AMENDED

Mental Health Services Act
FY 2014-15 Annual Update
and
Three-Year Program and
Expenditure Plan for
FY 2014-15 through FY 2016-17

August 2014

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MHSA County Compliance Certification

County: TRI-CITY MENTAL HEALTH SERVICES

Local Mental Health Director	Program Lead
Name: JESSE H. DUFF	Name: RIMMI HUNDAL
Telephone Number: (909) 623-6131	Telephone Number: (909) 784-3016
E-mail: jduff@tricitymhs.org	E-mail: rhundal@tricitymhs.org
County Mental Health Mailing Address: 1717 N. Indian Hill Boulevard, Suite B Claremont, CA 91711	

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

This Three-Year Program and Expenditure Plan or Annual Update has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Three-Year Program and Expenditure Plan or Annual Update was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on May 22, 2014.

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

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

Jesse H. Duff — Jesse H. Duff — 8/28/14

Local Mental Health Director/Designee (PRINT) — Signature — Date

County: TRI-CITY MENTAL HEALTH SERVICES

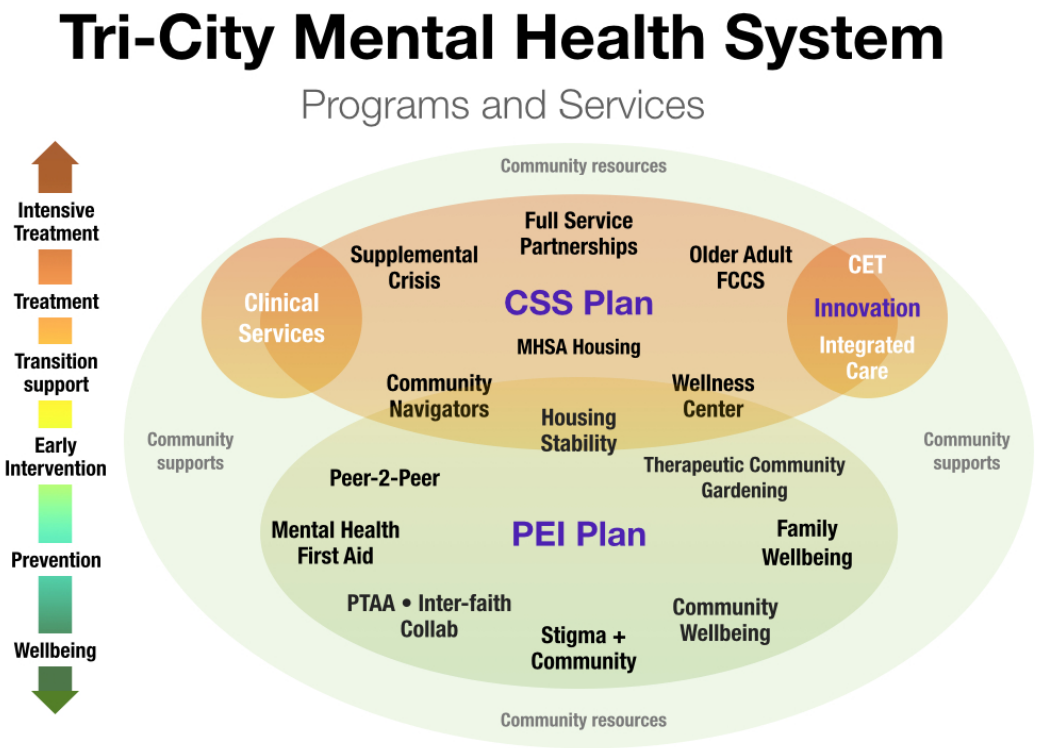
Introduction to Tri-City Mental Health Services

Tri-City Mental Health Services' System of Care

Tri-City Mental Health Services (TCMHS) was created in 1960 as a result of the Joint Powers Authority adopted by the cities of Claremont, La Verne, and Pomona. By understanding the needs of consumers and families, it provides high-quality, culturally-competent, behavioral health care treatment, prevention, and education in the diverse cities of Pomona, Claremont and La Verne.

TCMHS used the MHSA planning effort to create a unique and transformative approach to mental health service delivery. Guided by a vision of a system of care that is aimed at creating wellbeing in the three cities of Pomona, Claremont and La Verne, TCMHS plays a critical but not exclusive role in providing mental health supports and services. Rather, the system of care is made possible by the community's own capacity to care for its members without relying exclusively on expanded services provided by TCMHS. The role of TCMHS in this system of care is to provide services when necessary and to support the community's capacity to care for its members.

This orientation toward building a community's capacity for wellbeing, recovery, and mental health is the foundation of TCMHS's MHSA programming. The approach can be visualized using the following map of the emerging system of care and the MHSA investments that have been made to date:



Along the left side are the complete range of supports and services available, ranging from non-MHSA funded clinical services to MHSA-funded intensive treatments such as Full Service Partnerships to MHSA-funded programs aimed at prevention and wellbeing such as the Community Wellbeing grants. All of these programs are bolstered by formal and informal community supports. TCMHS envisions its system of care from this broad perspective, inclusive of formal and informal community supports that help community members maintain and improve their mental health with or without formal services provided directly by TCMHS.

Demographic Profile of TCMHS's Service Area

TCMHS serves the three-city population of Pomona, Claremont, and La Verne of approximately 215,000 persons with Pomona being the largest of the three cities. According to the U.S. Census (2010), 57% of the population is Latino, 26% is White, 9% is Asian Pacific Islander, 6% is African American, 2% is multiracial and less that one percent is American Indian. Forty-three percent of the population has an income that is less than 200% of the federal poverty threshold. Roughly 48% of the Tri City population speaks monolingual English, while 42% speaks Spanish as the primary language at home. Another 6.7% speak an Asian Pacific Islander language as the primary language, and 3.5% of the population speaks a language other than the ones already named. Forty-nine percent of the population is male, and 51% is female.

While these demographics describe the area as a whole, there are distinct differences in demographics of each of the cities as demonstrated in the following tables:

Table 1: Ethnic Distribution by City

	La Verne	Claremont	Pomona	Tri-Cities
White	55.4%	58.9%	12.5%	26.2%
Latino	31.0%	19.8%	70.5%	56.6%
African American	3.2%	4.5%	6.8%	5.9%
American Indian	0.2%	0.2%	0.2%	0.3%
API	7.6%	13.0%	8.4%	9.0%
Multi-Race/Other	2.6%	3.6%	1.6%	2.0%
Total	100.0%	100.0%	100.0%	100.0%

Table 2: Age Distribution by City

	La Verne	Claremont	Pomona
0-15	18.1%	16.7%	25.9%
16-25	14.2%	22.2%	18.6%
26-59	44.2%	38.9%	44.3%

60+	23.5%	22.3%	11.3%
Total	100.0%	100.1%	100.1%

Table 3: Primary Language Distribution by City

	La Verne	Claremont	Pomona
English	75.9%	76.1%	35.0%
Spanish	14.6%	9.4%	55.8%
API	2.5%	7.7%	8.1%
Other	6.9%	6.7%	1.1%
Total	99.9%	99.9%	100.0%

Table 4: Population in Poverty by City

	La Verne	Claremont	Pomona	Total
200% of Federal Poverty Threshold	6,165	5,197	80,600	91,962
Total Population	31,063	34,926	149,058	215,047
% of Population in Poverty	19.8%	14.9%	54.1%	42.8%

TCMHS has a current client base of 1116 persons. In FY 2012-13, TCMHS served more than 1,400 unduplicated clients who are enrolled in formal services. It has 142 full-time and 18 part-time employees and an annual operating budget of $17 million dollars. TCMHS strives to reflect the diversity of its communities through its hiring, languages spoken, and cultural competencies.

