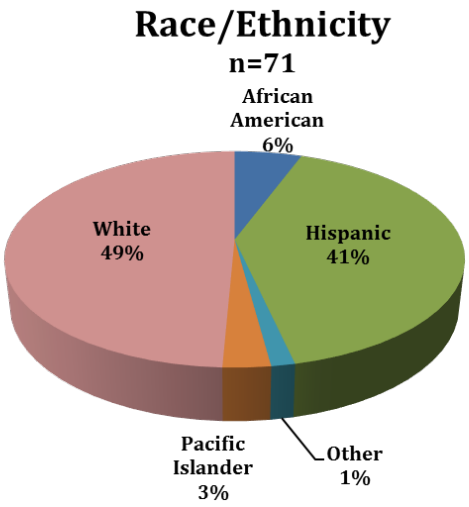
- Volunteers at the Family Partnership Center was fully implemented and increased volunteer's responsibilities to include, clothes closet, assistance with events and co- facilitating groups.
- FPC staff integrated into the Children's/TAY System of Care (CSOC) with other CSOC programs: Probation.
- Increased effort to have FPC staff do outreach work with families outside of the office.
- Increased capacity for activities and events with a building redesign

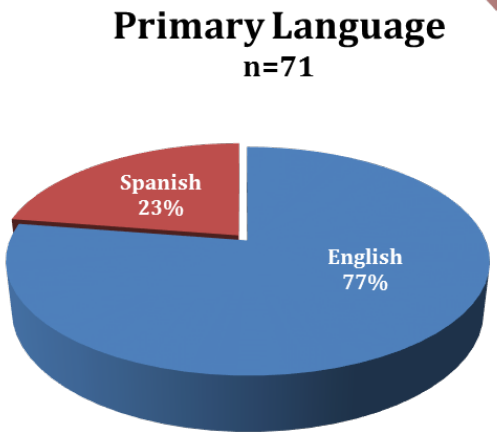
Challenges

- Program growth and staffing changes has temporarily delayed referrals as relationships are being developed
- Steering Committee with parents and caregivers has been on hold until a full-time Coordinator is hired.
- Changes in staffing contributed to issues with data collection. Team will address training needs to mitigate confusion and increase consistency.
- Engaging families in the field is always challenging.

Families Together
FY 2016-17
71 Individuals Served







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

Program Results for GSD Level of Care

How Much?

- 71 Individuals were served

How Well?

- 89% (71/80) of annual target of individuals served was met (Target:80)

Better Off?

- None available in report

The Consumer Empowerment Center (GSD-05)
Operated by Turning Point Community Programs in the Consumer/Family Affairs System of Care

Program Description

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

Target Population

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

Services and Activities

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

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

In FY 17-18, there are no proposed changes in the population expected to be served or the strategies to be used. The estimated number of individuals to be served is 500. Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2016-17

Total MHSA Budget	*Actual*	*Total Number Served*	*Estimated MHSA Cost Per Participant*
$550,112	***$550,402***	***723***	***$761***

FY 17-18 Budget	*FY 17-18 Projected*	*FY 18-19 Projected*
$509,377	***$508,437***	***$509,365***

Highlights

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

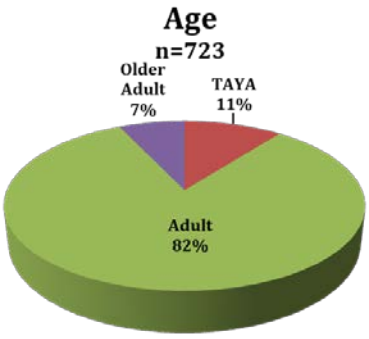
Challenges

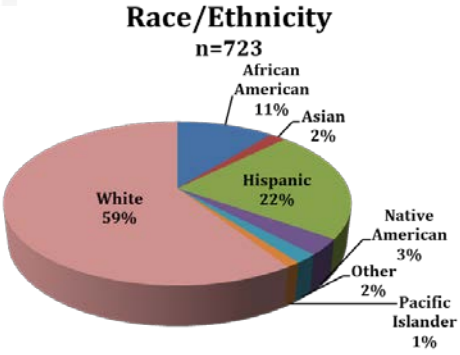
- Transportation continues to be a challenge as CEC does not have a vehicle for transportation which limits participation from people outside Modesto
- CEC relies heavily on fundraising efforts to help pay for activities and supplies as program funding is limited; CEC is a non-profit organization that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

The Consumer Empowerment Center

FY 2016-17

723 Individuals Served





How Much?

- 723 Individuals were served

How Well?

- 181% (723/400) of annual target of individuals served was met (Target: 400*)*
- 90% (130/145) of surveyed individuals were satisfied with services
- 88% (118/134) of surveyed individuals said that “Staff believed I could change”

Better Off?

- 81% (110/136) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems
- 66% (93/141) of surveyed individuals indicated that as a result of services, they feel they belong to their community.

Crisis Stabilization Unit (GSD-06)
Operated by Telecare Corporation

Program Description

The Crisis Stabilization Unit (CSU) provides clinical and psychiatric services and more intensive levels of care, including medication. The CSU opened in February 2016 and is co-located with the county's Community Emergency Response Team known as CERT and Warmline. The CSU's goal is to focus on recovery-centered care and create an opportunity for each individual to stay for a short time in a safe and less restrictive setting that an inpatient psychiatric hospital.

Target Population

Transition Age Young Adults 18-25, Adults 26-59, and older adults 60+ with mental illness and in crisis

Services and Activities

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

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

Future changes in estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2016-17

Total Budget	*Actual*	*Total Number Served*	*Estimated Cost Per Participant*
$1,070,478	***$374,430***	***465***	***$805***

FY 17-18 Total Budget	*FY 17-18 Total Projected*	*FY 18-19 Total Projected*
$1,088,450	***$1,055,562***	***$1,088,450***

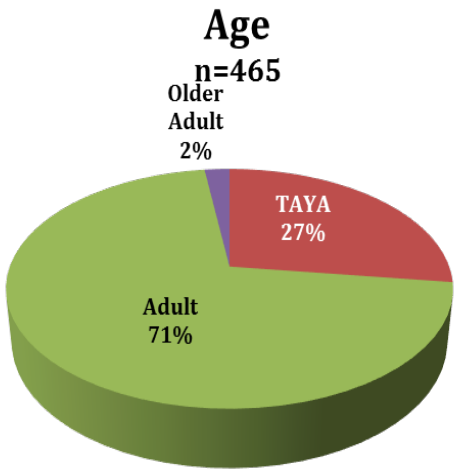
Highlights

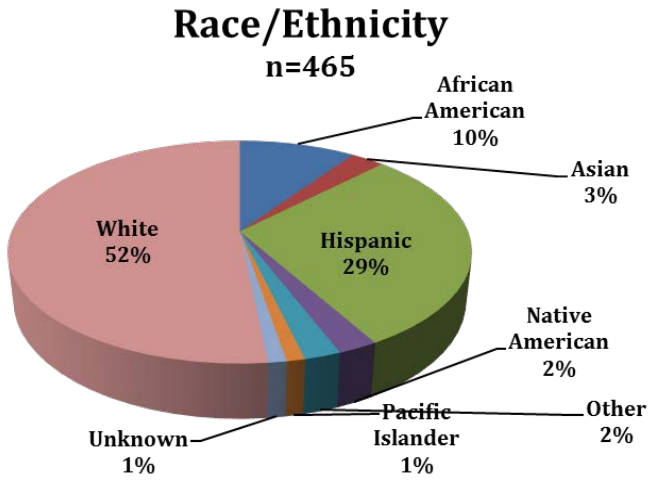
- During FY 16-17, the CSU provided services that diverted 85% of admitted clients from inpatient admissions.

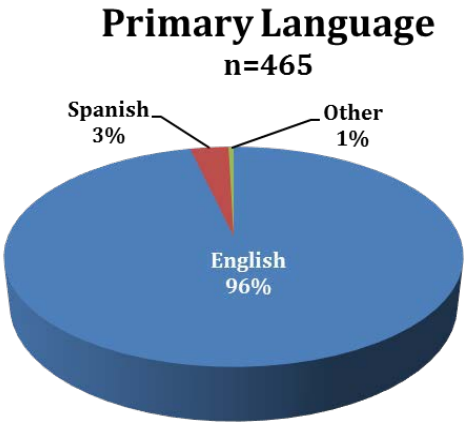
Challenges

- The CSU is a unique crisis program in that it works with both voluntary and involuntary clients in an unlocked setting. Being in an unlocked setting does limit the ability to accept clients who may need any level of physical management.
- Another challenge exists in the limited number of respite beds available. Often, a brief respite stay is the most appropriate level of care for an individual in crisis and the CSU is a limited resource.

Crisis Stabilization Unit (GSD-06)
FY 2016-17
465 Individuals Served







Program Results for GSD Level of Care

How Much?

- 465 Individuals were served
- 1 is the average number of clinical services per individual

How Well?

- 423% (465/110)of annual target of individuals served was met (target: 110)
- 2 days is the average length of GSD services

Better Off?

- None available in report

Garden Gate Respite (O&E 02)
Operated by Turning Point Community Programs in the Consumer/Family Affairs System of Care

Program Description

Garden Gate Respite (GGR) is a residential based respite program that introduces individuals from unserved and underserved populations to mental health services. GGR is a welcoming and engaging environment in the context of a home-like setting. The 11-bed facility is open 24 hours a day, seven days a week, and 365 days a year. Each guest receives an individual needs assessment to facilitate access to mental health services, case management, evaluations for AOD treatment, and other outreach and engagement services.

Target Population

Transition Age Young Adults (ages 18-25), Adults, and Older Adults from diverse and/or underserved populations who are either known or suspected to experience mental illness, and are either homeless or at risk of homelessness, incarceration, victimization, and/or psychiatric hospitalization.

Services and Activities

Garden Gate Respite provides crisis intervention with basic needs such as food, clothing, shelter, individual needs assessment to facilitate targeted crisis intervention case management and support services and linkage to outreach and engagement services. GGR is situated in a residential neighborhood adjacent to the BHRS Housing First Transitional Program's apartment complex for which GGR provides limited ancillary support. Staff members of GGR represent diverse cultures, including individuals with lived experience and family members of individuals with lived experience. Each guest at GGR is offered 1:1 peer support and groups that encourage leisure activities and stress reduction.

GGR works closely with community partners who offer mental health services, case management, crisis assessments, housing services, and alcohol and drug treatment. Referrals to GGR come from various community agencies including but not limited to: Modesto Police Department, Community Emergency Response Team (CERT), Peer Navigators, Consumer Empowerment Center, and Telecare Transition TRAC.

In FY 17-18, there are no proposed changes in the population to be served and strategies to be used. The estimated number of individuals projected to be served is 97. In the future, changes in the estimated number of individuals to be served will be based on approved program targets, fiscal sustainability, and stakeholder input.

FY 2016-17

Total Budget	*Actual*	*Total Number Served*	*Estimated Cost Per Participant*
$3,309,547	***$2,200,537***	***688***	***$3,198***

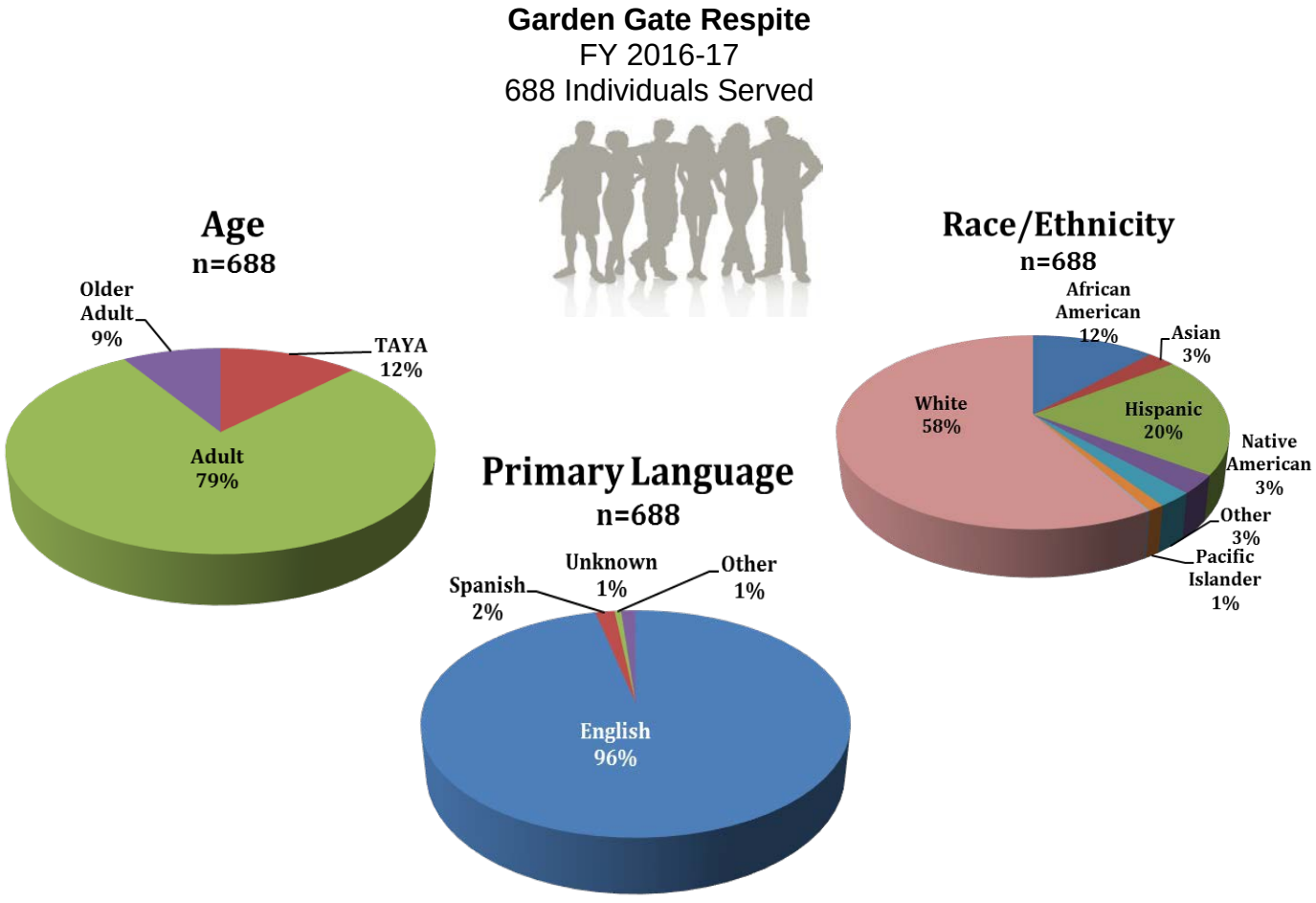
FY 17-18 Total Budget	*FY 17-18 Total Projected*	*FY 18-19 Total Projected*
$3,608,919	***$2,746,849***	***$3,497,934***

Highlights

- GGR offers proactive and collaborative case management to assist guests with accessing long-term placement, treatment planning, referrals to representative payee agencies, housing, and community support groups
- In-house social activities such as cooking, games, movies, poetry, and stress reduction
- GGR serves a wide variety of diverse individuals
- GGR actively created avenues for new referrals and linkages through presentations and participation in collaborative partnerships.

Challenges

- Challenges exist with having adequate staffing to maintaining 24/7 program coverage while scheduling of training, staff meetings, and interviews.
- Hiring, retention and training staff for a residential 24/7 program is a challenge while being competitive with the local job market.
- It is a challenge to educate the community as well as referring agencies about the services GGR provides. Complex medical issues and developmental issues generally require a higher level of care than short term respite housing can provide.
- Gaps in service exist in respite care for families, homeless with pets and a safe place to live while waiting for an intake assessment for admission in to SRC.
- Transportation is limited and public transportation is challenging for GGR guests who experience difficulty navigating independently in the community.
- Learning to collaborate effectively with the new multiagency Homeless Access Center, located at 825 12th Street Modesto has some challenges.



Program Results for O&E Level of Care

How Much?

- 688 Individuals were served (187 for housing, 120 for employment)
- 0.04 (8/187) is the average services per client for housing
- 0.02 (2/120) is the average services per client for employment

How Well?

- 372% (688/185) of annual target of individuals served were met (Target: 185; 97 Garden Gate, 88 Housing & Employment)
- 5 days is the average length of O&E Services
- 91% (48/53) of surveyed individuals were satisfied with services
- 93% (49/53) of surveyed individuals said that “Staff believed I could change”

Better Off?

- 86% (38/51) of surveyed individuals indicated that as a result of services, they deal more effectively with daily problems.
- 60% (31/51) of surveyed individuals indicated that as a result of services, they feel they belong to their community.
- 85% (258/304) of surveyed individuals indicated decreased stigma, increased self-care, increased access to community resources, or decreased need for extensive and expensive services.

Westside SHOP - Rural Access and Assessment (O&E-03)
Operated by Telecare Corporation in the BHRS Adult/Older Adult System of Care

Program Description

The Telecare Outreach and Engagement Team provides brief counseling intervention and engagement services that actively seek out, engage, assess, and refer individuals with serious mental illness to appropriate service providers and community supports within Stanislaus County's rural communities.

Target Population

Underserved Community Members: Adult and older adult clients who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services, but are not provided resources to support their recovery, wellness and/or resilience. Individuals who may have had only emergency or crisis oriented contacts and or services from the County may also be considered unserved.

Services and Activities

Services include brief counseling, behavioral health screening/assessment, referrals to BHRS and community partners, peer support group facilitation, and transportation that assists individuals with access services or peer/community supports. The Rural Access & Assessment Team designs and implements activities to inform the wider community about behavioral issues, services, and community support.

Rural Access and Assessment provides outreach services that seek to engage, assess, and refer individuals with serious mental illness to agency services and community supports.

Strategies include

- Individual Engagement;
- Referrals;
- Behavioral Health Services Navigation;
- Transportation that helps with access to services or community supports.

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

FY 2016-17

Total Budget	*Actual*	*Total Number Served*	*Estimated Cost Per Participant*
$140,000	***$121,603***	***722***	***$168***

FY 17-18 Total Budget	*FY 17-18 Total Projected*	*FY 18-19 Total Projected*
$140,000	***$138,908***	***$140,000***

Highlights

- Rural Access and Outreach staff built positive relationships with community agencies and worked in collaboration with Stanislaus County programs such as; DRAIL, Center for Human Services, CSA, Family Promise, and Modesto Collaborative
- Outreach to Modesto Police Department and Turlock Police Department
- Participated in the opening of the new Homeless Outreach and Engagement Center in downtown Modesto
- Extensive outreach resulted in an increase in referrals to the outreach programs from community agencies and clients referring other clients.
- Many individuals contacted the outreach team to thank them for the services they received

Challenges

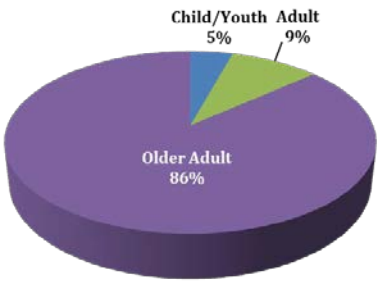
- Scarcity of mental health services/resources for uninsured (undocumented) individuals
- Transportation and child care for individuals living in the rural communities were barriers to access and remain in treatment.
- For the homeless population, there is a challenge in finding a place to safely leave their belongings or pets when obtaining treatment especially inpatient and residential treatment
- Limited housing and emergency shelters are a challenge when individuals want to seek mental health treatment

Westside SHOP - Rural Access and Assessment

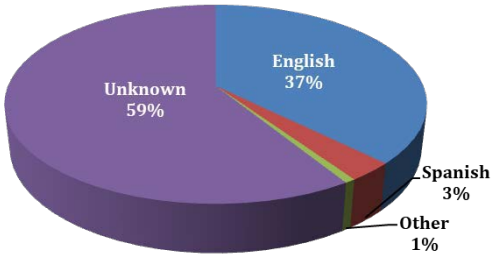
FY 2016-17

722 Individuals served

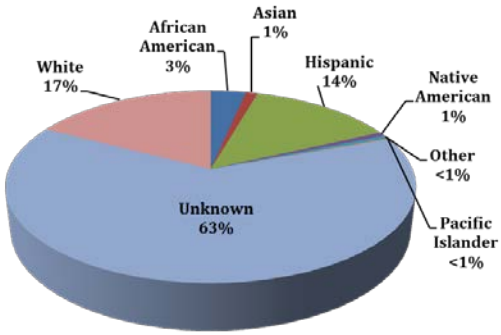
Age
n=722



Primary Language
n=722



Race/Ethnicity
n=722



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

Program Results for O&E Level of Care

How Much?