Description of Stakeholder Process

Tri-City Mental Health Services engaged in expansive community engagement and stakeholder processes throughout its MHSA planning and implementation efforts by including more than 6,000 people for its Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) plans. TCMHS's ongoing robust stakeholder engagement process demonstrates its commitment to ensuring that broad stakeholder and community participation takes a deep hold in our transformed mental health system.

Stakeholder perspectives include individuals who receive services; family members; community providers; leaders of community groups in unserved and underserved communities; persons recovering from severe mental illness; seniors, adults, and families with children with serious mental illness; representatives from the three cities of Claremont, La Verne and Pomona; veterans; representatives from the local school districts; primary health care providers; law

enforcement representatives; mental health, physical health, and drug/alcohol treatment service providers; faith-based community representatives; representatives from the LGBTQ community; representatives from LACDMH and other county agencies; and many others. Stakeholders participate in all aspects of the Mental Health Services Act, including policy development, planning, implementation, monitoring, improvement, evaluation, and budget allocations.

To arrive at this Annual Update and Three-Year Program and Expenditure Plan, TCMHS engaged stakeholders in a seven-month program review, evaluation, and planning process. To aid stakeholders' participation, we provided them an orientation packet which included information on MHSA, its five plans, a glossary of terms and acronyms, and a summary of the requirements for Innovation projects. Beginning in September 2013, four workgroups reviewed reports and data regarding the CSS, PEI, and INN projects and made recommendations for improvement and/or continuation of the projects. Workgroups also identified potential areas for learning and future Innovation projects. During the January 2014 meeting, TCMHS formed three additional workgroups to explore potential Innovation projects which are included here as the Proposed Innovation Plan. The stakeholders endorsed these proposed Innovation projects during the March 2014 meeting.

This Annual Update and Three-Year Program and Expenditure Plan was posted on April 21, 2014, and the required 30-day review process ended on May 20, 2014. Staff circulated a draft of the annual update by making electronic copies available on TCMHS's website and providing printed copies at various public locations (such as at the Wellness Center, libraries, etc.). Several methods of collecting feedback were available such as phone, fax, email, mail, and comments at the public hearing.

The public hearing was scheduled for May 22, 2014. The Mental Health Commission recommended the Three-Year Program and Expenditure Plan including planned Innovation Programs for approval, and the Governing Board approved the Three-Year Program and Expenditure Plan at this meeting.

Attachment A includes the sign-in sheets from the public hearing. Attachment B lists the demographics of those who were invited to participate in the planning process and public hearing. Attachment C is a summary of all the comments received at the public hearing; no changes were made to this plan based on comments from the public hearing. Attachment D is a summary of the recommendations stakeholders identified as areas for each program's improvement and opportunities for greater collaboration between programs and between additional stakeholders.

Introduction to the Annual Update and Three-Year Program and Expenditures Plan

Introduction

What follows are descriptions of each MHSA-funded program. The descriptions include updates to the program's development; performance outcomes for CSS, PEI, and INN programs; and cost per participant calculations for programs that provide direct services. The services provided in Fiscal Year 2012-13 by age group, number of clients served, and average cost per person are summarized in the table below as per the guidelines for this Annual Update and Three-Year Program and Expenditures Plan:

Table 5: Summary of MHSA Programs Serving Children, Including TAY

Program Name	Type of Program	# of Children or TAY Served	Cost Per Person
Full Service Partnerships - Child	CSS	58.58 FTC*	$20,923
Full Service Partnerships - TAY	CSS	65.99 FTC*	$19,304
Community Navigators	CSS	2,077**	$189
Wellness Center	CSS	2,045**	$476
Supplemental Crisis Services	CSS	70**	$910
TAY Wellbeing	Prevention	81**	$1,559
Family Wellbeing	Prevention	404**	$217
Housing Stability	Early Intervention	282**	$613
Therapeutic Community Gardening	Early Intervention	55**	$2,739

Table 6: Summary of MHSA Programs Serving Adults and Older Adults, Including TAY

Program Name	Type of Program	# of TAY, Adults, Seniors Served	Cost Per Person
Full Service Partnerships - TAY	CSS	65.99 FTC*	$19,304
Full Service Partnerships - Adult	CSS	114.5 FTC*	$20,581
Full Service Partnerships – Older Adults	CSS	11.67 FTC*	$21,231
Community Navigators	CSS	2,077**	$189
Wellness Center	CSS	2,045**	$476
Supplemental Crisis Services	CSS	70**	$910
Field Capable Services for Older Adults	CSS	28	$6,291

Program Name	Type of Program	# of TAY, Adults, Seniors Served	Cost Per Person
TAY & Older Adult Wellbeing	Prevention	81	$1,859
Family Wellbeing	Prevention	404**	$217
Housing Stability	Early Intervention	282**	$613
Therapeutic Community Gardening	Early Intervention	55**	$2,739
Modified Cognitive Enhancement Therapy	Innovation	16 FTC*	$19,857

* FTC means *Full-time Client.* Some people who begin a program may leave before completion. In order to accurately calculate a cost per person, Tri-City staff calculated the number of clients who continued in the program for all of FY 2012-13.

** Some programs cannot breakout the numbers of clients served by age group. These numbers represent the total number of clients served for the program in all age groups.

During the Stakeholder review process used to prepare this Annual Update and Three-Year Program and Expenditure Plan, stakeholders reviewed the available performance outcome data which is tracked for each program through our Results-Based Accountability process (RBA). Through the RBA process, TCMHS developed indicators to help us track the answers to the following three questions: 1) How much did we do, 2) How well did we do it, and 3) Is anybody better off? The performance data included in this plan is the same data that our stakeholders and staff reviewed.

Stakeholders also identified areas for each program's improvement and opportunities for greater collaboration between programs and between additional stakeholders. A summary of those recommendations is provided as Attachment D.

As per the guidelines for the Three-Year Program and Expenditure Plan, TCMHS considered services similar to those provided by the Mentally Ill Offender Crime Reduction Grant Program; however, those services were not considered a high priority by our stakeholders at this time.

Lastly, there were no shortages in personnel identified, nor additional assistance needs from education and training programs.

Full Service Partnership Programs (CSS funded)

TC-01: Full Service Partnerships

OVERVIEW

Full Service Partnerships (FSPs) are for people who are severely ill and at risk of homelessness or other devastating consequences. The program uses a "whatever it takes" approach to help people recover. The plan can include all needed services, including but not limited to traditional mental health services and safe housing. Each enrolled individual has a personal services coordinator and 24/7 staff support.

ORIGINAL RATIONALE

The CSS Plan requires counties to allocate at least 51% of the plan's total budget to FSPs. This requirement reflected significant evidence of success from pilot projects in California that were lauded across the country as models for successful mental health care.

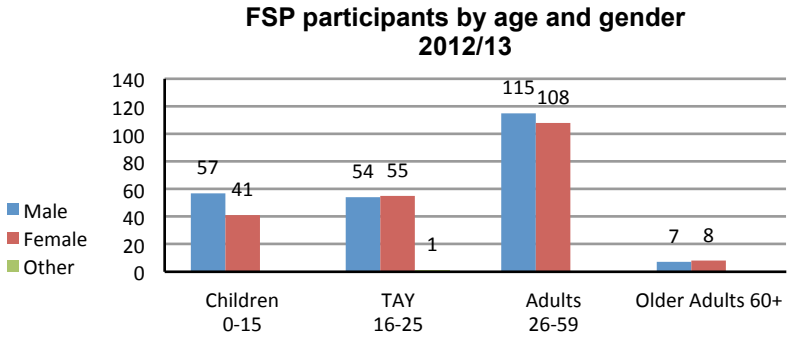
NOTES ON DEVELOPMENT • PROGRESS • LEARNING

FSPs continue to prove a highly effective intervention for people suffering from SMI/SED. One pattern that has emerged, however, is that we have not maintained maximum enrollment for adults and older adults. Staff turnover and understaffing are the principal causes for this under-enrollment. Once all staff positions are filled, staff members will partner with Community Navigators to increase outreach and engagement efforts for all FSPs, particularly those for adults and older adults.

A number of developments outside of the mental health system will likely impact FSPs and related services over time. For example, through the Affordable Care Act, more people will become eligible for public mental health services, including Full Service Partnerships. Because TCMHS provides Medi-Cal services through a contract with LACDMH, we will need to collaborate with LAC DMH to coordinate enrollment and provision of services, including FSPs. In addition, implementation of the new Local Control Funding Formula (LCFF) will impact how some school-aged children qualify for and can receive mental health services.

HOW MUCH DID WE DO?

445
individuals served
2012/13



IS ANYONE BETTER OFF: SUCCESS STORY

Initially in her FSP, a client refused medications management support and generally had poor insight into her illness and its consequences. After several months, she received approval for more frequent visits with her son of whom she had lost custody. She now participates actively in her treatment and attends Wellness Center groups. She recently received approval for subsidized housing through Shelter Plus Care.

Table 7: Cost per person estimate for FSPs, FY 2012-13

$ Source	0-15 58.58 FTC*	16-25 65.99 FTC*	26-59 114.5 FTC*	60+ 11.67 FTC*	**Total FTCs**
MHSA	2,690	7,386	12,023	11,899	161.50
Match	20,450	12,768	10,601	11,360	
Totals	**$23,140**	**$20,153**	**$22,624**	**$23,258**	
Uninsured MHSA $	$13,876	$18,114	$17,993	$15,157	89.24

* **FTC** means *Full-time Client.* Some people who begin FSPs leave the program before completion. In order to accurately calculate a cost per person for Full Service Partnerships, Tri-City staff calculated the number of clients who continued in an FSP for all of FY 2012-13.

Non-Full Service Partnership Programs (CSS funded)

TC-02: Community Navigators

OVERVIEW

Community Navigators help people in the Tri-City area connect to local resources, including informal community supports and available formal services. Navigators also provide education and stigma reduction services to local communities and organizations. All Tri-City Community Navigators are bilingual and bicultural. They regularly stay in touch with local resources, including community organizations, emerging and well-established health and mental health service providers, law enforcement agencies, schools, courts, residential facilities, NAMI programs, self-help groups, client advocacy groups, homeless shelters and others. The Navigators help build teams of volunteers and staff from other organizations and community groups. They involve people who have received services, family advocates, family members, and leaders of un-served and under-served communities whenever possible in identifying and helping leverage community supports.

ORIGINAL RATIONALE

One of the foundational premises of the Tri-City CSS plan is a belief that professionally delivered, publicly funded mental health services, by themselves, cannot deliver the outcomes we seek. Therefore, if we are committed to achieving the MHSA outcomes for everyone in need of support, we must develop a broader infrastructure to leverage all available community supports, including informal supports and professional services. Community Navigators and their teams are a crucial structure for helping people successfully access formal and informal supports when they are needed.

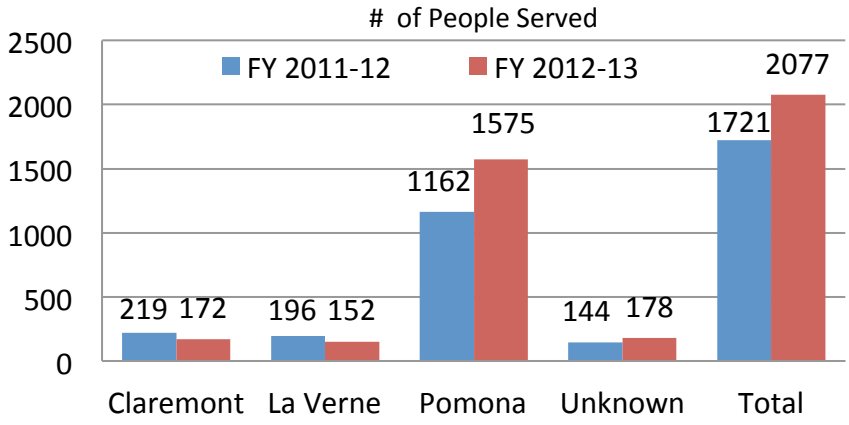
NOTES ON DEVELOPMENT • PROGRESS • LEARNING

In addition to the responsibilities identified above, Community Navigators also provide critical follow up to the Supplemental Crisis Services and FSP teams. Indeed, all TCMHS programs utilize the resources provided by the Community Navigators. The main challenge for the Community Navigators has been helping people who are homeless or in dire financial straits. In FY 2012-13, an additional Community Navigator was added to address the increased need for linkages and resources related to housing issues.

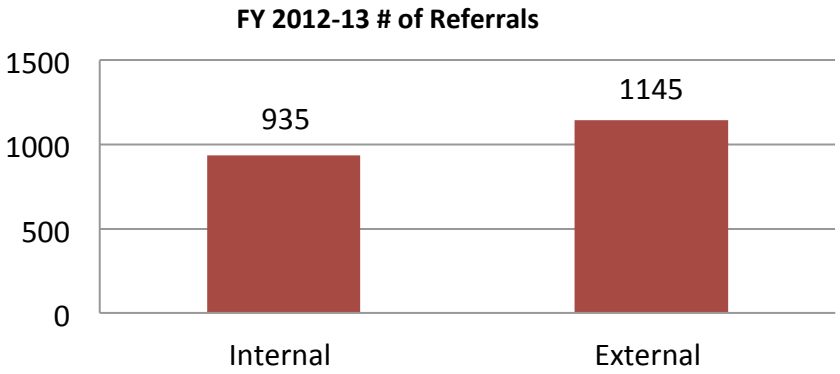
Referrals to Community Navigators may decline over time as they saturate the three cities with information about available resources. At the same time, other Tri-City programs—e.g., Full Service Partnerships, Peer-to-Peer Counseling, Therapeutic Community Gardening and Field Capable Services—are helped by the outreach and engagement efforts of the Community Navigators. This work will likely increase over time.

Survey data regarding how well Community Navigators do their work and outcomes ("is anybody better off?") are difficult to obtain since those who are served are not available for follow-up.

HOW MUCH DID WE DO?



HOW WELL DID WE DO IT?



IS ANYONE BETTER OFF: A SUCCESS STORY

A woman with three children ages 12 years, 11 years, and 18 months old was referred to a Community Navigator after visiting a food bank. The Community Navigator noticed that the woman appeared extremely anxious, and asked if she had ever been diagnosed with a mental illness. The woman had been diagnosed as Schizophrenic with delusions several years ago but stopped her medication during pregnancy. Soon after, the woman was enrolled in a Full Service Partnership. The woman and her children are currently being housed at a local motel. Additionally, the children received clothing, shoes, backpacks, and school supplies for the school year.

COST PER PERSON ESTIMATE FOR FY 2012-13: $189.11 ($392,792/2077)

TC-03: Wellness Center

OVERVIEW

The Wellness Center is a community hub for activities that promote recovery, resiliency and wellness for residents of the Tri-City area. The Wellness Center is open to people of all ages, focusing especially on people in recovery and their families. The Wellness Center sponsors support groups, and provides an array of holistic services through collaboration with other community partners.