- 1,529 Individuals were served
- 0.13 (2/1529) is the average number of clinical services per individual

How Well?

- 546% (1529/280) of annual target of individuals served was met

Better Off?

- None available in report

PREVENTION EARLY INTERVENTION (PEI)

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

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

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

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

There were also changes to existing programs to better serve the needs of those at risk of or with mental illness in Stanislaus County.

The following illustrates how PEI programs are structured and categorized in the new PEI redesign and presented in this FY2018-19 Annual Update:

PEI Structure

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

Stanislaus County has five (5) PEI categories that include 37 overall program areas. Many have more than one contracted agency to implement the program in communities across Stanislaus County that result in 37 programs across the county. Each program has a unique approach that incorporates community-based interactions with service recipients that strive to include MHSA values of cultural competency, community collaboration, wellness, recovery/resiliency, client/family driven services, and an integrated service experience.

PEI Budget

FY 2016-17

Total MHSA Budget	*Actual*	*Total Number Served**	*Estimated MHSA Cost Per Participant*
$5,263,610	***$4,520,702***	***5,380***	***$840***

FY 17-18 Budgeted	*FY 17-18 Projected*	*FY 18-19 Projected*
$4,980,596	***$3,856,755***	***$6,009,443***

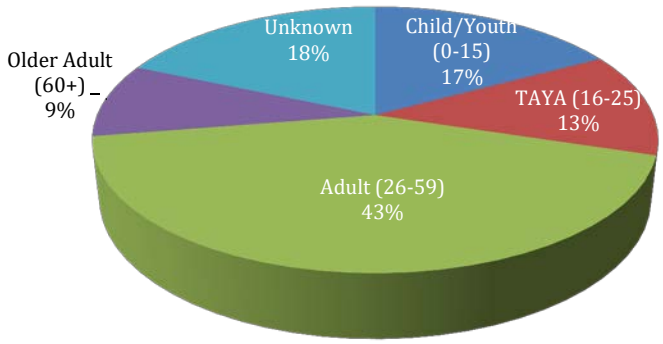
**Not unique count due to some types of services (outreach, presentations, trainings, etc.)*

Prevention & Early Intervention Program Results

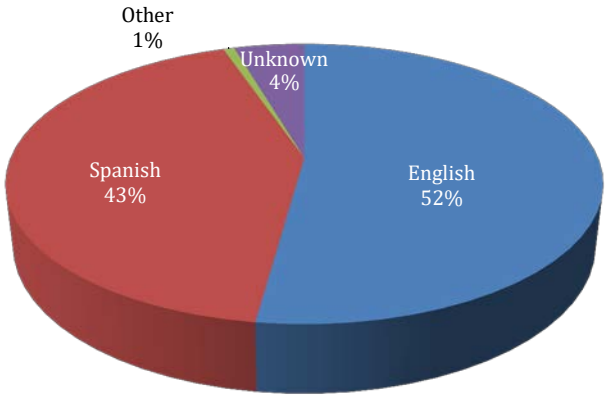
FY 2016-17

5,380 Individuals Served

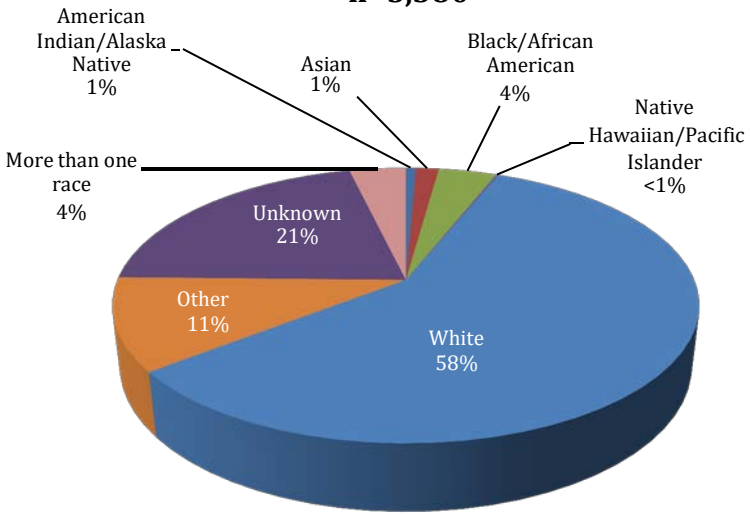
Age
n= 5,380



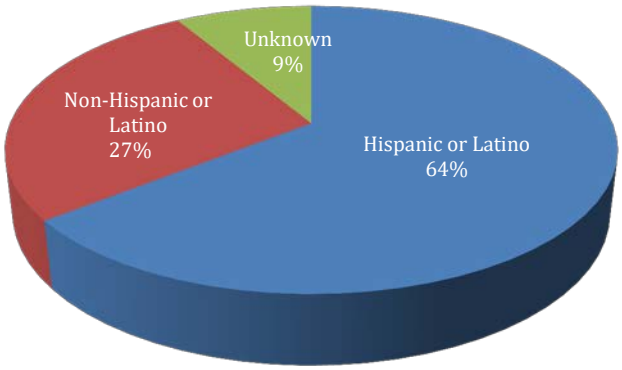
Primary Language
n=5,380



Race
n=5,380



Ethnicity
n=5,380



*Please note most unknowns are due to participants declining to answer.

Early Intervention

- 3,286 individuals were served through Early Intervention programs
- Over 20,000 services were provided
- 7,797 Brief Intervention Counseling services were provided to 1,841 individuals
- 908 services were provided to family members
- Individuals received an average of 4 counseling services

Prevention

- 1,692 individuals were served through Prevention programs
- Over 26,000 services were provided; 2,300 one-to-one support services or information and referrals
- Over 1,300 individuals participated in Promotores Programs throughout Stanislaus County
  - 1,580 services were dedicated to Promotora development, 905 focused on leadership
  - 1,197 one-to-one support sessions were provided by Promotores
  - Over 370 information and referral services were provided by Promotores
- 215 youth participated in leadership programs
- 572 presentations were given to more than 22,000 people through all PEI programs, covering the entire County; they focused on accessing services, stigma and discrimination reduction, suicide awareness, and recognizing the early signs of mental illness

Outreach for Increasing Recognition of Early Signs of Mental Illness & Stigma/Discrimination Reduction

- 3 BHRS trainings and 104 NAMI presentations were provided, specifically focused on recognizing early signs of mental illness and reducing stigma and discrimination
- Over 3,000 people were reached through these trainings and presentations
- Over 13,000 community members were reached through presentations including information about recognizing early signs of mental illness
- 1,115 potential responders, including peers, employers, teachers, and leaders of faith based organizations, were trained to recognize and respond effectively to early signs of mental illness
- Over 16,000 potential responders were reached through presentations
- Community members we are reaching have increased understanding and want to know more…
  - 92% (1,430/1,640) have a good understanding of mental illness and its symptoms
  - 82% (1,257/1,640) intend to learn more about mental illness

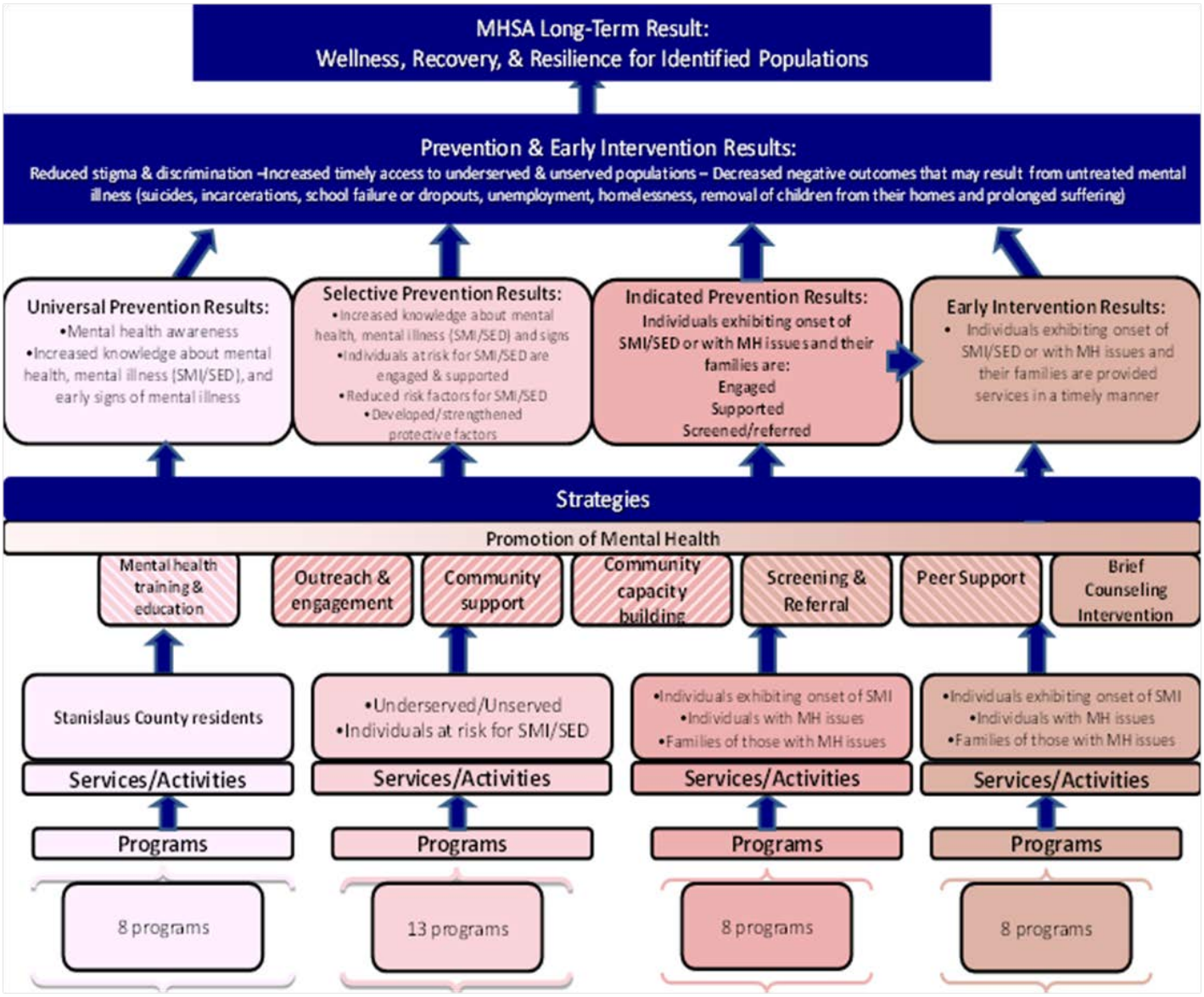
Suicide Prevention

- 1,656 calls were responded to through the Central Valley Suicide Hotline
  - 78% were concerned with mental health, social issues, or suicide
  - 40% (664) were crisis calls
  - 8 were “Talk Down” calls during which a high-risk caller was deterred from completing suicide;
  - 8 were “Active Rescues” when emergency services were contacted for the callers’ safety
- 1 Applied Suicide Intervention Skills Training and 1 Safe Talk suicide prevention trainings were provided
- 10 QPR (Question, Persuade, Refer), 1 Suicide Intervention for School Counselors, and 4 Youth Mental Health First Aid trainings were provided to school personnel across Stanislaus County
- 780 people were reached through these trainings and presentations

Access and Linkage

- 1,634 community members were reached through the dedicated Access and Linkage program
- 140 individuals in that program were connected to counseling services and 118 referred to other services
- 355 individuals across the system were referred to additional services, including treatment, community-based programs, and other prevention and early intervention programs
- 167 navigation services were provided that assisted individuals with transportation, appointments, and translation
- 59% of the referrals to treatment or early intervention were successful linkages
- 23 days was the average length of time from referral to all successful linkages
- 62% of the PEI services were provided outside of the office environment at homes, schools, places of worship, or Family Resource Centers

Theory of Change



EARLY INTERVENTION PROGRAMS

Program Description

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

Early Intervention Programs

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

Target Population

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

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

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

Services and Activities

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

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

Most Early Intervention programs provide services focusing on depression and anxiety through Brief Intervention Counseling, and the Patient Health Questionnaire-9 (PHQ-9) is used to help determine depression symptoms. However, LIFE Path services target those with early onset of psychosis (prodromal), and ART also targets students with early onset of SED. LIFE Path uses the Structured Interview for Prodromal Symptoms and Scale of Prodromal Symptoms (SIPS/SOPS) to determine early onset of psychosis.

Outreach, engagement, and access and linkage activities are integrated into Early Intervention programs to increase the effectiveness of the services. PEI regulations require that at least one program is dedicated to access and linkage. West Modesto King Kennedy Center has been identified as the program with this focus, and is described in the next section. However, all Early Intervention programs incorporate access and linkage activities and strategies.

In addition, all Early Intervention programs are committed to providing services that embrace the MHSA general standards:

- Community Collaboration
- Cultural Competence
- Client Driven
- Family Driven
- Wellness, Recovery, and Resilience Focused
- Integrated Service Experiences for clients and their families

See below in the Highlights section for specific examples of how programs champion these standards. The specific general standards addressed by the programs are indicated in parentheses after each highlight below.

FY 2016-17

Total MHSA Budget	Actual	Total Number Served*	Estimated MHSA Cost Per Participant
$2,477,069	$2,084,730	3,286	$634

*Unduplicated served

FY 17-18 Budgeted	FY 17-18 Projected	FY 18-19 Projected
$2,305,420	$1,822,021	$2,894,627

Highlights

Activities that bring about mental health and related functional outcomes and demonstrated effectiveness for the intended populations

- ***El Concilio*** support group members reported feeling less lonely and isolated, gained a sense of empowerment, improvement in coping skills, and reduced depression and anxiety. These services are also offered in Spanish. (2, 5)
- Students participating in Wellbeing Circles through ***RaPP*** built protective factors by taking part in check-ins within their classroom communities. Some students were also identified and referred to additional services by teachers and providers as needed. (1, 3, 4, 6)
- ***BHRS School Consultation*** staff facilitated Empathy Clubs at all school sites served, and connected and supported to their community by having dialogues about different terms that impact their school and wellbeing. The Empathy Club members also created friendship tables to support their peers who are struggling with making friends. This helped increase connection with each other and supports their wellbeing at school. (1, 3, 5, 6)
- ***BHRS School Consultation*** facilitated the establishment of a parent-led group focusing on building protective factors. Participants shared that the group enhanced their wellbeing, and they have increased parent involvement in the Waterford targeted schools. (1, 2, 3, 4, 5, 6)
- ***ART*** Well-being groups at Hutton House (a shelter for runaway and homeless youth) focus on basic coping skills, social and critical thinking skills, and engagement. According to self and staff reporting, the participating young people often use these skills in other areas of their lives. (1, 3, 5, 6)
- ***ART*** worked collaboratively with the Family Partnership Center to provide weekly parent and interactive child groups. The participating parents were actively engaged in shared learning and understanding of building protective factors through the *40 Developmental Assets*. (1, 3, 4, 5, 6)

Improved access to services for underserved populations

- The Mental Health clinician for ***Aging and Veteran Services*** has developed a close relationship with the Sociology Department staff and Master's program internship at California State University Stanislaus, resulting in an intern assisting with Brief Counseling. This results in increased access for the older adult population. (1)
- By offering PEI services in Spanish, ***Catholic Charities*** has helped to identify barriers that have previously prevented the Spanish speaking community from accessing services. There has been an increase in Spanish speaking clients seeking services with the agency directly related to community presentations, the radio spots and other outreach activities of the agency. (2)
- ***Aging and Veteran Services, Catholic Charities, El Concilio, and Golden Valley Integrated Behavioral Health, and Golden Valley Corner of Hope*** strategically offer counseling services, including support groups for El Concilio, in more accessible sites such as assisted living facilities, churches, health care centers, school and Healthy Start sites, and other community venues. This has allowed the clients with low incomes and/or poor transportation issues to seek mental health services. These counseling programs then can make referrals to other mental health services. (1, 2, 6)
- The ***Golden Valley IBH*** Patterson clinic provided behavioral health services three times per week, in both Spanish and English, and there is a language line that can be used for further support. Patients have shared that they feel comfortable being able to talk to a counselor that knows the Spanish language, making it easier for them to open up about stressors. (2, 3, 4, 6)
- ***Golden Valley Corner of Hope*** regularly disseminated information to the community by means of outreach at parks, under bridges, shelters, and other commonly known places where homeless individuals gather or access services. (2, 3, 4)
- ***Expanded Child Sexual Abuse Prevention and Early Intervention*** staff presented twice at CSU Stanislaus, reaching approximately 150 people each time. Presenting program information to this specific college population that is also culturally diverse is critical in reaching this underserved population. (1, 2, 3)
- ***LIFE Path*** facilitated Multi-Family Groups, which included Spanish interpretation services. These groups were important for family members and the success of the client. In addition, an Adult Life Skills Group encouraged the group to determine the topics discussed. (2, 3, 4, 5)

- ***Resiliency and Prevention Program (RaPP), BHRS School Consultation, Creating Lasting Student Success (CLaSS), and Aggression Replacement Training (ART)*** all played an important role in creating avenues for students to access services through the School Behavioral Health Integration initiative as services were offered at the site where students were already rooted. (1, 3, 6)
- ***Aggression Replacement Training (ART)*** collaborated with multiple high schools and junior high schools throughout the county, as well as Hutton House (a shelter for runaway and homeless youth) and Family Partnership Center (for families) that allowed the intended population to easily access services. (1, 6)
- ***BHRS School Consultation*** worked with both students and parents (Parent Café Model) through the schools to facilitate access and linkage to specialty mental health services and brief intervention counseling. (1, 3, 4, 5, 6)

Non-stigmatizing and non-discriminatory

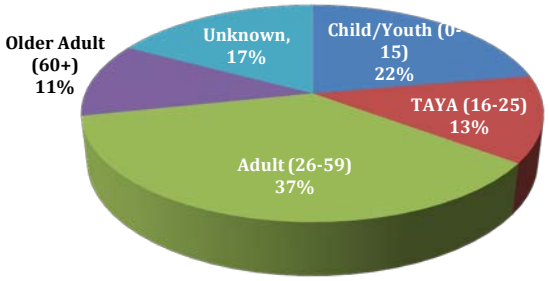
- All early intervention programs provided counseling and/or support services in community locations, which allowed individuals and families a means of receiving mental health services in a non-stigmatizing manner in a known and comfortable environment. (1, 2, 3, 4, 6)
- ***Golden Valley IBH and Corner of Hope*** served the whole health needs of approximately 37% of Stanislaus County MediCal clients. This includes medical, behavioral, and dental healthcare with case management, patient care coordination, and homeless care coordination. In addition to the environment being non-stigmatizing and non-discriminatory, it was also easily accessible and the service integration clearly espouses the MHSA standard of providing integrated service experiences for clients and families. (2, 3, 4, 6)
- The ***Golden Valley Corner of Hope*** clinician conducted community presentations with the homeless care coordinator, focusing on mental health awareness, mental and physical health, and stigma reduction. Participants shared that they feel confident about how to start the conversation with a patient with a mental health issue, and how to guide them towards appropriate help. (2, 6)
- ***RaPP*** utilized the mental health promotional materials, and informed and trained staff and parents regarding suicide prevention and community resources that assist in reducing stigma and discrimination. (1, 3, 4, 5, 6)
- ***CLaSS*** emphasized stigma reduction, especially during Mental Health Awareness month. Green ribbons were distributed and posters hung that have rip-off tags describing what to say or do if someone is sad, lonely, or worried. These resource materials were very successful at four school sites. (1, 3, 5, 6)

Challenges

- Hiring and retaining full-time bilingual counselors who can provide services in Spanish (threshold language), and other emerging languages in the community, has been a consistent challenge.
- Stigma, misconception, and fear continued to be a challenge for parent engagement. Adult male Latinos seem to be a difficult group to engage for mental health awareness information, workshops and direct client services.
- Clinicians have reported an increase in the number of “no shows” for brief intervention counseling services, which creates gaps in services. Capacity is affected, and it was necessary to create wait lists.
- Although PEI programs strive to provide culturally appropriate services, this continued to be a challenge, regardless of staff composition. It was recognized that creating trusting relationships with community members are critical to providing services sensitive to cultural nuances.
- Engaging the homeless population in early intervention services, including outreach, case management, and counseling, continued to be challenging.
- Engaging parents and teachers has been difficult within school environments when providing youth early intervention services.
- Consistent staffing can be a challenge in Early Intervention programs.