Staff members at this site include peer advocates, family members, clinical staff, and others. They provide a range of culturally competent, person– and family-centered services and supports that are designed to promote increasing independence and wellness. The Wellness Center is open 5 days a week, and for extended hours on many days. The Wellness Center supports people who have struggled with mental health issues accelerate their movement toward independence, recovery, and wellness.

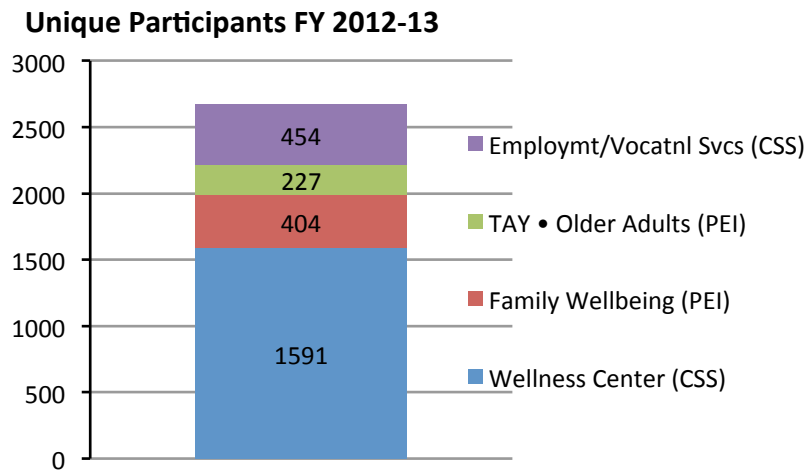
ORIGINAL RATIONALE

The Wellness Center was conceived as a place of support to people who have struggled with mental health issues so that they could accelerate their movement toward independence, recovery and wellness. It does not offer intensive counseling, medication or other more traditional mental health services. Instead, it provides self-help groups, peer and family support services, educational resources, recreational and cultural activities, assessment and linkage services, and other services to promote increasing independence. It also provides specialized supports and services for transition-aged youth.

NOTES ON DEVELOPMENT • PROGRESS • LEARNING

Offerings at the Wellness Center have expanded exponentially since the Center's opening. Some of the services delivered at the Center are funded by MHSA funding; other services are delivered by independent organizations and communities who partner with the Center and use its facilities. One of the emerging explorations for the Center is how to expand these partnerships and extend programming into other community settings across the three cities.

HOW MUCH DID WE DO?



HOW WELL DID WE DO IT?

37
monthly support groups

IS ANYONE BETTER OFF?

128
employment placements

IS ANYONE BETTER OFF: SUCCESS STORIES

A current participant referred a 19 year-old man to the Wellness Center by another participant. He began meeting with us, using the PC Lab, and participating in events. Soon after he began attending the Center, he had to leave his parent's house. Through our referral, he recently obtained his Forklift Certificate. He asked for additional help from us to get his driver's license. He now drives to work and rents a room in Pomona. He also enrolled in classes at Citrus College.

A journal entry from a participant: "About a year ago, I was involved in an altercation that landed me in juvenile court. There, I was ordered to complete community service as well as anger management. After searching of what seemed like hundreds of places, I found the Tri-City Wellness Center. At first, I didn't take the class seriously. I went just to get it over with. Then, something overcame me and I actually started participating. … I felt like a changed person. I can proudly say that I now think before I say/do anything. I learned to walk away from a situation before I get to my boiling point. Also, I learned techniques to calm myself down. … I can't thank the Wellness Center enough for transforming me from an angry-at-the-world teenager to a calm, happy, young lady."

COST PER PERSON ESTIMATE FOR FY 2012-13: $476.52 ($974,845/1591 Wellness Center + 454 Employment participants)

TC-04: Supplemental Crisis Services

OVERVIEW

The Supplemental Crisis Services program provides after-hours and weekend support to individuals who are suffering a crisis and who currently are not receiving TCMHS services. Local, on-call clinicians offer support to the person in crisis, police personnel, and others as appropriate. Support may be provided over the phone or at the crisis location. Paired with follow-up by the Community Navigators, the Supplemental Crisis Services program helps people with symptoms of serious mental illness prevent hospitalization and receive more appropriate care.

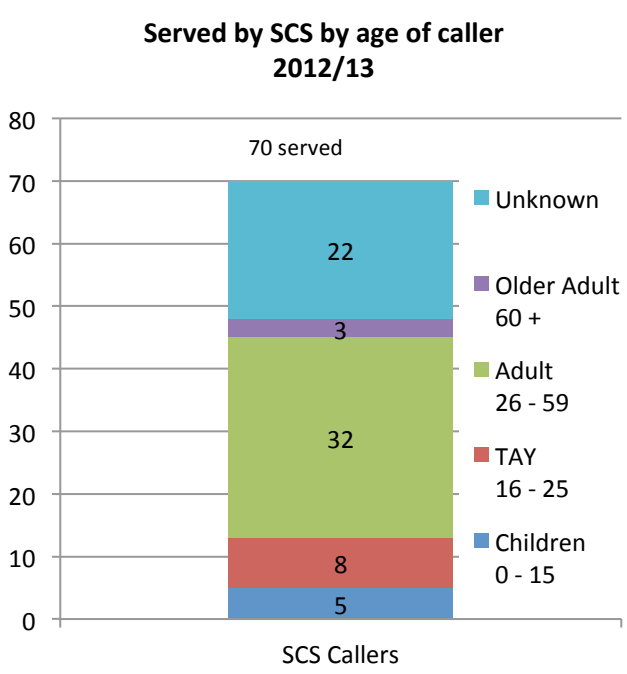
ORIGINAL RATIONALE

The Tri-City clinic and other area providers offer 24/7 crisis support to people they directly serve. People not currently receiving services, however, who suffer a crisis after hours or on weekends must rely on Los Angeles County's Psychiatric Mobile Response Team (PMRT). Given that the three Tri-City area cities are on the eastern edge of the county, PMRT response times can sometimes take hours. Such delayed support to the person in crisis and his/her family increases the likelihood that the situation will deteriorate, resulting in the person being sent to an emergency room, committed to a psychiatric facility, or incarcerated. The Supplemental Crisis Services program is designed to ameliorate and/or prevent these escalations.

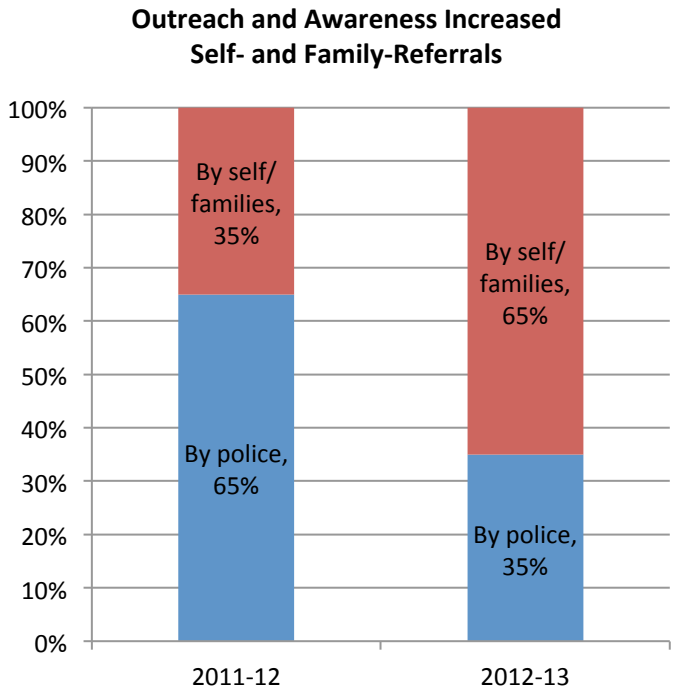
NOTES ON DEVELOPMENT • PROGRESS • LEARNING

The number of calls received is high and will likely continue to increase as the community becomes more aware of available services. In addition, TCMHS receives a significant and increasing number of non-clients who walk in during business hours needing crisis interventions. Tri-City incurs significant costs providing support to those who walk-in, including ambulance fees and other costs. In response, the Delegates recommended and the Tri-City Board approved an expansion of the Supplemental Crisis Services program for FY 2013-14 to enable services to be available 24/7, and to help defray the uncompensated costs of providing crisis services to people who are not enrolled in any program.