Early Intervention
FY 2016-17
3,286 Individuals Served

Age
n= 3,286



Primary Language
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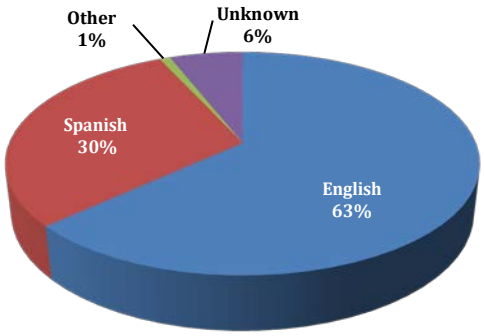

Race
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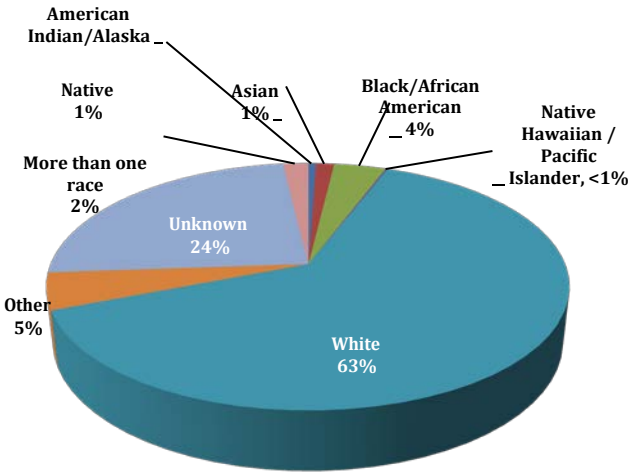

Ethnicity
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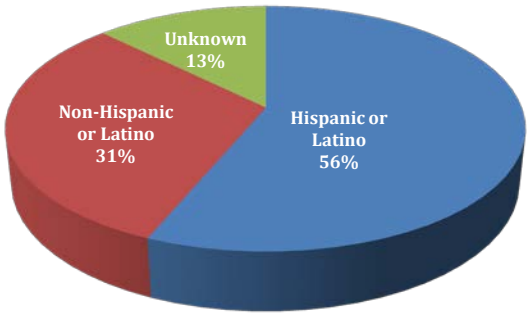


**Please note most unknown are due to participants declining to answer.*

PREVENTION PROGRAMS

Program Description

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

Prevention Programs

- **Peer Recovery Art Project**
- **RAIZ Promotores Program** *(Latino community in each of the dedicated cities/regions)
  - AspiraNet – Turlock
  - Center for Human Services – Ceres, Newman, Patterson
  - Oak Valley Hospital District – Oakdale
  - Riverbank Unified School District – Riverbank
  - Sierra Vista Child and Family Services – North Modesto/Salida, Hughson/Waterford/Denair/Empire/Hickman
  - West Modesto King Kennedy Center – West Modesto
- **Youth Leadership Initiative**
  - Center for Human Services – My Life Plan *(at-risk youth and TAYA in Patterson, Wesley, Grayson areas)
  - Sierra Vista Child and Family Services – The BRIDGE *(at-risk South East Asian youth and TAYA in West Modesto area)
  - Sierra Vista Child and Family Services – Hughson Youth Leadership *(at-risk youth and TAYA in greater Hughson Unified School District area)
  - BHRS – South Modesto Youth Leadership *(at-risk youth and TAYA in South Modesto area, including Spanish-speaking)
  - West Modesto King Kennedy Center – Leadership for the Future *(at-risk youth and TAYA in West Modesto area, including Spanish-speaking)
- **Collaboratives**
  - Assyrian Wellness Collaborative - Assyrian Community
  - LGBTQ-A Collaborative – LGBTQ-A Community
  - Stanislaus Asian American Community Resource-SAACR - Asian Americans
- **BHRS – Friends are Good Medicine**

Target Population

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

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

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

Services and Activities

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

Outreach, engagement, and access and linkage activities are integrated into Prevention programs to increase the effectiveness of the services. PEI regulations require that at least one program is dedicated to access and linkage. West Modesto Early Intervention has been identified as the program with this focus, and is described in the next section. However, all Prevention programs incorporate access and linkage activities and strategies.

In addition, all Prevention programs are committed to providing services that embrace the MHSA general standards:

- Community Collaboration
- Cultural Competence
- Client Driven
- Family Driven
- Wellness, Recovery, and Resilience Focused
- Integrated Service Experiences for clients and their families

See below in the Highlights section for specific examples of how programs champion these standards. The specific general standards addressed by the programs are indicated in parentheses after each highlight below.

FY 2016-17

Total MHSA Budget	*Actual*	*Total Number Served**	*Estimated MHSA Cost Per Participant*
$1,420,236	***$1,166,657***	***1,692***	***$690***

*Unduplicated served

FY 17-18 Budgeted	*FY 17-18 Projected*	*FY 18-19 Projected*
$1,277,214	***$937,951***	***$1,694,440***

Highlights

Activities that bring about mental health and related functional outcomes and demonstrated effectiveness for the intended populations

- ***Ceres Promotores*** successfully connected male Latinos to Early Intervention BIC services. These participants have self-reported high improvement on several of their mental health problems. (2, 3, 5)
- ***Ceres Promotores*** engaged 50 youth with activities that improved wellbeing and self-confidence. The focus was on addressing academic stress, relationships, identifying individual gifts and talents, building confidence and trust, and increasing healthy cultural and ethnic identities. Parents were also provided tools to support their children's wellbeing, and encouraged to stay involved. (1, 2, 4, 5)
- Participants of the ***Ceres Promotores*** leadership group were honored for their service to the community of Ceres in increasing the wellbeing of the community through the promotion of mental health and community building. Many voiced that they feel healthier, more productive and connected, and have an increased sense of worth. They also expressed that they gained knowledge and skills to communicate better; are less shy, more confident, and knowledgeable about mental health resources in our county. (1, 2, 5)
- Fifteen ***Hughson Community Promotores*** were trained as leaders. They subsequently planned and executed two summer camps in the communities of Denair and Waterford. The camps encouraged parent and child relationships, and promoted mental health with various parent/child activities. (1, 2, 5)
- Ten ***Newman Community Promotores*** were trained as leaders, and are utilizing their new skills through classes and engagement groups in their community, including groups focusing on issues related to mental health in the Latino community. (1, 2, 5)
- Eleven individuals were trained as ***North Modesto Community Promotores.*** This group of leaders expressed that they have become more open minded in regards to mental health conditions, and have additional interest in different aspect of mental health and how to increase the community's awareness and access to resources. (1, 2, 5)
- ***North Modesto Promotores*** shared how becoming a Promotora helped them in their efforts to build a richer and fuller life for their families; what they learned about mental health; and how beneficial it is to build lasting relationships, be more aware when monitoring personal wellbeing, and have a safe space to begin such practices. (1, 2, 5)
- ***Patterson Promotores*** are using their leadership skills in a variety of ways throughout their community:
  - Representatives on the English Learner Advisory Committee (ELAC) for their schools, some holding positions of President and Secretary and
  - Member of community agencies and faith based committees
  - Serving in civic groups
  - Volunteering for multiple organizations that serve the community
  - Board member for the Westside Health Task Force (1, 2, 3, 5)
- ***Riverbank Promotores*** led the Café en Viernes sessions, providing a welcoming, safe, and supportive environment for dialogue. Group participants elected the mental health discussion topics and relate what they learned to personal experiences. Participants shared that the open dialogue was therapeutic, made them feel better, and improved their emotional state. (1, 2, 5)
- ***Turlock Promotores*** led engagement groups that focused on the early signs of mental illness, stigma, and discrimination. Many participants recognized that before they attended the groups, they were struggling with stress, social isolation, sadness, and family problems, adjusting to their new community (those who moved from other California cities, Mexico or Latin America). They have expressed that their lives have been transformed by joining the groups and have a greater sense of belonging, self- leadership, self-confidence, and love by gaining new friends. They also feel that their skills improved and their knowledge in self-care and prevention increased. (1, 2, 5)
- Fifteen ***West Modesto Community Promotores*** led groups and listened to feedback about what challenges and needs are priorities in the community. This led to participants feeling as though they had a place where they belonged, and many new participants came back. They also encouraged their friends and neighbors to participate in the programs and to reach out for services and resources they may need. (1, 2, 5)
- ***West Modesto Promotores*** participants gained confidence and spoke up about their issues, fears, and obstacles. This dialogue amongst themselves created a platform for discussion about mental health, self-care, community involvement, and overall well- being. (1, 2, 3, 5)
- ***Friends Are Good Medicine*** connected with mental health consumers at local psychiatric hospitals, providing hope through peers who have experienced similar issues and have been able to recover with peer support. (5, 6)

- ***Friends Are Good Medicine*** trained almost 100 people in becoming faciliators of Self- Help Groups. These trainings empower individuals, increasing their confidence and own recovery and wellness. An example is an individual who started a group for those going through kidney dialysis procedures. (3, 5)
- ***LifePlan*** facilitated 82 youth groups among three school sites. A strong partnership with the schools and working relationships with staff and administration was critical for Lifeplan to be successful and to expand. Focused on youth empowerment and leadership, the conversations also surrounded mental health and wellbeing, as well as suicide awareness and the impact suicide has had on their lives. During the end-of-year celebrations, students shared how their positive experiences with the program impacted them. (1, 2, 3, 5, 6)
- ***The Bridge Youth Builder*** program fosters youth empowerment through both Western and Eastern cultural activities, service-learning projects, mentoring, and tutoring. The youth are encouraged to "take charge" and plan and implement their own activities. They are mentored and tutored, and in turn, are taught to mentor and tutor younger children. Career awareness and job readiness are also actively discussed. (1, 2, 3)
- ***West Modesto Leadership for the Future*** convened regularly in groups, involving 221 youth in discussions about themselves and their community. Youth also participated in a forum with another high school and UC Merced students to discuss community issues. Homelessness, mental health and gangs surfaced as important issues in their communities. They also shared what they learned from the mental health stigma reduction and suicide prevention workshops, advocating for the need for more services and resources for their community. (1, 2, 3, 5)
- ***South Modesto Youth Leadership Network's (SMYL)*** core purpose is to connect with peers within the community. This group of youth met this goal and increased their own protective factor:
  - Presented to youth in Spanish at another school when they saw a need, engaging and encouraging participation
  - Planned and implemented a trip to UC Santa Cruz to encourage college enrollment and understand what a University offers for mental health
  - Engaged in supportive relationships with peers and adults, defining boundaries and expectations
  - Developed problem solving skills by working together on a service project that challenged their group dynamics (assembling two bicycles and giving them to community members) (1, 2, 3, 5)
- ***Hughson YOUth in ACTion*** focused on youth engagement and development, community connection, and reaching youth and potential responders with information and awareness about mental health.
  - Ten community service projects promoted engagement in the community and offered a sense of belonging, as indicated in the youth's feedback.
  - Monthly groups fostered connections, and built trust in order to have open discussions regarding self-care and emotional challenges.
  - Leadership trainings and presentations developed the youths' skills
  - An Empowerment Rally in collaboration with the City of Hughson and Stanislaus County Sherriff's Department engaged youth and their families in a powerful and meaningful way that also reduced stigma and encouraged supportive connections. (1, 2, 3, 4, 5)

Improved access to services for underserved populations

- ***Ceres Promotores*** worked with Managed Care Plans and other mental health service providers to promote physical and mental health through workshops targeting parents of young children and women. Access issues were addressed for the Latino population. (1, 2, 5, 6)
- ***Hughson Promotores*** participated in a variety of outreach events, including local festivals, fairs, and service activities across the Southeast Stanislaus communities. The focus is on promoting access to appropriate services, including support groups and mental health treatment, as well as opportunities for leadership. (1, 2, 3)
- The Waterford Family Resource Center opened as a satellite office where ***Promotora*** support groups, one-to-one sessions, and network meetings are facilitated. Partners in the community have been identified that support Spanish speaking families, including school principals, counselors, and teachers, as well as community churches and the Bentley Health Center. (1, 2, 5, 6)
- ***Newman Promotores*** partnered with numerous local health providers to promote mental health and provide access information. (1, 2, 6)
- ***Oakdale Promotores*** reached out to over 200,000 Spanish speakers through a local radio station to create awareness and provide information about mental health services. (1, 2)

- ***Oakdale Promotores*** have shared information about accessing therapy services for Spanish speakers in the Oakdale community. Many families in the rural community have had a challenge in the past reaching out for needed mental health resources and help because of transportation issues, language barriers, and the uncertainty of how to access mental health services. (1, 2, 5, 6)
- ***Patterson Promotores*** were concerned with suicides that had occurred in the community and felt the need for more preventative work at a larger scale. Staff requested support from PEI for a collective structure to achieve social change and support community regarding wellbeing in conjunction with the Suicide Prevention Innovation Project. This is an ongoing effort to connect those in need of mental health services in a timely manner, and includes representation from local government, BHRS, first responders, public health, school districts, local health board officials, & community members. (1, 2, 5)
- ***Turlock Promotores*** connected community members participating in engagement groups with mental health services for themselves or relatives struggling with mental health issues. Promotores shared that as their groups learned there is help available, and that they should not be ashamed or afraid of asking for help, they felt more confident about reaching out for help. (1, 2, 3, 5, 6)
- The success of the ***West Modesto Promotores*** groups has led to an increase in the number of referrals to early intervention mental health services. Thirty participants were referred for mental health services, and 70% engaged in services. (1, 2, 5, 6)
- ***All Promotores Programs*** continued to improve access to mental health services for the Hispanic/Latino population by providing information and referrals after building trust within their respective communities. (2, 5)
- ***All Promotores Programs*** nurture the relationships with other community assets in order to improve mental health services access and the well-being of children, youth, adults, and elders, especially in the Hispanic/Latino communities. (1, 2, 5)
- ***Peer Recovery Art Project*** participated in several well-known events throughout the year, distributing materials and answering questions about access, reaching unserved and underserved populations and provided access information in non-stigmatizing venues.
  - Farmers' Market twice a week, reaching about 400 individuals and families
  - The Graffiti Car Show annually, reaching almost 100 individuals and families
  - Community Art Walk every month, reaching about 80 attendees (1, 2)
- ***Friends Are Good Medicine*** was present at a variety of events to answer questions about access to support groups and peer support. One event, the "Out of Darkness Walk" focused on raising awareness and reducing stigma associated with suicide. (1, 5)
- ***Hughson YOUth in ACTion*** participated in outreach events (28), community service projects, mental health presentations, and a youth rally. Participants gained knowledge on how to identify suicidal symptoms and how to access services. These events engage individuals and educate them about mental health services and support, and are designed to be an initial stage in the process of engaging individuals at risk for mental illness, individuals with early signs of mental health illness as well as first responders who can identify, support and provide referrals for these individuals. (1, 5)

Non-stigmatizing and non-discriminatory

- A young man who has Down syndrome and congenital heart disease became a trained ***Hughson Promotores*** leader, graduating from the RAIZ Promotores program. When he first attended meetings, he did not make eye contact, nor did he speak or interact with anyone except his stepmother. After a few months, this community leader engages with the network group and shares his gift with the community. He continues to grow in his leadership skills and feels part of the network group. (2, 3, 5)
- ***Newman Promotores*** has increased outreach efforts, increasing participation. Evidence that there is decreasing stigma in the Hispanic/Latino community around mental health, the community is now requesting information about mental health topics and activities to improve their mental health, resilience, and wellness. (2, 5)
- ***North Modesto Promotores*** partnered with schools and other groups to present information to the community about mental health wellness, and early signs of mental illness. The focus was on reaching Latinos at risk, and the culture was factored into the presentations to ensure cultural relevance and better understanding of the participants. A Community Anti-Stigma Event was also held, and those in attendance shared how shocking and rewarding it was for such a "taboo" topic to be openly discussed in the Latino community. (1, 2, 5)