HOW MUCH DID WE DO?



HOW WELL DID WE DO IT?



IS ANYONE BETTER OFF: SUCCESS STORIES

A caller who lost her job felt like she had no one she could ask for support. The team was able to link her to a Community Navigator and local support groups. The caller said that just having someone with whom she could talk helped her through this crisis.

A frequent caller lives alone and often feels frightened in the middle of the night. Knowing that the Supplemental Crisis team is available helps her feel less afraid. After encouragement from the team, the caller started participating in support groups at the Wellness Center.

An elderly woman called because she wanted to talk. Her speech sounded slurred, so the crisis therapist urged her to call 911. The woman called the next night to thank the crisis team, because it turned out that she required medical attention at an emergency room, and without the urging of the crisis therapist, she might not have received it.

COST PER PERSON ESTIMATE FOR FY 2012-13: $910.33 ($63,723/70)

TC-05: Field Capable Clinical Services for Older Adults (FCCS)

OVERVIEW

Through this program, TCMHS staff members provide mental health services to older adults where they are, such as in their homes, senior centers and medical facilities.

ORIGINAL RATIONALE

Older adults are the fastest growing demographic population in Claremont and La Verne. According to 2010 Census data, individuals aged 60 years and older comprise 23.5% of La Verne's population, 22.3% of Claremont's and 11.3% of Pomona's. While a number of programs provide health and social supports for older adults, there are few services to meet the mental health needs of this population. Older adults, especially frail elders, often have a difficult time accessing services in traditional venues and therefore need mental health services provided in locations convenient to them.

NOTES ON DEVELOPMENT • PROGRESS • LEARNING

TCMHS's Field Capable Services for Older Adults is a popular program. It is uncovering a deep need among older adults for mental health services provided outside of clinicians' offices. In addition, some older adults do not seek the care they need because Medicare does not cover long-term therapy.

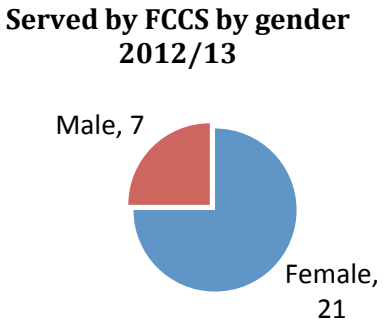
One challenge involves moving clients through this program into other community supports, so that more older adults can be served. Currently there is the capacity to serve 23 seniors at any one time. The longer seniors stay in this program, the fewer total number of people can be served.

To address this challenge, TCMHS is developing a wider variety and breadth of services to address the needs of those currently in the program. For example, there are two Wellness Center seniors groups, and TCMHS staff members are working to develop more support groups and transportation options.

In addition to improving the capacity for clients to move through the program, this program's success relies on effective outreach and engagement to achieve its target numbers. Unmet community demand can be identified and addressed with increased outreach and engagement activities performed by Community Navigators.

HOW MUCH DID WE DO?

28
individuals
served
2012/13



IS ANYONE BETTER OFF: SUCCESS STORIES

Vanessa (not her real name) was receiving adult outpatient services before she was transferred to FCCS about two years ago. Vanessa is blind and has a hearing impairment. She struggles with communication and has a hard time trusting other people. She transferred out of outpatient services in part because she did not trust the treatment team.

Vanessa's FCCS case manager began meeting frequently with her to build a relationship. Early on, the case manager and FCCS team focused on her basic needs, such as helping her learn how to better navigate around her room. The case manager also worked with Vanessa's In-Home Supportive Services worker to help her understand some of Vanessa's needs and mental health issues.

As Vanessa became more mobile, the case manager arranged for Make Seniors Smile to provide her with a wheelchair. Recently, the FCCS team gave her a radio, and now she sometimes dances to the music she hears. Vanessa is showing clear signs of independence, increased trust of others, and a willingness to work with others in her life.

COST PER PERSON ESTIMATE FOR FY 2012-13: $6,291/person ($176,143/28)

TC-06: MHSA Housing

OVERVIEW

In July 2011, the TCMHS Board approved a Comprehensive Housing Master Plan to construct or rehabilitate 100 short-term transitional and permanent supportive housing units. Permanent supportive housing units are living spaces where people who are homeless or at risk of homelessness and who suffer from one or more mental illness can receive an array of services designed to support their recovery.

ORIGINAL RATIONALE

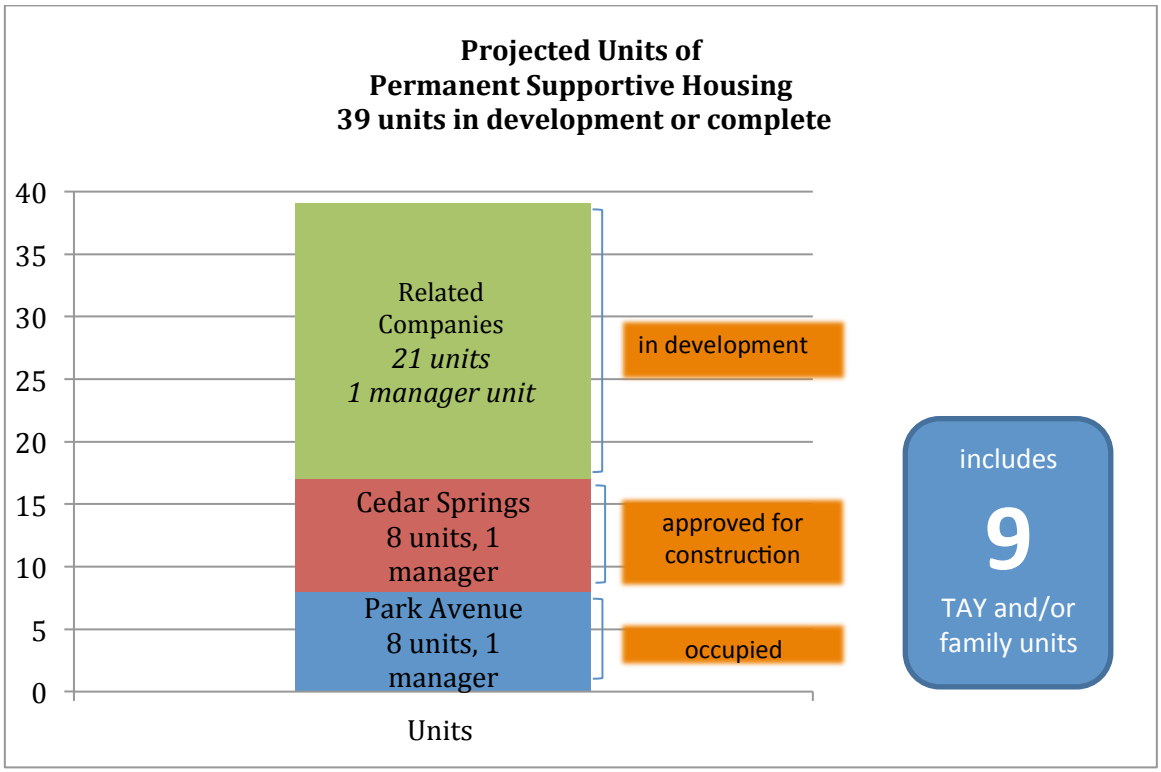
Sustaining recovery from mental illness is profoundly difficult if the person receiving services does not have the security of stable, safe and sanitary housing. Permanent supportive housing has proven to be a significant part of successful recovery plans for many people with serious mental illness. Such housing enables successful pathways to recovery and, ultimately, can reduce the cost of other services such as emergency room visits and incarceration. For many years, Tri-City, in collaboration with other private and governmental partners, has provided short-term transitional housing for individuals receiving services. Until recently, Tri-City lacked the resources to undertake efforts to supply long-term Permanent Supportive Housing. However, the CSS Housing plan now allows Tri-City to begin providing such long-term housing.