- ***Oakdale Promotores*** have helped decrease the stigma of mental health issues by bringing such topics of stress, anxiety, suicide, schizophrenia and depression to the forefront during community group discussions. Now, engaged individuals feel more comfortable to speak about these issues and then are shared by the participants at their homes, schools, and stores. Engaged individuals have reported that their sense of shame, due to stigma and discrimination, has decreased because of what they have learned. (1, 2, 5)
- ***Patterson Promotores*** provided a mental health topic once a month in the existing nutrition group at the Patterson Family Resource Center that included topics such as forgiveness and strengthening relationships. Stigma was decreased through this venue. (1, 2, 5)
- ***Riverbank Promotores*** led a youth-focused event about mental health, mental illness, and stigma "Ponte en mis zapatos" (Put yourself in my shoes) was executed with students in 7th and 8th grades who were primarily Hispanic/Latino. It promoted positive mental health and healthy relationships to approximately 90 youth. (1, 2, 5)
- ***West Modesto Promotores*** participated in multiple events that helped decrease stigma, including the Promotora Spring Family Day that brought approximately 200 community members to Mellis Park to learn about mental health and stigma reduction. There were community resource booths, refreshments, games, and activities for the children. (1, 2, 5)
- ***All Promotores Programs*** implemented at least one large-scale Stigma and Discrimination Reduction event that was relevant and appropriate for their communities. (1, 2, 5)
- ***All Promotores Programs*** offered activities and groups, many through cultural traditions and customs (such as dance groups), that focused on increasing mental health and wellbeing, as well as provided access to information to mental health treatment services when appropriate. (1, 2, 3, 5)
- ***All Promotores Programs*** partnered with community entities such as agencies, organizations, faith based groups and churches, and schools to bring information about mental health to the community through venues that are non-stigmatizing and non- discriminatory.
- ***Peer Recovery Art Project's*** community building event "Day of Hope" was designed to instill a message of hope in mental health consumers, families, educators, and service providers and spreading the *Each Mind Matters* message. It included speakers from various agencies representing state and county organizations as well as youth, consumers, and faith based representation. (1, 2, 3, 4, 5)
- ***Peer Recovery Art Project and Stanislaus County Office of Education*** facilitated a Friend to Friend Conference with over 600 youth, educators, and community members in attendance. Youth were engaged in art workshops, art was displayed, and peers answered questions and distributed *Each Mind Matters* materials. (1, 2, 3, 5)
- The ***Bridge Youth Builders*** completed service-learning projects that helped connect the youth to community and each other, increasing wellbeing in a non-stigmatizing manner. The projects included gardening/landscaping, a greenhouse project, mural touchup project, Back-to-School event, Bridge clean-up, The Bridge Community Center sign, HEAP (Home Energy Assistance Program) prep, and a Spring Picnic to promote mental health and well-being. (1, 2, 3, 5)
- ***West Modesto Leadership for the Future*** held Mental Health Stigma and Discrimination Presentations, reaching over 100 youth.
- ***YOUth in ACTion*** held 12 Mental Health presentations that included opportunities for conversation and dialogues that engage youth in active discussion related to stigma, mental health, and wellbeing. Youth also passed out green ribbons at Hughson High school giving them an opportunity to dialogue about mental health and stigma reduction in celebration of Mental Health awareness month. Strong collaborations with the schools and churches in the community offered this opportunity to reach youth and early responders in a non-stigmatizing and non-discriminatory manner. (1, 2, 3, 4, 5)

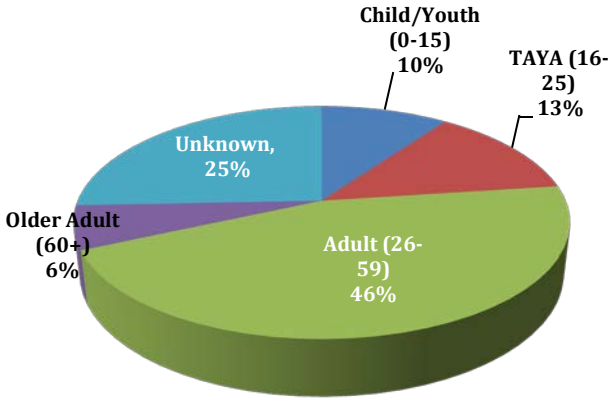
Challenges

- ***RAIZ Promotores Mental Health Prevention Program***
  - Promotores experience stigma, discrimination, and fear. In some cases, women seeking services fear that spouses or courts will take their children away if they know they live with a mental health challenge.
  - Promotores face timely access challenges when providing referrals to mental health providers; most do not have appointments for one to two weeks, which is discouraging when community members have the courage to take that first step to address mental health issues.
  - Undocumented women are fearful that they or their partner/spouse will be deported, or it will negatively impact their opportunity for U.S. citizenship, when seeking services for trauma, depression, and anxiety.
  - Delivering quality services can be impacted with the challenge of physical space and staff to participant ratios in programs with increasing numbers of participants.

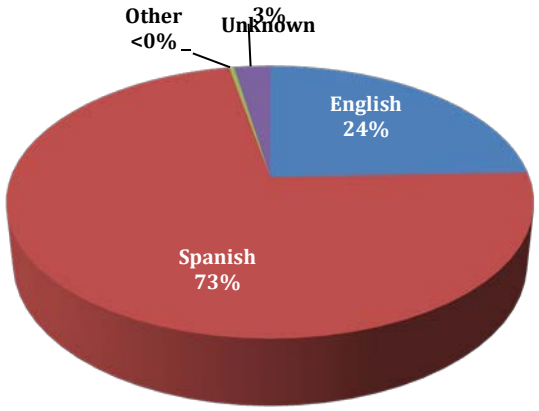
- ***Youth Leadership and Resiliency Programs***
  - It is challenging to recruit and retain youth members with competing priorities.
  - Parental permission can be difficult to obtain.
  - Transportation is a barrier that decreases participation and at times prevents youth from participating altogether.
  - The lack of consistent and adequate meeting spaces can also be a barrier.
- ***Other Prevention Programs***
  - Challenges with staffing can have a direct effect on programs. Shortages and inconsistent leadership can lead to negative impacts on the services and program outcomes. However, programs have been resilient and have continued to prioritize quality of services.

Prevention
FY 2016-17
1,692 Individuals Served

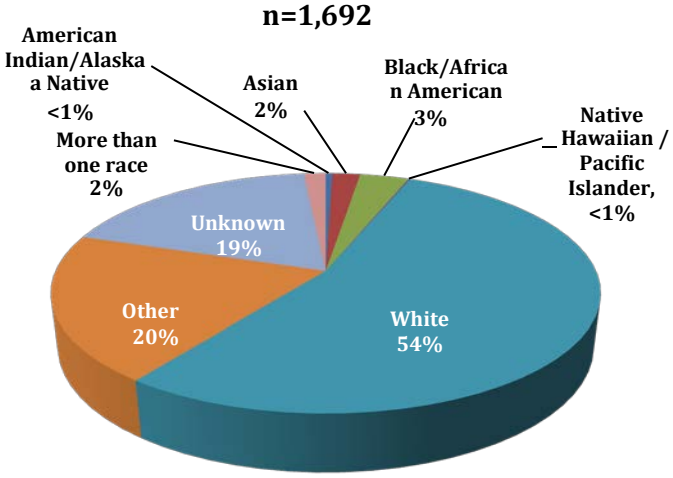
Age
n= 1,692



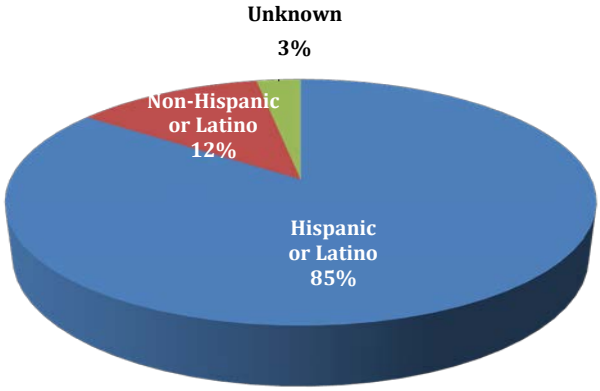
Primary Language
n=1,692



Race
n=1,692



Ethnicity
n=1,692



*Please note most unknowns are due to participants declining to answer.

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

Program Description

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

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

Outreach Programs for Increasing Recognition of Early Signs of Mental Illness

- **Each Mind Matters Campaign**
- **Know The Signs**
- **BHRS – Community Trainings**
  - Mental Health First Aid (MHFA) (potential responders/gatekeepers)
  - Youth Mental Health First Aid (potential responders/gatekeepers)
  - Mental Health First Aid – for Spanish speakers (Spanish speaking community)
- **NAMI (National Alliance on Mental Illness)**

Stigma Discrimination Reduction Programs

- **Each Mind Matters Campaign**
- **Know the Signs**
- **CalMHSA Contribution**

Suicide Prevention Programs

- **Each Mind Matters Campaign**
- **Know the Signs**
- **BHRS – Community Trainings**
  - ASIST (Applied Suicide Intervention Skills Training) (potential responders/gatekeepers)
  - Safe Talk *(potential responders/gatekeepers)
- **Stanislaus County Office of Education (SCOE)– Training/Education** (Youth, TAYA, potential responders/gatekeepers)
- **Kingsview – Central Valley Suicide Prevention Hotline** (individuals with suicidal ideation or at risk)

Target Population

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

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

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

Services and Activities

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

- PEI staff, other BHRS staff, and contracted partners are trainers for the following trainings that are provided free of cost to the community and targeted populations across the county:
  - Mental Health First Aid (MHFA)
  - Youth Mental Health First Aid
  - Applied Suicide Intervention Skills Trainings (ASIST)
  - NAMI Provider Education Course
  - Toward Effective Self Help Group Facilitator training
- PEI also provides staff support to several cross-cultural community-based collaborative/partnerships that help promote emotional health and wellbeing by decreasing stigma, disparities, and barriers to mental health resources.
- Stigma and discrimination reduction activities also include presentations, trainings, and events, marketing campaigns, speakers' bureaus, and efforts to encourage self- acceptance for individuals with a mental illness. All PEI programs integrate one or more of these activities in their program delivery.
- A primary suicide prevention service offered through PEI is the suicide hotline provided by the Central Valley Suicide Prevention Hotline (CVSPH). CVSPH is nationally accredited by the American Association of Suicidology and operates the hotline 24 hours a day, 7 days a week, ensuring that our county residents have access to suicide prevention support and emergency services when appropriate.
- Other suicide prevention activities include campaigns, training, and education focused on suicide information and prevention.
- CalMHSA provides support in the areas of suicide prevention and stigma and discrimination reduction, and also is the fiscal agent for CVSPH.

Outreach, engagement, and access and linkage activities are integrated into these programs to increase the effectiveness of the services. PEI regulations require that at least one program is dedicated to access and linkage. West Modesto King Kennedy Center has been identified as the program with this focus. However, all programs incorporate access and linkage activities and strategies to the extent possible

In addition, all PEI programs are committed to providing services that embrace the MHSA general standards

- Community Collaboration
- Cultural Competence
- Client Driven
- Family Driven
- Wellness, Recovery, and Resilience Focused
- Integrated Service Experiences for clients and their families

See below in the Highlights section for specific examples of how programs champion these standards. The specific general standards addressed by the programs are indicated in parentheses after each highlight below.

FY 2016-17

Total MHSA Budget	*Actual*	*Total Number Served**	*Estimated MHSA Cost Per Participant*
$381,453	***$490,335***	***1,671***	***$293***

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

FY 17-18 Budgeted	*FY 17-18 Projected*	*FY 18-19 Projected*
$ 1,277,214	***$ 937,951***	***$ 1,694,440***

Highlights

Activities that bring about mental health and related functional outcomes and demonstrated effectiveness for the intended populations

- ***Central Valley Suicide Prevention Hotline*** staff responded to 1,656 calls, listening to and assisting callers who needed to be heard. (3, 4, 5)
- ***SCOE – Training/Education*** offered three new training programs to better support school based mental health clinicians and build resiliency in students.
  - Training for graduating high school students headed to college and their parents focused on wellness and resiliency strategies for college and communication strategies for parents and college students to use during the transition into independent adulthood
  - Two trainings developed to help school counselors build intervention skills for students who are showing signs of suicide and how to address the needs of youth exposed to trauma. These were very successful trainings. (1, 3, 4, 5)

Improved access to services for underserved populations

- ***Central Valley Suicide Prevention Hotline*** staff is trained to provide resources and referrals to local mental health services when appropriate. (5)
- ***Central Valley Suicide Prevention Hotline*** operated 24 hours a day, 7 days a week and provided services in Spanish, and interpreters in over 150 languages. (2, 5)
- ***SCOE – Training/Education*** collaborated with a new and motivated partner from Modesto Junior College. The new partner at MJC helped launch new events there, strengthened ongoing activities and boosted collaboration with other activities scheduled with SCOE and CSUS. As a result, additional events were held to support the mental wellness of college students at CSUS and MJC and to help increase access to mental health services. (1, 3, 5, 6)

Non-stigmatizing and non-discriminatory

- Participants trained in ***Mental Health First Aid*** responded very positively to the information. One participant stated, "This gave me a lot of insight about the subject matter and this is something all people should be aware about." (5)
- ***Mental Health First Aid*** participants were exposed to information about mental illness and stigma. One of the goals of the training is to reduce stigma, and one participant shared, "I felt it has helped me be more open minded in reducing stigma surrounding mental illness." (5)
- ***BHRS Community Trainings*** filled up quite quickly and there continues to be increased interest of community members in the Mental Health First Aid Trainings. (1, 5)
- ***BHRS Training*** added 3 new Mental Health First Aid trainers in order to meet the community demand for the training. (1, 5)
- All PEI programs were contracted to distribute ***Each Mind Matters, Know the Signs*** materials and present relevant information to their communities. (1, 5)
- Fifteen ***NAMI*** speakers presented to schools, colleges, medical providers, churches, community groups, Probation, and Promotores in non-stigmatizing environments. (1, 2, 5)
- ***NAMI*** activities were featured in *The Modesto Contentment Magazine*. The article was entitled "NAMI fights for Mental Health Awareness" and focused on the NAMI Walk, NAMI on Campus (at Modesto Junior College and CSU Stanislaus), and two of NAMI's speakers. (1, 5)
- ***BHRS Community Training*** began offering Safe Talk, 3-hour suicide alertness training. It has received very positive response. (5)
- ***Safe Talk*** participants learned to recognize signs of suicide. One participant shared, "Very good eye opening. I feel better prepared." Another stated, "I found the training very informative. I think it is a great benefit to recognize signs to be able to help those in need." (5)
- ***Central Valley Suicide Prevention Hotline*** received National Accreditation and is recognized as a best practices call center by the American Association of Suicidology. (5)
- ***SCOE – Training/Education*** again participated in the college collaborative, which organized six events serving students and staff at both colleges. Film screenings were offered on topics related to mental wellness and internationally renowned experts on addiction and suicide recovery. The collaboration agreed to continue to meet at least quarterly to continue working to advance mental wellness across all levels of education systems, even when funding ended. (1, 5, 6)

Challenges

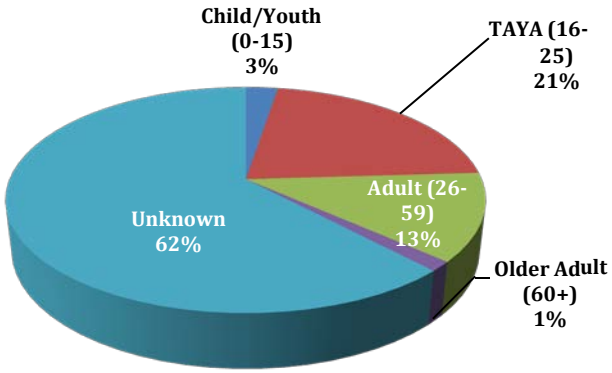
- ***Trainings***
  - It is a challenge to meet the demand of the community for trainings.
  - Trainers leave organizations (one MHFA trainer and one ASIST trainer), and that means some trainings could not be offered.
  - It is expensive to train trainers, and sometimes trainings are not offered when needed (ASIST).
- ***NAMI***
  - Recruiting and retaining bilingual Spanish/English presenters is difficult.
  - It takes time to build the capacity of speakers to convey their stories and make lasting connections.
  - It is challenging to present in rural communities consistently.
  - Connecting with school sites can be difficult.
- ***Stanislaus County Office of Education – Training/Education***
  - A challenge throughout all of the school districts was the availability of school personnel to attend Mental Health First Aid training. The time allocated for professional development has been negotiated by represented groups, therefore the inability to consistently host more workshops
  - Low registration numbers can prevent workshops from being conducted.
- ***Central Valley Suicide Prevention Hotline***
  - A challenge has been educating the public about the phone number, as a way of reducing and eliminating the stigma associated with utilizing this type of support.
- ***West Modesto King Kennedy Neighborhood Collaborative Community-Based Early Intervention Services (WMKKNCCBEIS)***
  - The clinician does not have time to provide case management services. The population needs follow up between the times they see the clinician.
  - There is an increase of requests from parents to provide mental health treatment interventions for their children.
  - The allocated time to see clients is not enough, especially for the monolingual clients who feel that more time is needed in the process for explanation and delivery of services.

Outreach for Increasing Recognition of Early Signs of Mental Illness

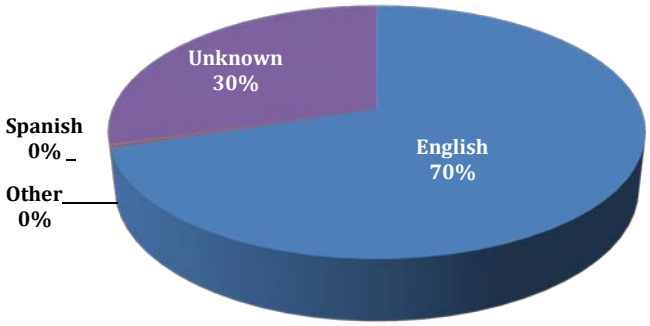
FY 2016-17

1,671 Individuals Served

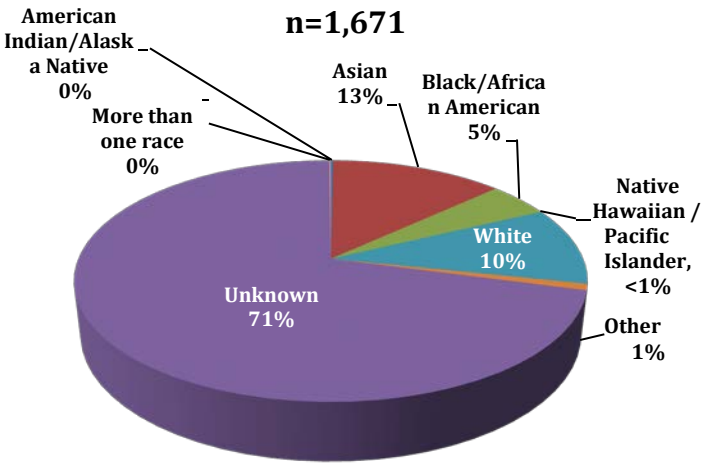
Age
n= 1,671



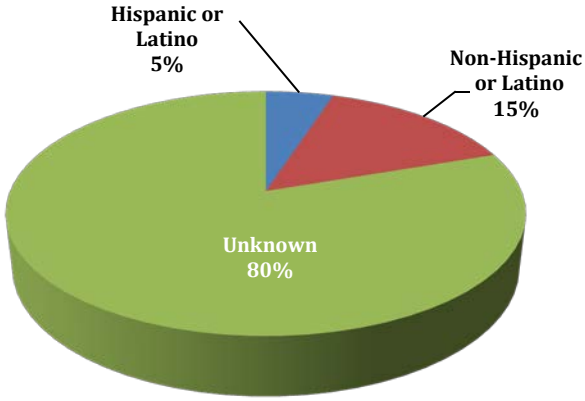
Primary Language
n=1,671



Race
n=1,671



Ethnicity
n=1,671



*Please note most unknowns are due to participants declining to answer.

Access and Linkage
West Modesto Early Intervention

Program Description

Access and Linkage to Treatment means connecting children with severe mental illness, and adults and seniors with severe mental illness as early in the onset of these conditions as practicable, to medically necessary care and treatment, including but not limited to care provided by county mental health programs. Examples include focusing on screening, assessment, referral, and/or mobile response.

Access and Linkage Program: *West Modesto King Kennedy Neighborhood Collaborative Community-Based Early Intervention Services (WMKKNCCBEIS)*

Target Population

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

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

West Modesto Early Intervention program primarily serves the geographic community of West Modesto and the underserved/unserved populations within it. The program serves mostly adults and older adults, and all races and ethnicities. Staff is also bilingual Spanish/English to serve the Spanish speaking population.

Services and Activities

All PEI programs are designed and implemented to help create access and linkage to treatment and improve timely access to mental health services for individuals and families from underserved populations when appropriate. Services are provided in convenient, accessible, and culturally appropriate settings using strategies that are non-stigmatizing and non- discriminatory.

Outreach, engagement, and access and linkage activities are also integrated into all programs to increase the effectiveness of the services. PEI regulations require that at least one program is dedicated to access and linkage. West Modesto King Kennedy Neighborhood Collaborative Community-Based Early Intervention Services has been identified as the program with this focus. However, all PEI programs incorporate access and linkage activities and strategies, and West Modesto King Kennedy Neighborhood Collaborative Community-Based Early Intervention Services is also a program providing Brief Intervention Counseling (BIC) services.

In addition, all programs are committed to providing services that embrace the MHSA general standards:

- Community Collaboration
- Cultural Competence
- Client Driven
- Family Driven
- Wellness, Recovery, and Resilience Focused
- Integrated Service Experiences for clients and their families

See below in the Highlights section for specific examples of how programs champion these standards. The specific general standards addressed by the programs are indicated in parentheses after each highlight below.

FY 2016-17

Total MHSA Budget	Actual	Total Number Served*	Estimated MHSA Cost Per
$381,453	$490,335	1,671	$293

*Unduplicated served

FY 17-18 Budgeted	FY 17-18 Projected	FY 18-19 Projected
$373,843	$336,890	$653,574

Highlights

Activities that bring about mental health and related functional outcomes and demonstrated effectiveness for the intended populations

- To strengthen treatment effectiveness and outcomes for individuals:
  - Clinicians engaged community through outreach, advocacy, attending meetings, and visiting with community partners and staff, to ensure the quality of care and effectiveness of services. They provided access information and linkage assistance, and then followed up to ensure the linkage occurred. (1, 3, 4, 5, 6)
  - Cultural and linguistically appropriate approaches to mental health treatment interventions were provided. Responsive care required clinicians to recognize and address clients' behaviors, values, practices, attitudes, and beliefs as they improved their physical and mental health. (2, 3, 5)
  - Clients received the resources to succeed and stay independent in the community. (3, 5)

Improved access to services for underserved populations

- The program maintained a strong connection to other programs, including Promotores, ensuring that individuals could be identified and linked to appropriate services. (1, 5, 6)
- Early Intervention BIC groups had been created, but the program's Community Liaison started the Prevention Engagement Group to more effectively connect individuals to services. A total of 23 groups were held with a total attendance of 181 individuals. Attendance was consistent, and approximately 50% of the group attendees were linked to counseling services as well. (3, 5, 6)
- Through outreach at five events, staff provided mental health and access information to over 1,000 participants. (1, 5)

Non-stigmatizing and non-discriminatory

- Client retention and timely access to mental health services increased by clinicians building trust and rapport and being culturally and linguistically responsive while communicating with clients who were from various ethnic and cultural backgrounds. In an effort to reduce stigma and to help clients to access behavioral health services, clinicians provided a safe place for clients to come and not feel shamed or judged. (2, 3, 5)
- The Community Liaison and Clinician conducted six Mental Health and Stigma Reduction presentations to 182 attendees. (1, 5)

Challenges

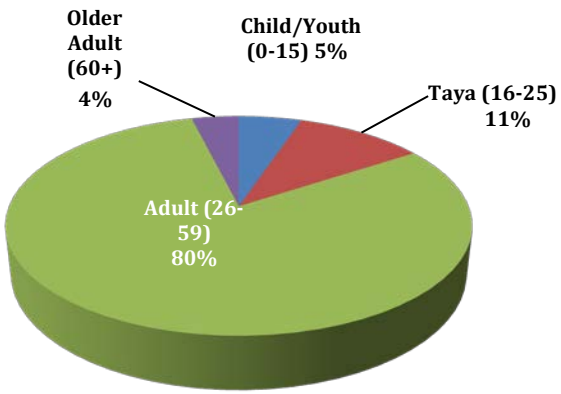
- The clinician did not have enough time to provide case management services. The population needs follow up between the times they see the clinician.
- There was an increase of requests from parents to provide mental health treatment interventions for their children.
- The allocated time to see clients was not enough, especially for the monolingual clients who feel that more time is needed in the process for explanation and delivery of services.

Access and Linkage

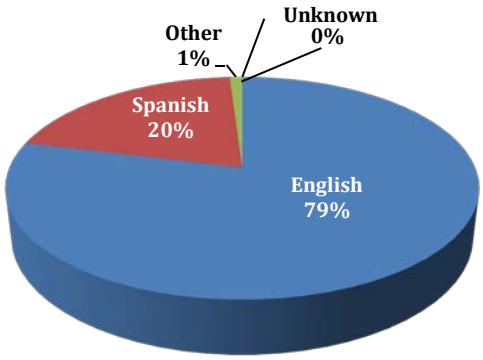
FY 2016-17

387 Individuals Served

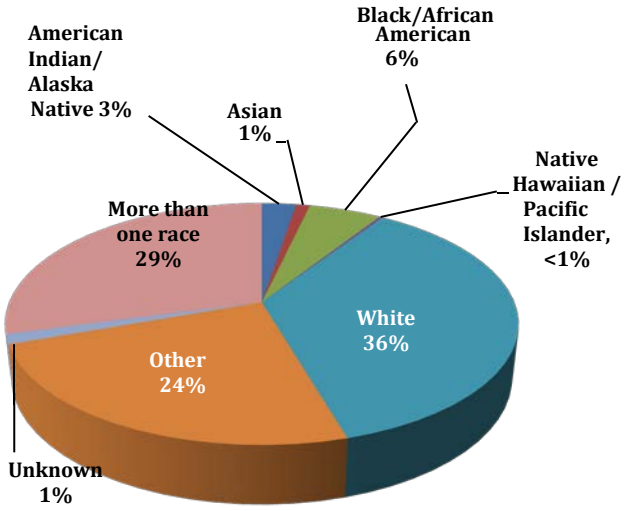
Age n= 387



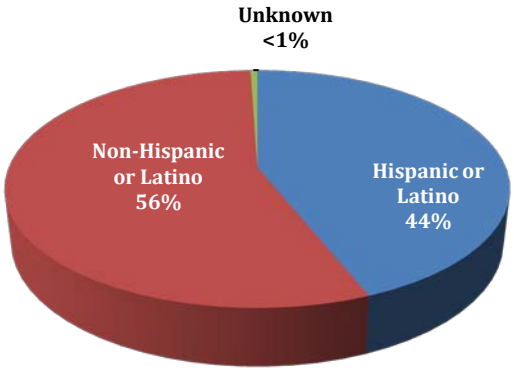
Primary Language n=387



Race n=387



Ethnicity n=387



*Please note most unknowns are due to participants declining to answer

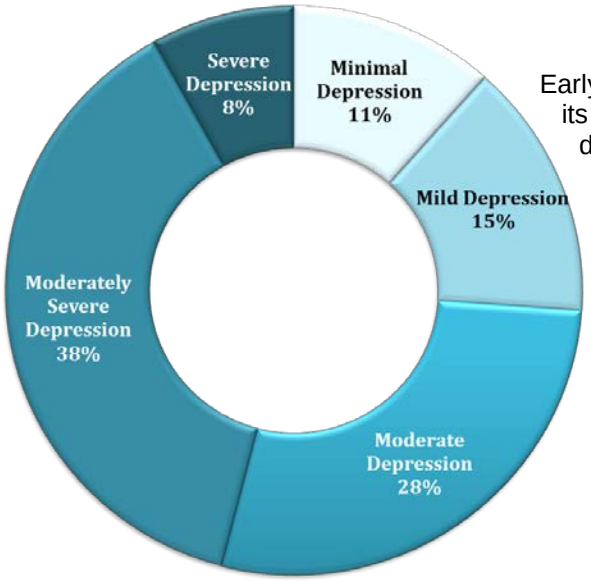
PHQ-9 Results

Early Intervention programs utilize the PHQ-9 (Patient Health Questionnaire) tool to screen and monitor the severity of depression, and response to treatment/clinical improvement. The tool is used for screening, and is also administered at the first counseling session, every three months during counseling, and at last session. Improvement in PHQ-9 scores indicates a decrease in depression severity (a decrease of 5 or more points is a standard for *clinical* improvement). The following are FY16-17 PHQ-9 results:

n=494 individuals includes matched pairs only (initial and most recent scores)

51% of the individuals indicated a ***decrease in depression severity*** after receiving Brief Intervention

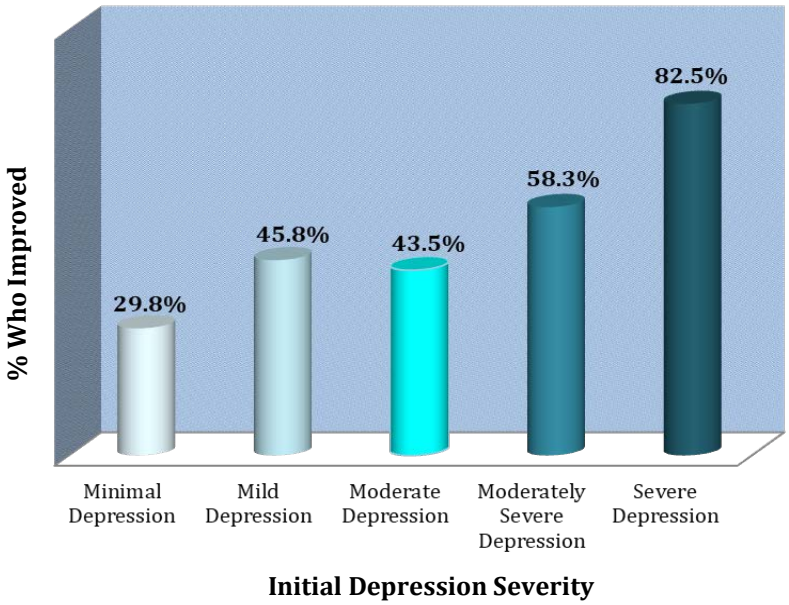
Initial Depression Severity
n=494



Early Intervention programs strive to address mental illness early in its emergence. The chart to the left illustrates the severity of depression that individuals indicate initially upon engaging in Early Intervention services. Almost half of the individuals indicated severe or moderately severe depression at the outset of beginning brief intervention counseling.

The chart to the right shows the percentage of individuals who started early intervention services with minimal to severe depression symptoms, and the percentage in each category who improved. The category with the greatest percentage of individuals who improved was those who started with severe depression – ***82.5% of individuals who started with severe depression symptoms improved*** after brief intervention counseling.

% Individuals Who Improved by Initial Depresession Severity
n=494



The PHQ-9 tool asks individuals to rate how often they have been bothered by specific problems over the last 2 weeks using the following scale:

Not at all	Several Days	More than half the days	Nearly every day

BIC programs help participants decrease the number of days that participants experience the problems, working towards "Not at all". These programs positively impacted the frequency of negative symptoms, indicating improvement as illustrated below.

Negative Symptom	% who improved after BIC*
Little interest or pleasure in doing things	**46%**
Feeling down, depressed, or hopeless	**39%**
Feeling bad about yourself or that you are a failure or have let yourself or your family down	**29%**
Feeling tired or have little energy	**23%**

*% of individuals who initially experienced the negative symptom *nearly every day* who experience it less frequently (or not at all) after Brief Intervention Counseling

Wellbeing Survey Results*

The Stanislaus County BHRS/PEI Wellbeing Survey was developed to help assess where individuals are in their journey of wellness, recovery, and resilience. The survey helps measure wellbeing, risk factors, and protective factors across PEI programs. The majority of PEI programs (29) administered the surveys, resulting in **2,418** individuals completing 2,862 surveys during FY2016-2017 (individuals may complete surveys in multiple programs). Community members participating in Promotores Programs make up about 37% of the responses, but all categories of Prevention and Early Intervention programs are represented in the results.

The survey is based on multiple elements of wellbeing, all of which play important roles in an individual's overall wellbeing, as illustrated below:

Below are highlights for responses about Resiliency, Relationships, Community, Engagement, Meaning, and Overall Wellbeing.

- Because of their involvement with PEI programs:
  - **75%** reported their wellbeing improved
  - **77%** created meaningful relationships
  - **70%** know how to talk to others about important things
  - **74%** know how to access mental health services
  - **79%** are more hopeful about their future

The Wellbeing survey highlighted some positive results for individuals participating in PEI programs. It also pointed to some areas that PEI programs can work to make better.

WORKFORCE EDUCATION & TRAINING (WE&T)

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

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

BHRS had (6) six programs operating during FY16-17:

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

WE&T Budget:

FY 2016-17

Total MHSA Budget	*Actual*
$763,395	***$482,067***

FY 17-18 Budgeted	*FY 17-18 Projected*	*FY 18-19 Projected*
$657,326	***$523,146***	***$638,688***

Highlights:

- More outreach was provided to all sites and the community to raise awareness of volunteer services.
- 21 CASRA Based Stipend Program participants completed the academic requirements and volunteer/practicum hours needed to receive their Skills Recognition Certificate for the MJC 9- Unit Psychosocial Rehabilitation Program.
- Students in the Career and Outreach Academy learned about important topics such as how labeling and the stigmas attached to mental health may affect people. They gain understanding about these topics, how they negatively affect people on a daily basis and how they can help decrease stigma and labels.
- The OSHPD MHLAP Program awarded 16 recipients within the Stanislaus County PMHS each $10,000 to repay educational loans in exchange for a 12-month service obligation in a hard-to-fill or retain position.
- BHRS Training Division applied for and was approved as a continuing education provider the California Association of Marriage and Family Therapists (CAMFT) for LMFT's, LCSW's and LPPC's.

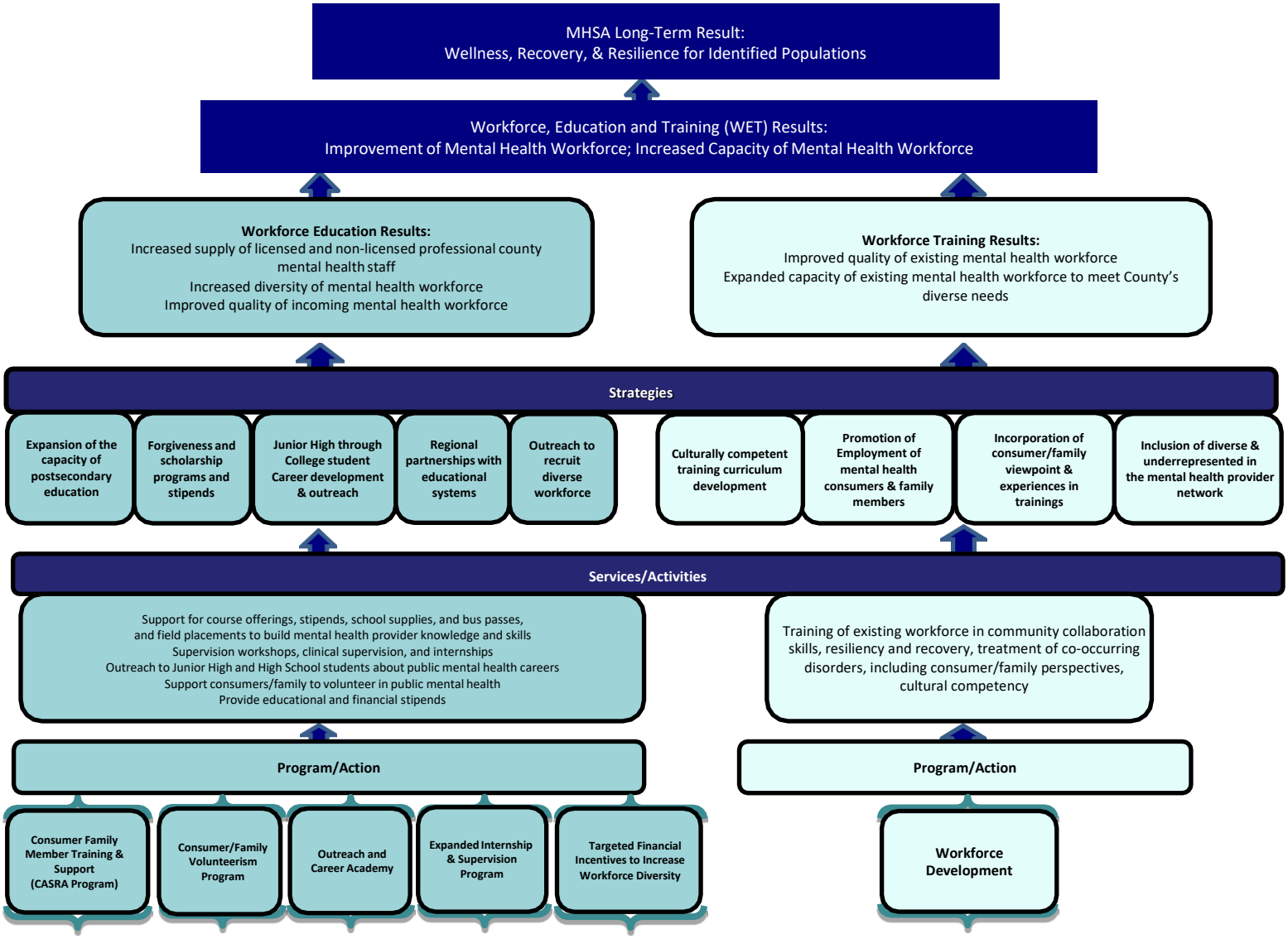
Challenges:

- Due to the challenge to provide clinical supervision and field placement coordination, BHRS was unable to offer clinical student placements this year.
- Some challenges exist with stipend students who do not maintain contact with the program and fail to respond to inquiries from the programs as to their status. BHRS has an agreement with the Psychology and Social Work Departments at CSUS in which they are to monitor the status of the stipend recipients, some process improvements are needed.
- Demand for training is remain high. At times, the demand is not met despite multiple offerings and sessions in the same offering.

In addition, all WE&T programs are committed to providing services that embrace the MHSA general standards:

- Community Collaboration
- Cultural Competence
- Client Driven
- Family Driven
- Wellness, Recovery, and Resilience Focused
- Integrated Service Experiences for clients and their families

Theory of Change:



WE&T Workforce Development
Operated by Human Resources and Training Division of Behavioral Health and Recovery Services

The goal of the Workforce Development program is to increase overall and specific competencies in staff throughout the public mental health workforce as well as expand capacity to implement MHSA essential elements. Training for skill building is at the core of Workforce Development. The trainings offered address a variety of key content identified during the stakeholder planning process.

Key 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.

Trainings are designed to include consumer and family member perspectives and include consumer and family member trainers when appropriate. Workshops and trainings are offered to BHRS and organizational provider staff with the overarching goal of enhancing knowledge and skills, especially in the areas of recovery and resilience and evidence-based practices.

Highlights

- Trainings continue to fill up quickly with staff and community expressing appreciation for the variety of offerings.
- BHRS Training Division applied for and was approved as a continuing education provider with the California Association of Marriage and Family Therapists (CAMFT) for LMFT's, LCSW's and LPPC's.
- Presentations within the graduate programs at Cal State University Stanislaus (CSUS) were offered in an effort to increase interest in future graduates to seek employment within the public mental health system and specifically with BHRS.

Challenges

- Demand for training remains high. At times, the demand is not met despite multiple offerings and sessions in the same offering.
- Trainer's availability, venue availability and overall calendar availability is challenging to support mandatory departmental trainings.

WE&T Workforce Development

FY 2016-17

Program Results for WE&T Workforce Development

How Much?

- 182 Trainings were supported by the BHRS Training Program (n=3432)
- 24 Trainings were paid for through WET money (n=975)
- 26 Trainings were sponsored by the PEI Program (n=493)

How Well?