NOTES ON DEVELOPMENT • PROGRESS • LEARNING

TCMHS wants to increase permanent supportive housing in the Tri-City area. Given the demographics of people served by Tri-City and the relative sizes of the three cities, the locations for housing that would provide the most impact are in Pomona. Unfortunately, Tri-City has encountered vocal and persistent opposition from some city residents to two proposed housing projects in Pomona. Recent action by the City of Pomona has resulted in the need for TCMHS to rethink the design and location of one or two scattered site projects in partnership with Clifford Beers (totaling approximately 40 units).

Ultimately, TCMHS may need to explore other (perhaps less optimal) sites for these and future projects. One lesson learned is that the success of any housing development effort appears to be closely related to effective anti-stigma efforts.

HOW MUCH DID WE DO?



IS ANYONE BETTER OFF: SUCCESS STORY

A young man who struggled for some time with severe psychosis became homeless. Tri City Full Service Partnership staff members engaged him regularly, encouraging him to enroll in a Full Service Partnership to receive the intensive services that might help him begin his recovery. Following stabilization and discharge, the young man moved into a unit of permanent supportive housing at Park Avenue and continued working his recovery plan through the Full Service Partnership. Today, ten months later, he's taking his medications, is back in college and planning to transfer to a four-year college. His ability to move into Park Avenue and have a secure and stable place to live was a vital factor in his recovery.

Prevention Programs (PEI funded)

PEI-01: Community Capacity Building

Three projects make up the Community Capacity Building program; they are the Community Wellbeing Project, Mental Health First Aid and Stigma Reduction Among Cultural Groups. They are detailed separately below.

PROJECT: Community Wellbeing Project (CWB)

OVERVIEW

In this program, *community* is defined as a group of individuals who rely on each other for support and can act together. The program provides small grants and technical assistance to help communities build their capacity to strengthen the wellbeing of their members and the community as a whole. The program focuses on providing support to communities at greater risk for mental illness.

ORIGINAL RATIONALE

The Community Wellbeing Program is designed to help communities develop and implement community-driven plans to improve and sustain the mental and emotional wellbeing of their members. Particular focus is on unserved and undeserved communities who often struggle to access appropriate mental health and other services.

NOTES ON DEVELOPMENT • PROGRESS • LEARNING

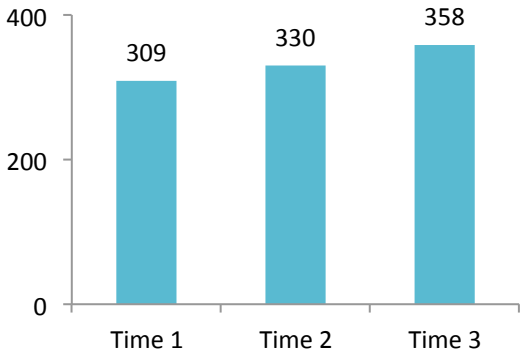
One of the challenges of the first year of this program was that some communities required far more technical assistance and group support than we originally anticipated. Another challenge was that while grantees were accepted based on the strength of their application, not all of them could demonstrate the characteristics of "community" as defined by this program.

To mitigate these challenges, TCMHS instituted new quarterly reporting procedures to help communities more regularly evaluate their progress and encourage them to plan for the next quarter. We also incorporated an interview process for all potential grantees to allow the selection team to get a better sense of the community. We think that this helped level the playing field for those communities with less grant writing experience by giving them an opportunity to demonstrate their strengths in person. In FY 2013-14, we have reduced the number of communities selected to better support the ones chosen. Savings from the fewer number of the communities chosen have been re-directed to other community capacity-building efforts.

TCMHS sees increased ownership of the programs by the communities. Of the fifteen communities in the program, eight are repeat grantees and seven are new. Their needs are different, so it is as though TCMHS is operating multiple grant programs simultaneously since the nature of the support they need is specific to each community.

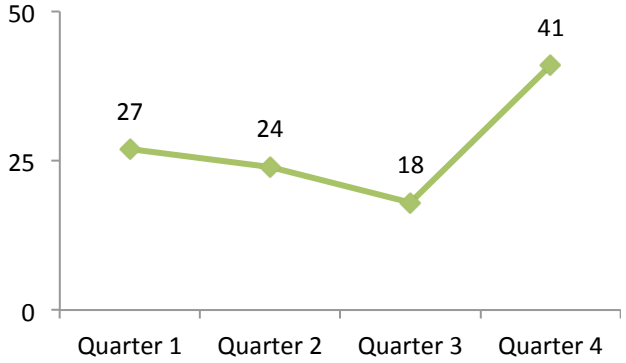
HOW MUCH DID WE DO?

People participating in Wellbeing surveys



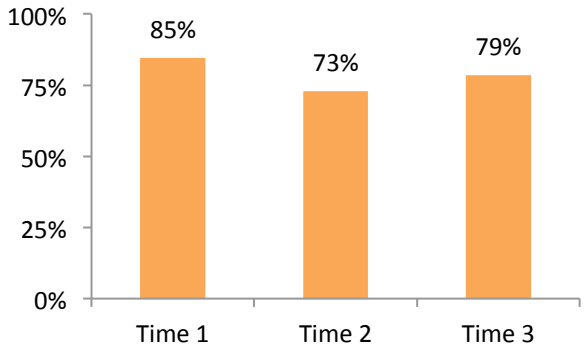
HOW WELL DID WE DO IT?

Number of individual community support sessions

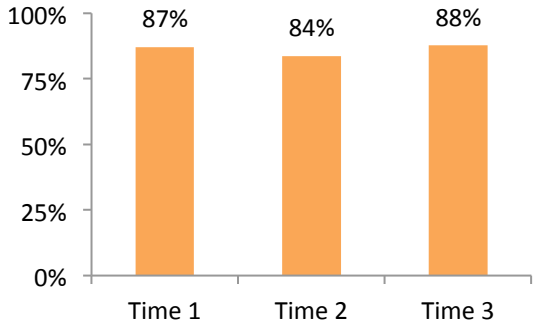


IS ANYONE BETTER OFF?

Community members report supporting each other



Community members report better relationships with others



*Note: Data are from Wellbeing surveys conducted three times during the year. Time 1 refers to Quarter 2, Time 2 refers to Quarter 3, and Time 3 refers to Quarter 4.