CAMFT required a change in the evaluation questions used to gather information regarding training effectiveness which took place mid fiscal year as indicated by the dates for data collection below:

7/1/16-1/16/17

- 83% of the participants felt their understanding/knowledge of the subject matter improved as a result of this training. (n=220)
- 90% of the participants felt their skills on the subject improved as a result of the training. (n=220)
- 85% of the participants felt this course included context related to diverse populations/cultural competency. (n=220)

1/17/17-6/30/17

- 97% of the participants felt the content was appropriate to my education/experience/licensure level. (n=653)
- 98% of the participants felt the course content was current and relevant to practice. (n=653)
- 97% of the participants felt the course teaching methods/technology/handouts supported the seminar. n=653)

Better Off?

- Southeast Asian Culture, Immigration & Trauma Informed Care – "Thank you! Your training raised my awareness regarding the trauma among Southeast Asian population."
- Collaborative Documentation – "I came into training totally opposed to collaborative documentation. I understand it and will make every effort to implement and see as an asset."
- Seeking Safety – "Presenter kept my attention. She was very knowledgeable and non-judgmental. Feel like I have good understanding of Seeking Safety."
- Introduction to Mindfulness: Training for Behavioral Health Providers – "All of the information presented today was very well presented and helpful. I very much enjoyed this topic and learning about all the different types of meditation/mindfulness."
- Professional Resilience and Optimization: Compassion Fatigue – "Dr. Gentry was very knowledgeable and informative. He used several ways to explain the information. I can use this to help myself, my family and my clients."

WE&T Consumer Family Member Training & Support
Operated by Human Resources and Training Division of Behavioral Health and Recovery Services in Partnership with Modesto Junior College and Community-Based Organizations

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

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

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

Highlights

- One of last year's challenges has been overcome by finding an alternative way to purchase textbooks at a lower cost allowing us to purchase more textbooks for our Textbook Loan Program.
- 17 of our participants have been placed in volunteer positions that allowed them to meet the specified hour requirements for each MJC Psychosocial Rehabilitation Program course.
- The program is maintaining a steady increase in the recruitment of individuals from diverse ethnicities into the behavioral health field. All CASRA Based Stipend Program participants are either consumer/family members or they come from a diverse and underserved community.
- A total of 124 students received CASRA stipends in FY 16-17.
- Forty-three (43) CASRA Based Stipend Program participants completed the academic requirements and volunteer hours to receive their Skills Recognition Certificate for completion of the MJC 9-Unit Psychosocial Rehabilitation Program.
- Three (3) additional CASRA Based Stipend Program participants have received their Associate of Arts Degree in Human Services at MJC.
- Fourteen (14) CASRA Based Stipend Program participants serving as volunteers have been hired in the public mental health system. Five (5) by BHRS and three (3) by community partner agencies, and six (6) by outside facilities that work with mental health clientele.
- Among the CASRA Based Stipend Program participants, thirty-two (32) are bilingual or multi-lingual.

Challenges

One of the components of the MJS 9 unit psychosocial rehabilitation program (PSR) is student's completing one semester of 10 – 20 hours per week in a practicum, in a setting where they can observe and possibly participate using what they have learned. Outreach to BHRS program about the PSCR program and what the practicum entails make it possible for MJS PSR students to complete their practicum. It can be a challenge to outreach adequately to create placement opportunity.

WE&T Consumer Family Member Training and Support

FY 2016-17

124 Individuals Served

Program Results for WE&T Consumer Family Member Training and Support

How Much?

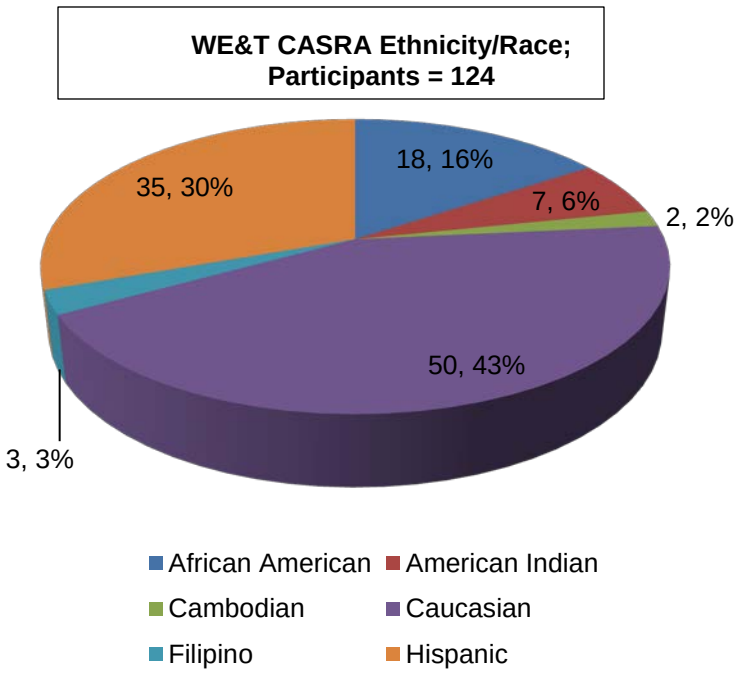
- 124 CASRA Based Stipend Program participants representing diverse ethnicities/cultures received
- education stipends
- 21 of the participants received field placement with BHRS or our community partner agencies
- 2 CASRA Based Stipend Program orientations and 2 classroom presentations were held at MJC to raise awareness about the program
- Collaboration with the Behavioral and Social Science Departments at MJC

How Well?

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

Better Off?

- 21 CASRA Based Stipend Program participants completed the academic requirements and volunteer/practicum hours needed to receive their Skills Recognition Certificate for the MJC 9-Unit Psychosocial Rehabilitation Program
- 3 CASRA Based Stipend Program participants have received their Associate of Arts Degree in Human Services
- 5 CASRA Based Stipend Program participants have chosen to continue their education at California State University, Stanislaus
- 14 CASRA Based Stipend Program participants were hired in the public mental health system; 5 by BHRS, 3 by partner agencies and 6 by outside facilities working with mental health clientele.



WE&T Consumer Family Member Training and Support

FY 2016-17

124 Individuals Served

CASRA Based Stipend Program Participant Feedback/Comments

I would like to say that this program is very helpful and has a lot of resources.

I love the CASRA Program. The staff is amazing. Being in the CASRA Program was the best opportunity I have had.

This program has helped me to be able to get closer to my degree. I'm really happy this program is available to students like me.

The staff has helped me be a successful student. I really appreciate it. □

I appreciate the knowledge, support, and direction I have received from the CASRA personnel.

CASRA really helped me reach out to the community. Meme has totally supported me a great deal and has been there for me every step of the way. I would not be where I am at in life without their support.

I want to comment on the staff: All of the staff members have been fabulous in helping me with not only my application process, my long-term educational goals, but also in being there when I needed their advice on certain course-load questions; for example in taking certain classes that would not overburden me and set me up for failure. In my interactions with Meme in particular, they have been very valuable in the selection process of my classes. Three cheers for the CASRA program!

Thank you all, for all you do for all of us. God Bless.

Since meeting with Marian I have found her to be a great help and a wonderful source of information and advice. Thank you very much to Marian and other staff, Melissa and Amber, for all your efforts. It is greatly appreciated.

WE&T Expanded Internship and 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 behavioral health field.

Highlights

- The advanced clinical supervision group supervision continues to support staff in obtaining their goal towards licensure through the Board of Behavioral Sciences.
- Many of the graduate students who received stipends remain employed through either BHRS or primary contracted agencies.

Challenges

- Due to the challenge to provide clinical supervision and field placement coordination, BHRS was unable to offer clinical student placements this year.
- Maintaining expert clinical supervision for the amount of clinical interns remains a challenge.
- Retaining licensed staff is a challenge as they find opportunities with other behavioral health organizations.

WE&T Expanded Internship and Supervision Program

FY 2016-17

Program Results for Expanded Internship and Supervision Program

How Much?

- Approximately 45 entry-level Mental Health Clinicians are employed by BHRS, at any one time, which require clinical supervision to meet BBS requirements.

How Well?

- 4 Stipend recipients completed their employment payback in Stanislaus County public health organizations in FY2016-17.
- 10 BHRS staff passed the clinical exam and obtained licensure through the Board of Behavioral Sciences.

Better Off?

- BHRS staff, upon completion of their MFT/LCSW licensing exam, reports that the advanced clinical group supervision was beneficial during the exam preparation process. The key elements were the support and accountability provided helped them to pass the exam.

WE&T – Outreach and Career Academy
Operated by West Modesto King Kennedy Neighborhood Collaborative

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

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

Highlights

- Six students were chosen and participated in the Mark Twain Junior High Wellness Project for the 2016 - 2017 school year
- This year, the students chose a mental health career they were interested in, did research and presented to the rest of the group. They were given opportunities to role-play their career choice during one of our sessions
- Students learned about important topics such as how labeling and the stigmas attached to mental health may affect people. They gain understanding about these topics, how they negatively affect people on a daily basis and how they can help decrease stigma and labels.
- Another component was the unit on Bullying. Students discussed how it affects youth mentally, physically and socially. As part of this unit, students were presented information on suicide awareness and how to recognize the signs of suicide.
- The students had the opportunity to interact with medical interns from nearby Paradise Medical Office. Some of the interns may be working in West Modesto in the future and wanted to be involved with some of the positive activities in the community
- For the community service component, students participated in Love Modesto on April 8, 2017 and helped clean the Helen White Memorial Trail in West Modesto.
- The 2016 -2017 Mark Twain Junior High Wellness Project ended the year with a luncheon at Texas Roadhouse Restaurant for the students and one parent. Each student received a certificate of recognition and their stipend.
- Three of the six students from this group will return to Mark Twain and would like to participate next year.

Challenges

- More students are interested in being part of the program than we have slots. Will look at the feasibility of having students participate for only one semester. Thus allowing for 12 participants per school year.

WE&T – Outreach and Career Academy

FY 2016-17

6 Individuals Served

Program Results for WE&T – Outreach and Career Academy

How Much?

- 6 students participated in the Academy

How Well?

- The students report positive experiences learning about mental health and wellness in the program.

Better Off?

- Students report they have taken advantage of opportunities to apply their stigma reduction learning either at school or within their family.
- 3 of the students are interested in learning more of next year's program.

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 as well as, gain valuable experience for future employment endeavors. 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 (MJC), referred to as "Volunteers with Practicum Assignment". Volunteers were placed in BHRS programs as well as community-based organizations.

Highlights

- A successful BHRS Volunteer Celebration took place on April 7, 2017. There were 120 invitations sent and 80 individuals attended this event. The feedback was excellent as well as the venue.
- Process improvements were established for time card data entry and processing into PeopleSoft.
- Process improvements were achieved between the program sites, volunteers, and the Volunteer Office Team that will enhance communication and improved customer service expectations.
- More outreach was provided to all sites and the community to raise awareness of volunteer services.

Challenges

- Volunteer staff worked to increase communication with MJC to coordinate BHRS presentations at MJC to ensure all presenters had the updated procedures and protocols.
- Developing job descriptions and job expectations for the volunteers.

WE&T Consumer Family Member Volunteerism

FY 2016-17

119 Individuals Served

Program Results for WE&T Consumer Family Member Training and Support

How Much?

- 119 volunteers participated in the program
- 12 volunteers were hired either by Stanislaus County or other outside organizations

How Well?

- 21,983 volunteer hours were accumulated by the program.
- Dollar value to the department ($23.07 an hour) equaled $507,164.
- 13 BHRS sites participate in the program by using volunteers

Better Off?

Comments received regarding the Volunteer Program included the following:

- "Volunteer office is friendly and provides excellent customer service and always with a smile."
- "I've had a very good experience volunteering for BHRS. Melissa and Amber are very nice people with good positive attitudes. Volunteering for BHRS gave me the opportunity to work for the county. Overall thanks to Melissa and Amber for the wonderful experience"
- "Being able to volunteer and be a part of this office was such a great experience for me. I was able to learn new skills and also improve the skills I already had going into this volunteer program here at BHRS. Everyone I worked with was kind and helpful. I would quickly recommend others to be a part of this office and volunteer like I did. I'm, very grateful to have been able to participate and work around these people."

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

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

Additionally, on a statewide basis, the Mental Health Loan Assumption Program (MHLAP) funded by MHSA and administered through the Office of Statewide Health Planning and Development (OSHPD) is available within this program. MHLAP is a loan forgiveness program designed to retain qualified professionals working within the public mental health system.

MHLAP was created by the Mental Health Services Act (Act), passed by California voters in November 2004. The Act provided funding to develop a loan forgiveness program in order to retain qualified professionals working within the Public Mental Health System (PMHS). Through the Workforce Education and Training component of the Act, $10 million is allocated statewide on an annual basis to loan assumption awards. An award recipient may receive up to $10,000 to repay educational loans in exchange for a 12-month service obligation in a hard-to-fill or retain position within the County's PMHS challenges.

Highlights

- BHRS awarded a total of 2 stipends this year and all recipients met desirable classifications for hard to fill positions identified in the WE&T plan workforce needs assessment.
- The OSHPD MHLAP Program awarded 16 recipients within the Stanislaus County PMHS each $10,000 to repay educational loans in exchange for a 12-month service obligation in a hard-to-fill or retain position
- BHRS Human Resources and Training Division regularly supports those who have entered into the mental health field by informing them of announcements from sources for financial incentives; E.g. OSHPD Mental Health Loan Assumption Program and the National Health Service Corps Loan Repayment Program.

Challenges

- Some challenges exist with stipend students who do not maintain contact with the program and fail to respond to inquiries from the program as to their status. BHRS has an agreement with the Psychology and Social Work Departments at CSUS in which they are to monitor the status of the stipend recipients, some process improvements are needed.

WE&T Targeted Financial Incentive to Increase Workforce Diversity

FY 2016-17

Program Results for Targeted Financial Incentives to Increase Workforce Diversity

How Much?

- The OSHPD MHLAP Program awarded 16 recipients within the Stanislaus County PMHS. Each individual to repay the $10,000 educational loan in exchange for a 12-month service obligation in a hard-to- fill or retain position

How Well?

- 16 MHLAP awardees are currently employed and completing their payback through BHRS or primary contracted PMHS agencies.
- 4 Stipend recipients completed payback by working at BHRS or with one of the five primary contract agencies in the FY 2016-17.

Better Off?

- 4 Stipend recipients continue to work within Stanislaus County.

CAPITAL FACILITIES (CF)

Capital Facilities/Technological Needs (CF/TN) funding and guidelines were made available to Counties in 2008. Initial CF/TN funding was very limited. By statute, 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 (W&I 5892(b)).

Building projects funded with CF must be permanently affixed to the ground and used for the delivery of MHSA services to individuals with mental illness and their families or for administrative offices. Capital Facility funds may be used by the County to acquire, develop or renovate buildings or to purchase land in anticipation of acquiring/constructing a building. Establishing a capitalized repair/replacement reserve for buildings acquired or constructed with Capital Facilities funds and/or personnel cost directly associated with a Capital Facilities Project, i.e., a project manager is allowable. Other guidelines apply.

Services and Activities

To date in Stanislaus County, CF funding has been used solely for the construction of the Crisis Stabilization Unit (CSU). The CSU opened its doors in February 2015 to expand capacity to provide clinical and psychiatric services and more intensive levels of care, including the ability to provide medication. The CSU was identified and developed with stakeholder input.

The CSU is co-located with the BHRS Community Emergency Response Team known as CERT and Warm Line. The CSU's goal is to focus on recovery-centered care and create an opportunity for each individual served to receive treatment in a less restrictive setting. The project is funded through CSS - General System Development (GSD) dollars for operational costs.

Updates on services provided by the CSU in FY16-17 are included in the CSS section of this Annual Update.

No additional Capital Facilities Projects are in development at this time.

TECHNOLOGICAL NEEDS (TN)

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

BHRS has four (4) TN projects/Operating in FY 2016-17

- Electronic Health Record
- Consumer/Family Access to Computing Resources
- Electronic Data Warehouse
- Electronic Document Imaging

Services and Activities

Electronic Health Record

- Piloted the integrated Mental Health Documentation and Electronic Health Record (EHR) Navigation Training
- Provided EHR training to BHRS and contractor staff
- Provided medication services via tele-psychiatry, improving access and efficiency of services

Consumer/Family Access to Computing Services

- Transitioned and trained two new technicians
- Finished replacing all of the old computers with new/updated computers

Electronic Data Warehouse

- Continued to create additional views for different reporting requirements and for department dashboards
- Continued efforts to transition the Data Warehouse to a new computer server to increase performance

Electronic Document Imaging

- Scanned and attached Mental Health Plan referrals and other electronic documents to clients' EHR charts, which increases chart information available in the EHR
- Increased the number of lab results scanned and attached to client's charts

TN Budget:

FY 2016-17

Total MHSA Budget	*Actual*
$1,243,702	*$1,070,015*

FY 17-18 Budgeted	*FY 17-18 Projected*	*FY 18-19 Projected*
$1,076,325	*$941,176*	*$959,037*

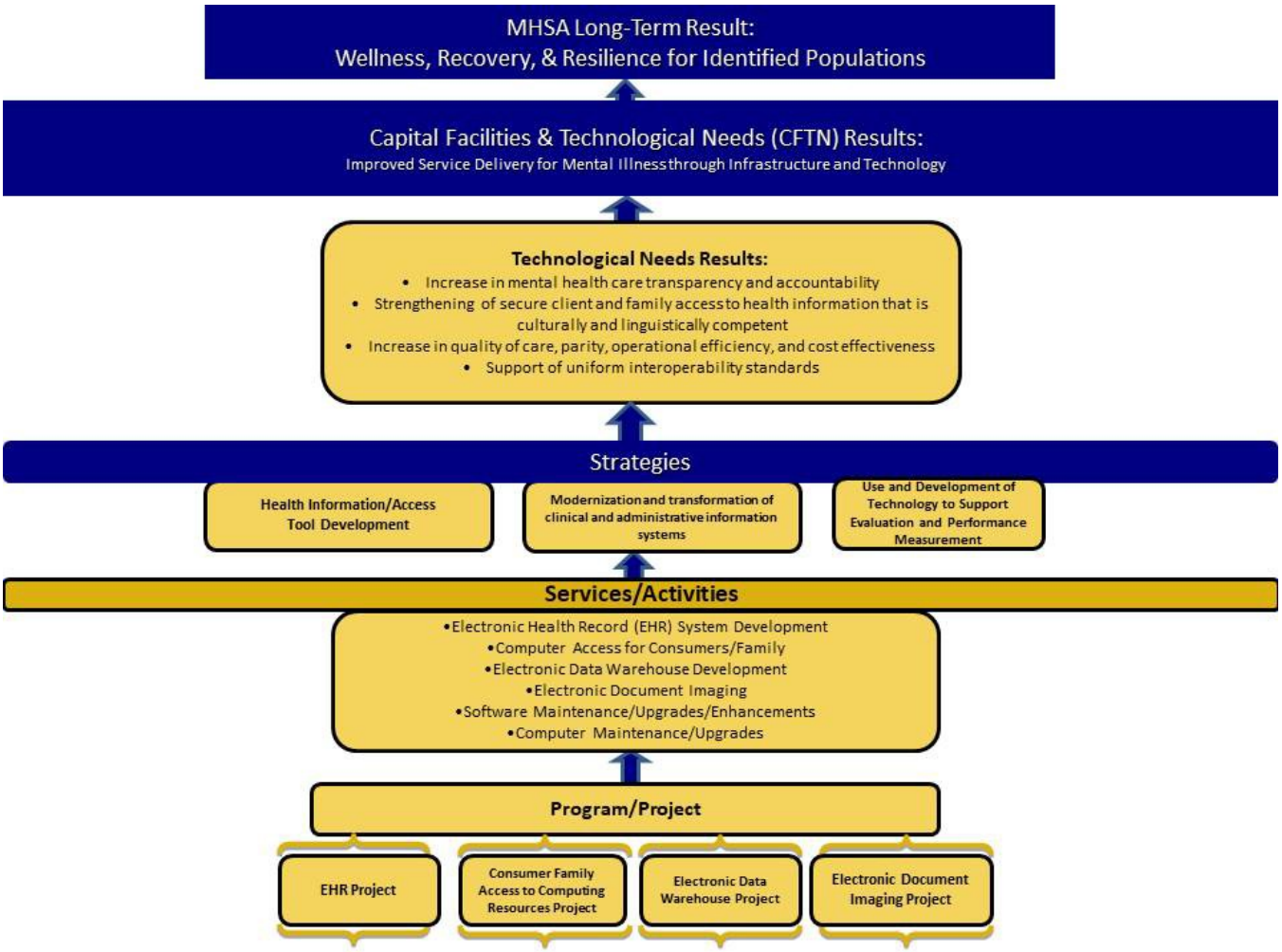
Highlights

- During the months of September, October, and November 2016, BHRS and Contractors piloted the Integrated Mental Health Documentation and Electronic Health Record Navigation Training. The trainings were previously separate, but it was important to provide a more comprehensive training that focused on the functions of diverse staff. Making this change resulted in increasing the capacity to provide the appropriate level and length of training for individuals.
- There was a significant increase in the electronic documents scanned and attached to clients' EHR charts. Mental Health Plan referrals made up 27% of the increase. This increase is significant to the efficiency and effectiveness of the EHR for staff and consumers as it allows for more complete electronic access to chart information, including assessment outcomes.
- Employing two technicians has helped covered the needs of multiple sites.

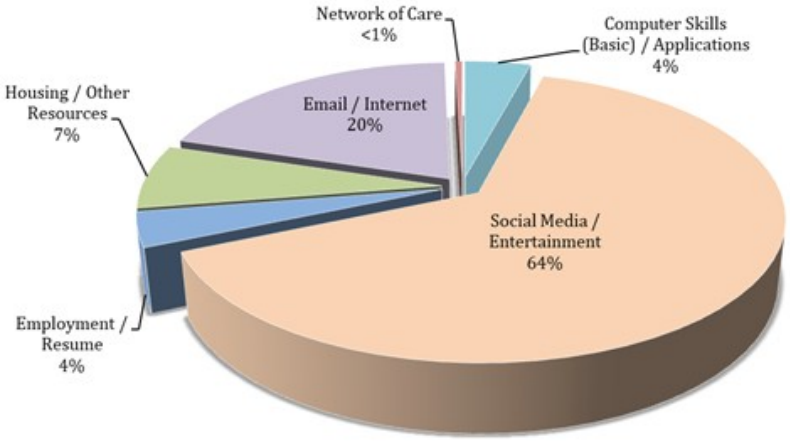
Challenges

- Newly hired staff usually experience some challenges while learning the EHR system and using new technologies. The resources dedicated through MHSA Technological Needs funding help alleviate these challenges.
- Engaging consumers and family members in using the Network of Care continues to be a challenge. This is a great resource to Stanislaus County residents, but most consumers have specific needs when they request technical assistance.

Theory of Change:



Categories of Consumer / Family Computer Technical Assistance
FY 2016-2017
TA occurrences* = 1,127



How Much?

- 564 BHRS and Contractor staff were trained to effectively use the HER
- 175 staff successfully completed the Integrated Mental Health Documentation and EHR Navigation Training
- 1,127 technical assistance occurrences assisted consumers in accessing computing resources
- 2,052 electronic documents were scanned and attached to clients' EHR charts, representing a 97% increase from last fiscal year; part of this increase is due to the 275 scanned Mental Health Plan referrals, allowing easy access to the assessment outcomes in the HER

How Well?

- 86.5% of the electronic documents attached to charts were lab results (1775/2052), critical documents for treatment
- Improved the accessibility and efficiency of medication services by providing 477 medication services via tele- psychiatry
- Successfully finished replacing 100% of the old computers dedicated to the "Consumer/Family Access to Computing Resources" project with new/updated computers

Better Off?

- The Data Warehouse continues to be instrumental in the process of data analysis and outcomes reporting for decision making. The data warehouse was utilized for report and dashboard development, including LOCUS (Level of Care Utilization System) reports, Productivity dashboards, and multiple SSRS (Sequel Server Reporting Services) reports.
- Consumers and families received technical assistance in the following computing resources categories:

INNOVATION (INN)

Innovation funding is intended for unique, never-before-tried, time-limited programs to develop new and effective practices and approaches to mental health service delivery.

The intention is to make a contribution to learning in one or more of the following ways:

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

Innovation projects are guided by MHSA values of community collaboration, cultural competence, a client/family driven mental health system, a wellness, recovery, and resiliency focus, and integrated Service Experiences for clients and family members.

The projects must serve one of more of the following purposes:

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

In FY 16-17 BHRS had two projects funded for this MHSA component. Each project reflected an unmet need and was developed through a community planning process.

The projects are as follows:

- INN-16 – FSP Co-Occurring Disorders
- INN-17 – Suicide Prevention Innovation Project (SPIP)

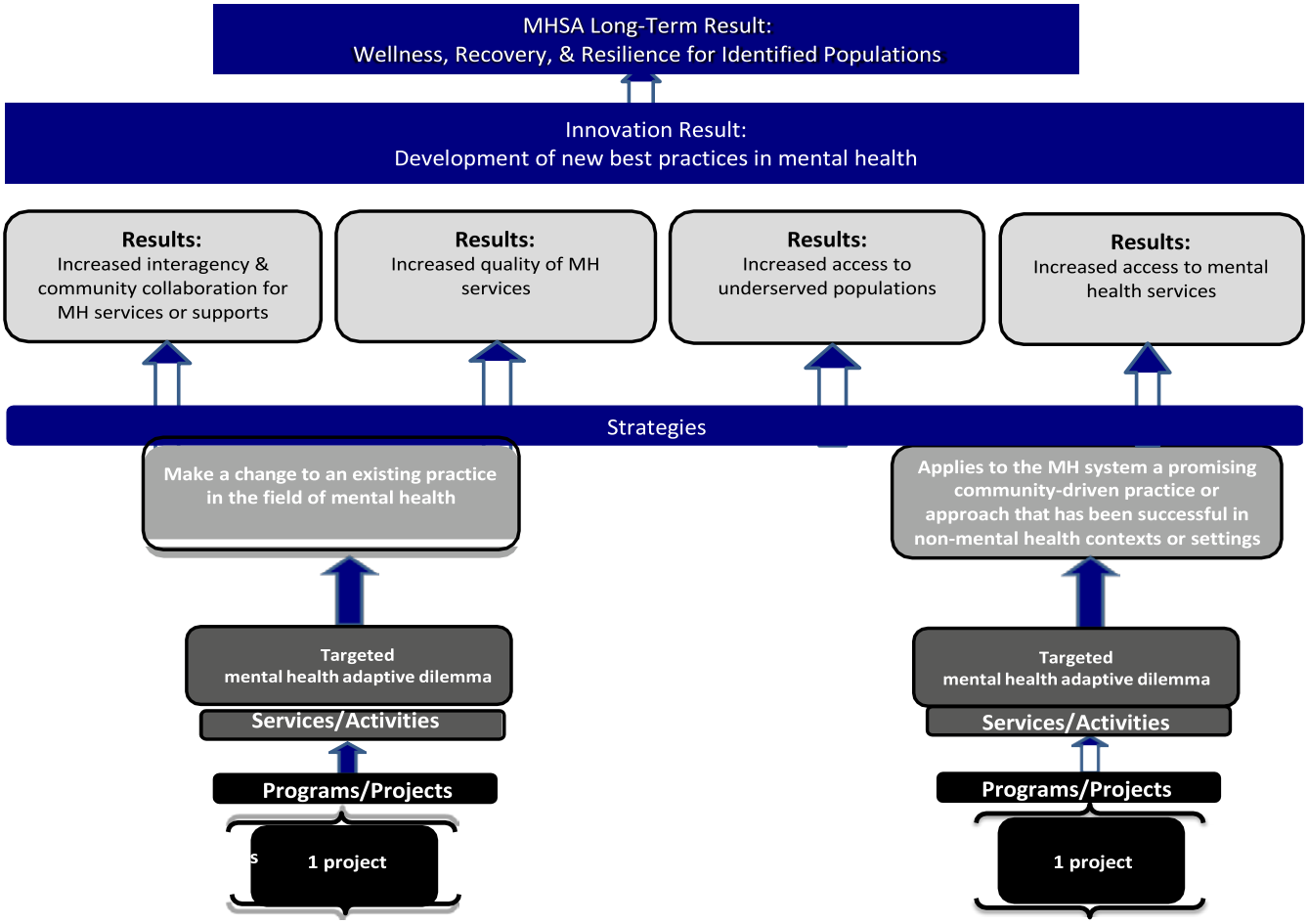
INN Budget:

FY 2016-17

Total MHSA Budget	*Actual*
$1,928,393	***$1,054,489***

FY 17-18 Budget	*FY 17-18 Projected*	*FY 18-19 Projected*
$1,807,884	***$1,084,961***	***$2,957,694***

Theory of Change:



FSP Co-Occurring Disorders Project (INN – 16)
Operated by Behavioral Health and Recovery Services

Project Description:
This innovation project is a three year Full Service Partnership (FSP) focused on testing the efficacy of an FSP providing evidence-based treatment approach of Assertive Community Treatment (ACT). The uniqueness of the approach lies in the initial "lens" through which individuals are viewed and the services that are offered as the "lens" informs what is needed for the individuals' recovery needs and strengths to be developed.

Targeted Population:
Adults with both serious mental illness and co-occurring substance use disorder.

Strategy:
This Innovation project explores making a change to an existing mental health practice/approach, including adaptation for a new setting or community/treatment options for people struggling with both substance abuse and mental illness.

Specific strategies and activities with individuals served include integrated primary care access, a "housing first" approach, and co-location on an SUD/Co-occurring treatment site under a stage-based co-occurring treatment philosophy and practice. Team-based, client-centered, stage-based treatment, low case load ratio, 24-7 availability, in vivo services, and access to supportive services funds are strategies to be employed.

Primary Purpose:
Increase the quality of mental health services, including measurable outcomes

Learning Proposed:
- Will clients be successfully engaged by receiving a combination of services through this new FSP?
- Will using stage-based treatments for both mental health and SUD concurrently lead to improved outcomes for clients participating in the FSP project?
- What engagement strategies and interventions will emerge from this concurrent stage-based approach that is most effective for this population?
- While utilizing the concurrent stage-based approach, what practices/processes are most effective from staffs' perspective?
- Will access to integrated primary care positively affect outcomes?
- Will employing an integrated "Housing First" approach positively affect outcomes?
- Will co-locating this FSP on an SUD/Co-Occurring treatment site lead to increased peer support, SUD treatment follow through and linkages to mental health and SUD resources?

The overarching learning outcome focuses on helping to inform the behavioral health field about what combination of strategies and services are most effective at the different concurrent mental health and SUD recovery stages for people with these co-occurring issues.

Highlights/Challenges

- An important element of the program has been utilizing the Housing First model. Clients who have been provided housing from the program have been able to reduce their drug use and stabilize mental health symptoms.
- A co-occurring lens leads to utilizing a client-centered, non-judgmental harm reduction approach that "meets clients where they are". This approach supports a client who may be using illicit substances or not using coping skills for mental health and refrains from setting unrealistic expectations for clients. This approach and the ensuing relationships make recovery possible.
- Advocacy is important for the population served. Many programs already have a perspective of the clients, but program staff works to help open the service providers/community view of the clients in a less biased, non-judgmental way. The program also provides support to other service providers and community member to assist clients in their journey of recovery.
- The majority of clients have been referred through other county programs/contract programs. The clients reported this program "is different than other programs." They have also reported that having 24/7 on-call support has been helpful, stating, "You're always there for me when I need someone." Other client comments:
    - "You're always there for me and you show you care."
    - "When I relapsed, you weren't mad at me. You guys did not criticize me and put me down like (others)."
    - "Other programs are less understanding when we fall down. They are less understanding and judgmental."
    - "You guys reward us when we do good things."
    - "I like the people who work with me."
- The Assertive Community Treatment (ACT) model and team approach allow all FSP staff to know each client and have relationships to meet needs more effectively.
    - Interventions are more effective when trust can be built to better understand clients' symptoms and values.
    - Clients can benefit from the reduced caseloads as staff has more time to spend building relationships and engaging clients. Typically, the staff/client ratio is 1:7.
    - A team that can communicate effectively and learn from each other is essential in this program.
- Shared understanding of program goals and expectations is important.
    - When staff know and understand the expectation of the program, interventions can be aligned with the goals, which helps staff identify which interventions are appropriate in different circumstances.
    - The clients receive consistent messages and interventions from every staff member.
- Staffing has been a challenge.
    - This program has been consistently understaffed by at least 1 staff member and up to 4 staff members at any one given time. With a program of 7.5 staff total, being understaffed creates a major challenge in providing needed services to clients.
    - Understaffing also causes additional stress for on-call employees to cover the time equitably.

Below is a summary of key data for FY2016-17

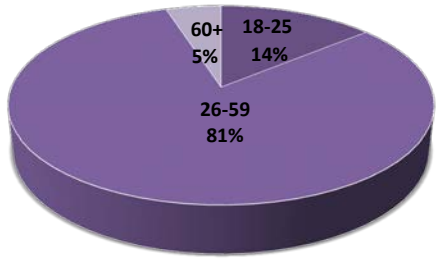
Sub Unit	Program Name	Unique Clients Served	Total Assignments**	Total # of Days Open	Assignment Average Length of Stay (days)	Client Average Length of Stay (days)
3120	**COD FSP Mental Health Engagement**	55	59	2231	38	41
3121	**COD FSP Mental Health Assessment**	6	6	8	1	1
3122	**COD FSP Mental Health ACT**	40	43	7131	166	178
3125	**COD FSP SUD Assessment**	11	12	12	1	1
3126	**COD FSP SUD ODF**	4	4	61	15	15
Total		*116	124	9,443	76	81
Unique unduplicated count		**65**		**9,443**		**145**

* Duplicated across COD SU **Includes all assignments open > 1 day

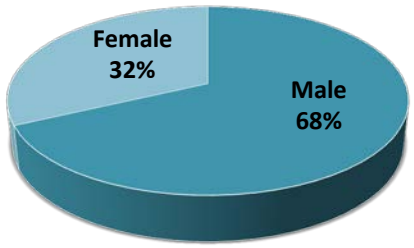
- First COD FSP client in the program entered on 4/11/16 to SU 3120
- Of the 57 clients discharged, 44% met their goals or transferred to another appropriate program

Demographics:

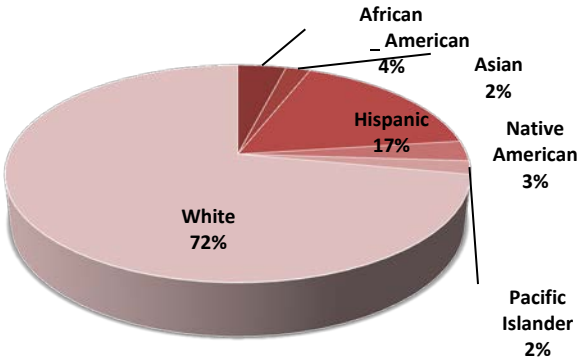
Age n=65



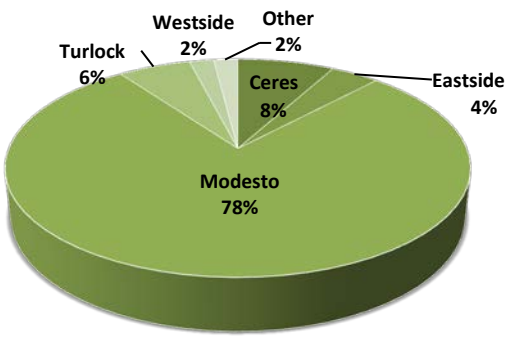
Gender n=65



Race/Ethnicity n=65



Region of Residence n=65



Suicide Prevention Innovation Project (INN-17)
Operated by Behavioral Health and Recovery Services

Project Description:
Over the three-year project period, the Suicide Prevention Innovation Project will use and evaluate the Collective Impact Model as a new best practice or approach to the mental health system.

The project will form and regularly convene stakeholders and partners from various sectors of the community to establish the Suicide Prevention Advisory Board (project collaborative). The Advisory Board will use the Collective Impact Model as its framework to learn about and address suicides in Stanislaus County. The primary purpose is to increase the quality of mental health services, including measurable outcomes. In addition to the primary purpose, the project will also evaluate the Collective Impact Model as a new practice and the impact it has on our community's ability to collaboratively work together on large-scale issue like suicide.

Strategy:
To introduce the application of the Collective Impact Model to the mental health system as a promising practice or approach that has been successful in a non-mental health setting. The Collective Impact Model was adopted as the innovative approach for the project because it allows for cross-sector perspectives, collaboration and the ability to address complex root causes.

The Collective Impact Model is a framework used to tackle deeply rooted and complex social problems. It is the commitment of a group of stakeholders from different sectors of the community, with a shared vision for solving a specific-complex social problem. The model is based on 5 core principles:

- **Common Agenda** – various stakeholders come together, collectively define the problem and create a shared vision to solve it
- **Shared Measurement** – stakeholders agree to collect data and track progress and success in the same way over time, to ensure efforts remain aligned and support shared accountability
- **Mutually Reinforcing Activities** – diverse actions among stakeholders that are coordinate through an agreed upon plan, to maximize results
- **Continuous Communication** - building trust and relationships among all stakeholders through consistent open communication
- **Backbone Organization** – a dedicated team to convene and coordinate the participation and work among the stakeholders

Primary Purpose:
Increase the quality of mental health services, including measurable outcomes

Contribution to Learning:
Introduce a new application to the mental health system of a practice or approach that has been successful in a non-mental health context or setting.

Learning Proposed:

- Through collective efforts, will the group develop a shared understanding of suicide data in our county? If so, how will the shared understanding impact suicide prevention planning?
- Can a collaborative use data and combined information from multiple sources to develop a suicide prevention strategic plan that the community will support and embrace?
- What methods are most effective in increasing suicide prevention awareness in Stanislaus County?
- Will the collaborative impact the rate of suicide in Stanislaus County? Will specific demographic groups be impacted?

Highlight of activities

September 2016 – June 2017:

Prior to Start of Project

- April 2016 the Suicide Prevention Innovation Project was approved by the Oversight and Accountability Commission.
- May– August 2016 recruitment and hiring activities for the Project Manager position were conducted.
- No additional project activities were conducted until the Project Manager was hired.

September – December 2016

- Project Manager was hired and the project officially began in early September 2016.
- Recruitment activities to fill the project's Administrative Clerk/Event Planning Specialist and Data Analyst positions were conducted.
- The initial project plan was reviewed; timeline adjustments were made to allow adequate time for the initial project start up tasks to be completed.
- The project (internal) team structure was established. The Project Manager began to coordinate and convene project team meetings with the Project Evaluator and Leadership from the implementing community agency (Behavioral Health and Recovery Services).
- Researched and established a list of potential collaborative partners and stakeholders from various sectors of the community (e.g. faith based leaders, government agencies, law enforcement, health care, education, community based organizations, etc.) affected by suicide or involved in suicide awareness, prevention or post intervention; to form the Suicide Prevention Advisory Board (project collaborative).
- Researched and established agreements necessary with other partners and agencies to access data needed for the project.