IS ANYONE BETTER OFF: SUCCESS STORIES

Families who live in the Laurel Apartments in Pomona have fully embraced the idea of community. At a recent learning event, community members shared how they depend on and rely on each other for strength and support. The entire community has become an extended family—to the point that they are comfortable enough to look after each other's children. The Spanish-speaking families have become far more involved with each other and the larger community, and the network of relationships continues to grow. Members of the community say that the word that describes them (in Spanish) is "convivencia" - people who live separately (in different apartment units) but share together.

PROJECT: Mental Health First Aid (MHFA)

OVERVIEW

Mental Health First Aid (MHFA) is a nationally recognized prevention program that trains individual community members (Mental Health First Aiders) to recognize the early warning signs of someone who may be experiencing mental and emotional distress. This evidenced-based program begins with a premise that just as people can master basic first aid for physical distress (such as the Heimlich maneuver or CPR) without being doctors, people can also master basic mental health first aid without being clinicians.

ORIGINAL RATIONALE

The Mental Health First Aid (MHFA) program will train scores of people in community-based settings to intervene quickly and effectively to offer support when someone is experiencing mental and emotional distress. In this way, community members can offer support and encourage connections to appropriate and professional help to people in distress, thus extending the impact and reach of the system of care.

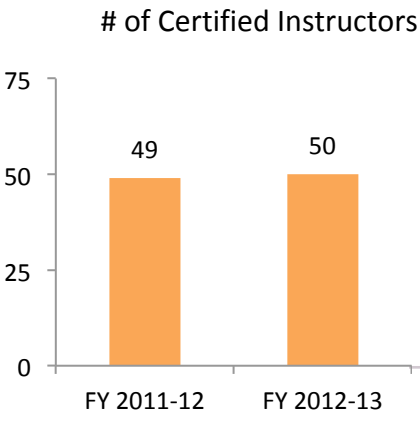
NOTES ON DEVELOPMENT • PROGRESS • LEARNING

The program initially set a goal of training 1,000 Mental Health First Aiders within three years but met that goal in less than two years. This rapid success generated ideas to extend and improve the program. For example, the time commitment for certified instructors to maintain their certification was burdensome. Based on feedback received from the instructors, the National Council for Behavioral Health adjusted the length of the class from 12 hours down to 8 hours. The instructors then were able to take advantage of this modified curriculum, which was adopted by TCMHS over the past year. The curriculum also has been translated into Spanish and adapted for youth, both of which are offered by the TCMHS trainers.

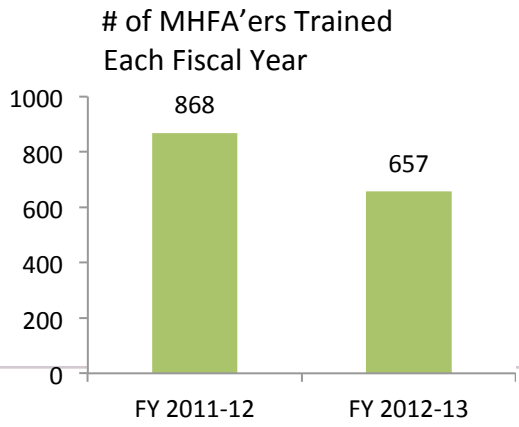
MHFA trainers now receive fewer requests for the original MHFA trainings from partner institutions as they reach “saturation” among their staff or members. In response, TCMHS expanded the program to include additional trainings beyond the core MHFA curriculum, including:

- Everyday Mental Health (EMH) – a brief overview of the most common mental health disorders found in the US;
- The Recovery Model (TRM) – an introduction to a humanistic approach to the treatment of mental illness; and,
- Suicide Prevention—a training to support primary care physicians in the implementation of state-of-the-art suicide prevention practices while minimizing the disruption of normal practice operations.

HOW MUCH DID WE DO?



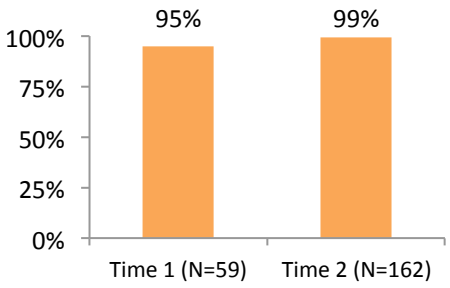
HOW WELL DID WE DO IT?



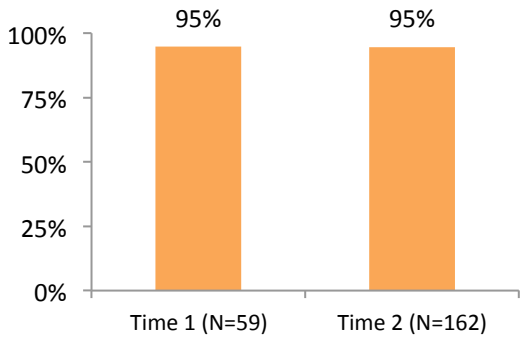
1525
2-year total

IS ANYONE BETTER OFF: MHFA Training Survey Responses

Participants report they can reach out to someone experiencing a mental health problem or crisis



Participants report they can recognize and help correct misconceptions about mental illness and mental health



*Note: MHFA surveys were conducted twice – in Quarters 3 and 4 of the fiscal year.

IS ANYONE BETTER OFF: SUCCESS STORIES (REPORTED BY MHFA'ERS)

"I rendered MHFA to a woman who was cutting her arm. She said it was common practice and she knew what she was doing. She was not communicating with others but I was able to get through to her, calm the situation and peacefully end the incident and get her to a mental health facility."

"I assisted a woman whose son recently completed suicide, a person who was hoarding and facing eviction and another person who was recovering from substance abuse by using my MHFA skills."

PROJECT: Stigma Reduction Among Cultural Groups Program

OVERVIEW

The Stigma Reduction within Cultural Groups project is a one-time prevention project begun in March 2012. The program engages leaders and members of underserved cultural groups in conversations about mental illness. The purpose is to gather information to make services more relevant and culturally sensitive to every cultural group and community and to increase their mental health awareness.

ORIGINAL RATIONALE

By helping groups recognize in their own time and on their own terms the cultural beliefs that prevent members of their communities from accessing help for mental illness when in need, TCMHS seeks to eradicate stigma towards people with mental illness. By engaging cultural groups through meaningful and intimate dialogue about stigma, this project seeks to learn how underserved communities in the three cities understand stigma and support their members who experience symptoms of mental illnesses.

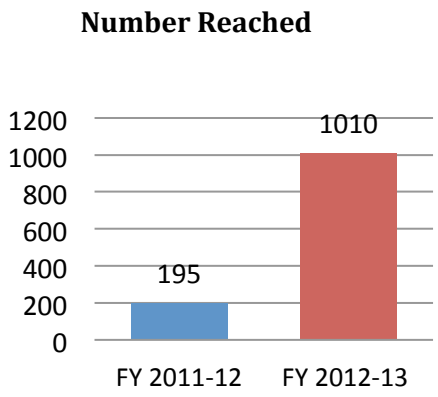
NOTES ON DEVELOPMENT • PROGRESS • LEARNING

Recent events around the Permanent Supportive Housing Program and other community developments suggest the need for reexamining the focus and strategies of any anti-stigma effort in the Tri-City area.