January – April 2017

- Save the date invitation was sent to all potential Advisory Board members.
- Data Analyst was hired late February 2017.
- Researched, collected and analyzed suicide and suicide-related data for the Advisory Board to review.
- Began to develop the project evaluation matrix and tools based on the project's proposed "Learning Questions."
- Held the Suicide Prevention Advisory Board Kick-off Convening meeting to engage potential Advisory Board members. There were approximately 70 attendees from various sectors of the community, which included service providers, faith based leaders, government agencies, law enforcement, health care, education and several community based organizations representing diverse and underserved populations. At the meeting, a project overview and review of the Collective Impact Model was provided.
- Established the commitment of approximately 35 collaborative partners and stakeholders, forming the Suicide Prevention Advisory Board.
- Administrative Clerk/Event Planning Specialist was hired in early March 2017.
- April 2017, the first of fifteen Advisory Board meeting was held and attended by 34 members. The purpose of the meeting was to collectively review data and establish a shared understanding of the problem of suicide in Stanislaus County. The meeting data presentation included recent Stanislaus County suicide death demographic data.
- Began to implement several project evaluation and tracking tools (e.g. meeting evaluation forms, tracking logs, sign-in sheets, member commitment forms and observation data).

May – June 2017

- Began to research an evaluation tool for use in establishing a baseline for the level of collaboration and effectiveness of the Advisory Board.
- Coordinate the participation and work among the stakeholders to create the June Advisory Board meeting data presentation. The collaborative presentation was comprised of data from five Board members. The data presented included national and state suicide death and attempt data, as well as indicated data for several local target populations.

Challenges

- In the initial proposed project plan, the Suicide Prevention Innovation Project was planned to start following OAC approval in early March 2016. Although the project was approved in late April 2016, it did not start until September 2016.
- The initial plan provided three months to recruit and fill project positions. Filling the project positions required more time than anticipated. The project was fully staffed approximately six months after it began, in early March 2017.

HOW LIVES ARE CHANGING

MHSA funded services, supports and activities have made a difference in the lives of thousands of people in Stanislaus County. Sharing stories of how individuals are achieving more happiness, family support, individual wellness and connection to community is an important part of the Annual Update. There are many more success stories than could be included here. These few personal stories* represent the accomplishments and resiliency of many in our community.

**Personal stories have been edited for content and length. Individual's names have been changed for confidentiality reasons.*

Community Services and Supports (CSS)

Westside SHOP (FSP-01)

"Sam" received services from Partnership TRAC in FY16-17. Sam has been taking medication for an illness of schizophrenia, attending all scheduled appointments, staying in contact with the case manager and beginning to enjoy some stability in everyday life. As a result, Sam has begun to repair family relationships, develop a community of support by participating in community walks and attending family parties. Sam has significantly reduced the amount of anger outbursts and auditory hallucinations that, in the past, resulted in hospitalization and risk of losing housing. Sam is now very active in practicing mental health recovery habits and is actively learning new coping skills strategies to help with managing symptoms and finding new ways to enjoy life.

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"Lupe" is a 26-year-old Hispanic individual who has been receiving services from Telecare FSP for seven months. Lupe was referred to Telecare following a first hospitalization for psychotic symptoms resulting in grave disability. Leading up to the hospitalization Lupe would go days without eating or sleeping, would wander the streets with her two-year-old child in the middle of the night. Family members intervened and provided care for the child but Lupe was in denial of the impact the mental illness was having on their lives. Family members were successful in pushing Lupe into treatment by threatening to contact child protective services. Telecare staff successfully engaged Lupe to accept and follow through with medication treatment for the psychiatric symptoms. Lupe received education on self-care, mental health stigma, how to identify mental health symptoms early and use appropriate ways to manage symptoms and keep herself and son safe. Lupe's willingness to engage and Telecare's readiness to meet Lupe with invitation and understanding led to significant improvement in symptoms and avoided contact with CPS. Lupe continues to learn to be a better parent with ongoing support of family. When Lupe requested assistance with job seeking, Telecare provided linkages that resulted in ongoing, successful part time employment and ongoing independence for Lupe.

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"Penn" is a 37-year-old Caucasian individual who has received services from Telecare FSP since 2013. Prior to engagement in treatment with Telecare, Penn struggled with severe depressive symptoms, low self-esteem, hopelessness, difficulty getting out of bed, isolating from others, anxiety in social situations, and difficulty maintaining sobriety when all resulted in severe impairment in Penn's social functioning. These symptoms resulted in difficulty with maintaining housing, being banned from local motels and becoming homeless. Penn had 13 crisis hospitalizations and was often found intoxicated, unclothed, and in unsafe situations that resulted in victimization that worsened symptoms of Post-Traumatic Stress Disorder (PTSD). Since engaging in treatment with Telecare FSP, Penn has been able to sustain contact with the case manager, attend groups, participate in volunteer activities, return to church and built relationships with others. After years of going from unsuccessfully maintaining housing in crisis respite care, board and care or motels, Penn has been able to maintain housing for more than one year at a room and board. With greater periods of sobriety, Penn has exhibited increased insight and acceptance of substance use and mental health symptoms as well as accepted needed medical treatment. Penn progressed from lashing out aggressively toward others to taking time to understand the emotional responses and choosing less emotional responses toward others. This was achieved by going over the situations and emotions with the case manager, calling for help when needed, or taking time and space to regulate emotions with a goal of improving relationships with others. Penn continues to be successful with weekly support and fully utilizes Telecare FSP services. Penn has expressed gratitude toward Telecare and feels life is stable and better than it has been in years.

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Juvenile Justice (FSP-02)

JJ age 17 was initially referred by probation because of ongoing family conflicts, unstable housing, and difficulty maintaining hope for the future. JJ was provided with intensive case management and counseling services, with daily contacts. JJ was able to complete the terms of probation in the first year of services, but due to some poor choices again became involved in the juvenile justice system. With the support of the FSP program and willingness to get help JJ was able to find full time employment, open a bank account, complete terms of probation, and complete school through the Come Back Kids program. J.J. met all treatment goals throughout this process and followed up after termination of services to share the accomplishment of purchasing a car, and maintain stable housing.

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When "The Spot" opened BHRS was looking for youth who were connected with Juvenile Justice that possessed leadership skills, desire and willingness to volunteer. Ruben a 16 year old Hispanic youth on probation possessed these traits and was asked to volunteer. Ruben volunteered at "The Spot" for about 6 months to gain work experience, and develop social skills. While volunteering Ruben built enough self-confidence to start applying for jobs and soon landed a job working in a restaurant. He was able to help with family finances, as well as show younger sibling a good work ethic. Ruben is off probation, still employed, and stops by "The Spot" to say "hi" periodically.

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Integrated Forensic Team (FSP-03)

"Tina" a 33 year old individual was referred to IFT after returning from Napa State Hospital. Tina had a mental health assessment while incarcerated at the Public Safety Center and during the assessment Tina was often nonsensical in her speech, delusional in her thinking, and irritable in her mood. Tina completely denied any mental health symptoms and at the same time went on to describe a history that included hospitalizations "over 35 times" in Stanislaus County "because my mind isn't right". During incarceration IFT staff successfully engaged Tina in considering treatment and from there began to build more rapport.

Tina's documented history included extensive contacts with the mental health and criminal justice system including state hospital reports, arrest records, and treatment notes from time in custody. Through these records it was learned that Tina had been diagnosed with both schizophrenia and a mild intellectual disability. Records also indicated a long history of cocaine abuse, beginning in adolescence. Tina had been referred to BHRS services many times but had always refused. Tina began services with IFT Assertive Community Treatment Team immediately upon release from custody. The path to recovery was not an easy one and she struggled with for years with staying engaged in treatment, often refusing to have any contact with staff apart from crisis interventions. Tina continued to require frequent law enforcement contacts as well as frequent hospitalizations (11 hospitalizations in 2016). IFT staff never gave up, and through consistent use of motivational interviewing techniques slowly built a stronger rapport. Tina gained housing in the Garden Gate apartment complex in May 2017. Living in this apartment was a real achievement and meant she would have stable, independent housing for the first time in years. Tina began to thrive in this new environment; meeting neighbors, attending housing groups, and learning new independent living skills. Tina takes great pride in the home and often says "I feel safe finally". IFT staff provided intensive case management, individual rehabilitation, and medication services to support Tina to assist her to maintain housing. Since acquiring the apartment, Tina has had no crisis contacts, had no arrests, keeps frequent contact with program staff, and has developed a community of support. Recently, Tina has begun talking of attending substance use treatment stating "I'm ready to get clean".

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High Risk Health and Senior Access (HRHSA) (FSP-06)

"Felisa" a 19 year old Hispanic young adult with a complicated diagnosis of Bi-polar illness and a serious medical condition was referred to HRHSA by the BHRS Conservatorship Investigation office and Doctor's Behavioral Health Center (DBHC). Felisa was exhibiting aggressive behaviors towards herself and others which required one to one observation for over three weeks while hospitalized at DBHC. An assessment by Valley Mountain Regional Center (VMRC) ruled out diagnosis of developmental delay. Another complexity of the situation involved Felisa's mother and siblings who had experienced physical attacks by Felisa and being afraid to have her live at home. In contrast to this fear, Mom's strong cultural beliefs and desire to have her child home and difficulty setting boundaries had to be considered. Ultimately, for Felisa's mental illness and medical condition to be appropriately treated, the BHRS Public Guardian sought a temporary conservatorship.

Felisa was young for a temporary conservatorship to be considered and placement was challenging. HRHSA bi lingual staff members were assigned to work with Felisa through daily contacts, medical and psychiatric evaluations to determine what medication Felisa could tolerate. A wraparound service effort was needed for this young person to return to her family. The team worked with mom directly and through referral to other services to educate her about her child's mental and physical illnesses and how to cope with her own emotions, improve parenting skills and resolve citizenship issues so they could obtain other financial assistance.

Eventually, Felisa's symptoms began to reduce and the aggressive behaviors began to come under her control. HRHSA worked with Josie's TRAC to gently transition Felisa. At Josie's TRAC, located at Josie's Drop-in Center, there are other young adults and social supports with age mates.

HRHSA used "whatever it takes" approach with Felisa and were inspired by her resilience.

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

ISA staff members are continuously willing to be inspired and celebrate small successes and steps towards recovery by the individuals they serve. At the beginning of the year "Paul" came to the ISA. Paul had recently been hospitalized and was showing significant psychiatric symptoms, regular aggression as well as significant substance use. With program support, Paul was able to demonstrate willingness and ability to maintain contact with treatment providers and maintain housing which resulted in termination of the conservatorship. Over the past year, Paul has been a regular and positive participant at groups, individual therapy and taken an involved approach to case management services. Paul currently has several months of sobriety from substances and is showing significant insight. Paul has expressed a desire to return to school, and with continued progress, that is a likely goal to accomplish over this next year.

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Central Star FSP (FSP–08)

"Mickey" was 9 years old when he and his family were referred to Central Star FSP services. They had been in multiple other local mental health programs, including his most recent enrollment with Therapeutic Behavioral Services. A central theme of Micky's issues involved becoming extremely agitated and showing intense irritability, temper and physical aggression. His parents were very tired and irritated with his behaviors, and their reaction to him was challenging their ability to support Micky to learn emotional self-regulation. Micky refused to actively participate in TBS sessions and appeared unable to accept positive verbal reinforcement either at home or in the school environment. Mickey was diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD). His home environment was overly focused on parental attempts to try to control his behavior, and constant family verbal discussions about what to do about him and his behavior. Micky's parents reported they struggled to manage his medication regime, both having difficulties in obtaining his ADHD medications and in not following through with regular medication administration. As a result, they interpreted Micky's poor response as the medicines not having much benefit. Micky's parents expressed feeling lost and hopeless for not "getting the right treatment" for their child.

Central Star staff began to work with Micky to help him learn how to manage his symptoms of ADHD by reducing and replacing his maladaptive coping responses with healthy, effective coping skills that would show a positive impact on his ability to function at home and at school. The primary framework for working with Micky and his family were the Family and Systems Treatment (I-FAST) approach and Cognitive Behavioral Therapy (CBT). Sessions included both family and individual sessions, with parents as the primary focus of some interventions to gain alignment between them on when and how to use the interventions effectively. Toward this end, sessions were set aside for Micky's parents to get answers to their questions and to express their feelings and obtain referrals for their own needs. They were given contact numbers to reach FSP staff for any concerns and to assure there was sufficient continuity of care among the FSP/CFT team. Micky's therapist used Thera play and puppetry to create a positive therapeutic alliance, opportunities for emotional expression, and gentle testing scenarios to exploring and build Micky's frustration tolerance. Psychological education and coping skills training was geared to Micky's cognitive and developmental level so he could experience rapid, repeated successes trying out new ways of seeing things and behaving with others.

Approaching the end of treatment, Micky has shown great emotional and cognitive gains. By his own proud self-report, Micky's anger (5/10 scale) and impulsivity (8/10 scale) symptoms declined. Micky's mother and sibling report they now understand Micky much better and have more patience with him. Micky's mother also shared that Micky has not had any bad reports from school for a while. Micky's mother recognized the learning within herself and her family members, that they are all better at managing their own emotional responses, as well as at managing Micky's behaviors. Micky is better able to express his feelings directly, rather than act them out, and is having many positive interactions with his parents.

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Community Response Team and Warm Line (GSD-02)

"Winn" came to the Peer Navigation (PN) team, within Warm Line, with a very long history of severe alcohol abuse and was at one point clinically dead from alcohol poisoning, revived and sent to Doctor's Medical Center (DMC) for treatment. Winn was homeless when a church organization reached out and offered alcohol and drug treatment support at Stanislaus Recovery Center (SRC) by paying the residential fee. Peer Navigators met Winn while waiting for intake assessment for entry into SRC. Winn received treatment in the Co-occurring Treatment Team (COT) program at SRC residential program and successfully completed the 60 day program. During treatment Winn fully engaged in the program by sharing hopes for recovery, disclosing drug and alcohol use history and mental illness issues and asked for help with basic needs. Winn re-connected with the Peer Navigation Team as part of the discharge plan. Winn requested support with grief counseling at Community Hospice. Winn had sustained four years of sobriety in the past but relapsed when their father passed away. Currently, Winn has maintained continuous sobriety since completing treatment and works in a crisis stabilization unit where the extensive recovery background supports the skills to help others struggling to achieve and maintain recovery. Winn is also involved in giving back to the community by offering outreach and engagement support to others in need.

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Consumer Empowerment Center (CEC) (GSD-05)

"Ren" was referred by Probation through the AB109 program, named for an assembly bill that focused on realignment within the justice system. Ren had a 20+ year history in prison, was homeless and shared that all he knew was institutional life. While Ren participated in a mandatory program with Probation, he also participated in voluntary activities at CEC such as; peer-support groups, recovery-oriented groups, and volunteer opportunities. Ren began to feel it was possible to develop trust in others at CEC and committed to tasks that historically he never would do because of feeling "I had been mandated to do things for so long".

Ren actively participated in recovery-oriented services and maintained his sobriety and engaged in behavioral health services from IFT to obtain case management and housing. Additionally he was able to focus on medical issues and have surgeries for long neglected issues.

Ren successfully completed Moral Reconation Therapy (MRT) a systematic, cognitive-behavioral, step-by-step treatment strategy designed to enhance self-image, promote growth of a positive, productive identity, and facilitate the development of higher stages of moral reasoning. Ren graduated MRT and became a role model in supporting other MRT classes alongside Probation Staff. Ren successfully completed the formal commitment to Probation and continues to voluntarily support their probationers with referral and support to CEC.

He actively participates in community engagement efforts through the Stanislaus County Chief Executive Office's Community System of Care and the Point in Time Count that engages with homeless individuals. Ren seeks peer support and checks-in with CEC staff to talk about difficulties in the current living situation or struggles with a painful past. Today Ren celebrates freedom from institutions, maintains recovery practices and now is a house manager for a housing program in Stanislaus County. Ren can offer hope to others as he knows exactly how they feel. He continues to check in and say hello to CEC and remind the members that everyone has a chance at recovery.

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Crisis Stabilization Unit (CSU) (GSD-06)

It is always a success at the CSU when an individual in crisis is able to come into the CSU, get rest, get help and go back out to their life with resources they needed. "June" is one example of such a person. She had recently relocated to Stanislaus County with her son and had many situational and emotional stressors that contributed to need for CSU services. After a brief stay, June was optimistic and equipped with a referral for her son's development needs and for her own emotional needs. She expressed gratitude to CSU staff and felt that she and her son would be going forward in life.

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Garden Gate Respite (O&E-02)

"Bob" was homeless and trying to get his life back together when an IFT staff member brought him to Garden Gate Respite. Bob was highly motivated for change, accepted support easily and attended all groups including local community AA/NA meetings. Bob connected with the Consumer Empowerment Center (CEC) staff for additional community support. Eventually Bob went to live in a supported housing complex in the community, applied for employment, and passed the Life Scan background check. Initially, he sought employment at the Warm Line, however, it was reported recently he now works for Stanislaus County.

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A staff member from Josie's Place Service Team (JPST) brought in a transgender female, "Dylan" who was receiving services at JPST but needed additional support and respite housing. Dylan had aged out of foster care and became homeless resulting in increased risk of psychiatric hospitalization, incarceration, and victimization on the streets. Garden Gate staff provided support and encouragement and found that Dylan was highly motivated to get on her feet and start a new life. She attended most of the groups at Respite and visited Josie's Drop in Center daily for peer group support. The housing support and socialization Dylan received resulted in her increased willingness to cooperate with more formal treatment and support services in the community. She was able to get hormone therapy started while staying at Respite and stated that she very happy about becoming the true person she wants to be. She was transitioned from Garden Gate Respite to Aspiranet Transitional Housing for Emancipated Foster Youth for long-term support.

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Outreach and Engagement/Underserved Rural Communities (O&E-03)

Outreach & Engagement Team encountered "Caro" at Garden Gate Respite (GGR) and referred her to O&E Latino Access for a mental health screening. "Caro" was a transition aged young adult Latina previously living with her adoptive mother when the Outreach team met her at GGR. Caro was having serious difficulty coping with very challenging and unstable family circumstances for years, multiple past traumas, no family support and strong thoughts of self-harm that resulted in 3 suicide attempts. "Caro" was referred for services and supports with Telecare Fast TRAC Team and has since been stable and actively working on her goals.

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Public Comment Form

Stanislaus County Behavioral Health & Recovery Services
800 Scenic Drive, Modesto, CA 95350
209 525-6247 fax 209-525-6291

Please complete and send into our office Attn: Leng Power MHSA Manager or email comments to lpower@stanbhrs.org

Mental Health Services Act (MHSA)/Prop. 63

Annual Update FY 2018-19
30-Day Public Comment Form

May 30, 2018 – June 28, 2018

PERSONAL INFORMATION (Optional)

Name:_____ Agency/Organization: _____

Phone Number:_____ Email address:_____

Mailing address: _____

MY ROLE IN THE MENTAL HEALTH COMMUNITY

__ Consumer/Service Recipient
__ Family Member
__ Education
__ Social Services
__ Service Provider
__ Law Enforcement/Criminal Justice
__ Probation
__ Other (specify) _____

GENERAL COMMENTS REGARDING THE ANNUAL UPDATE CONTENT

PLEASE SHARE ANY CONCERNS ABOUT THE ANNUAL UPDATE