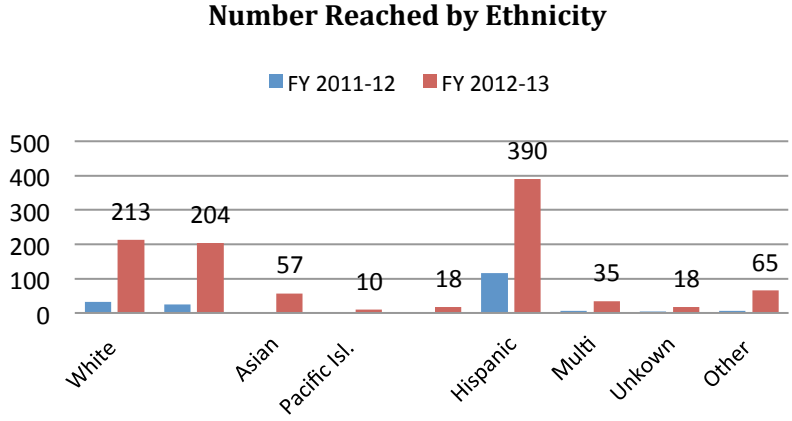
Learning conversations such as the ones undertaken by this project are an important adjunct to education/awareness about mental health stigma because they help get to core beliefs. When we find culturally-appropriate ways to talk about mental health, people are motivated to seek needed support. Multiple conversations are needed with different groups to understand how to communicate more effectively. The focus of future conversations will expand to non-ethnic cultural groups such as LGBTQ and law enforcement.

This program was designed as a one-time effort to help us learn what positive effects could emerge from this approach and is scheduled to end at the end of FY 2014-15. Given the evolving understanding of different approaches and intentions of anti-stigma work, TCMHS may revisit the need for this program as part of a broader conversation in FY 2014-15.

HOW MUCH DID WE DO?



HOW WELL DID WE DO IT?



IS ANYONE BETTER OFF: A SUCCESS STORY

A faith-based sober living residence in Pomona that houses Latino, African-American, and Anglo individual and families was engaged for stigma reduction. Residents and leaders alike, including those with diagnoses of mental illness who were actively symptomatic, rejected mental illness as valid and felt that it was an excuse for bad behavior.

After a series of conversations exploring the origins of their beliefs about mental illness, they began to share personal stories. Common themes emerged including trauma, rejection, guilt, shame and failed treatment. Empathy for the mentally ill started to replace the blame prevalent during the initial discussions. Community members increasingly accepted the idea of mental illnesses as disorders deserving the same merit as physical illnesses. Stigma was so drastically reduced that leaders now actively refer residents to NAMI PV and Tri-City for mental illness. The leaders requested that NAMI PV return to lead a series of follow up stigma reduction and mental health awareness trainings for new community members.

PEI-04: Family Wellbeing Program

OVERVIEW

In this prevention program, staff and volunteers build trusting relationships and provide support to family members and caregivers of people who struggle with mental illness. The focus is particularly on family members from unserved and under-served communities. Programming includes support groups, 1-1 support, and an array of culturally-appropriate activities focused on wellness interests, e.g. exercise, cooking, other interests—that can attract family members and other caregivers from vulnerable communities into peer support experiences.

ORIGINAL RATIONALE

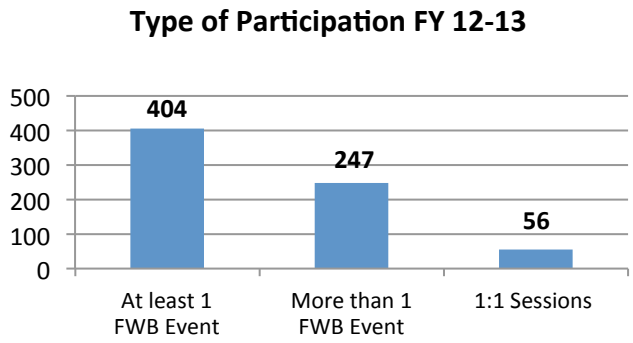
For this project, delegates chose to focus on family members and caregivers, particularly of young children, as a way of providing support to children and youth in stressed families. Data at the time the PEI plan was first developed indicated discernible, and in many cases significant increases in domestic violence calls, violent crime, suicide attempts, and other indicators of mental and emotional distress within families and communities across the three cities. These and other indicators of mental and emotional distress were increasing at precisely the time when local governments, schools, foundations, and service providers were suffering severe budget cuts.

NOTES ON DEVELOPMENT • PROGRESS • LEARNING

Demand for the Family Wellbeing supports has steadily increased since the inception of the program. Staff and volunteers now support a wide array of support groups, all of which become contexts for peer support toward recovery and wellbeing. These groups include Teen Hour, LGBT and Allies, Crochet, Creative Writing Group, Cooking Class, Kids Hour, Music Group, Writing to Heal Group, United Family Support Group, Limited to Limitless, Spirituality Group, and Summer Camp.

HOW MUCH DID WE DO?

404
unique individuals served 2012/13



IS ANYONE BETTER OFF: TWO SUCCESS STORIES

A 6-year old boy was referred by Pomona School District to be assessed by Tri-City. Because he did not meet medical necessity, he was referred to the Wellness Center. After expressing concerns about bullying, the mother and son were encouraged to attend the Kids Hour and United Family for support. He began attending Kids Hour, and his self-esteem and confidence visibly increased. He developed communication skills and was able to set appropriate boundaries with the other children. He can now share his feelings appropriately with others and is developing meaningful friendships at school.

A 15-year old girl was exhibiting problems at home with her mother. After several group sessions she requested to have a TCMHS counselor meet with her and her mother to discuss some issues. A TCMHS staff member met with the family for about 3 sessions, and the outcome was successful. Both the girl and her mother agreed to participate in family therapy and participate in the United Family Support Group. The mother shared: “We are doing better since we started therapy, and the group has helped me understand my daughter.”

COST PER PERSON ESTIMATE FOR FY 2012-13: $217.02 ($87,675/404)

PEI-05: Student Wellbeing Program (SWB)

OVERVIEW

The Student Wellbeing Program includes K-12 Student Wellbeing and College Student Wellbeing. Both programs provide support for the three school districts and area public and private colleges to expand and better integrate their efforts to promote the mental and emotional wellbeing of their students.

ORIGINAL RATIONALE

The Student Wellbeing Program was designed in recognition of the vital role that the three schools districts (serving approximately 49,000 students) and ten colleges (serving approximately 31,500 students) play in the lives of children and transition-aged youth and in recognition of the increased stress and challenges faced by students, families, and the education system during the economic downturn and devastating budget cuts to core education and support programs. TCMHS and stakeholders sought to find new ways to support students under increasing and debilitating stress even as they have to dismantle programs they have relied on for years.

NOTES ON DEVELOPMENT • PROGRESS • LEARNING

The K-12 Student Wellbeing program provided for a variety of trainings and projects aimed at improving the wellbeing of students and teachers in the three school districts. Each district selected projects that suited their needs. Pomona Unified School District conducted trainings for selected staff in Capturing Kids' Hearts which provides tools for administrators, faculty, and staff to build positive, productive and trusting relationships among themselves and their students. Bonita Unified School District prioritized projects that addressed the need for enhanced communication and resources access systems, and the need for on-campus services for students. Claremont Unified School District provided mini-grants for these projects in order to reach as many schools as possible with site-identified interventions, nine of which were aimed at students' wellbeing and one at teachers' wellbeing.

The College Student Wellbeing program experienced delays in implementation during the 2011-2012 year, but it is on track to complete their mini grant projects as well as launch the Campus Campaign for Strengthening Student Health and Resiliency during the 2013-14 year.

HOW MUCH DID WE DO?

2,184 people served 2012/13 through 10 mini-grants in Claremont

100 teachers and staff trained in 2012/13 in Pomona

129 elementary students provided counseling in Bonita

24 mini-grant projects implemented on local college campuses

IS ANYONE BETTER OFF?

One of the College Wellbeing mini-grants was for a series of workshops for Cal Poly Pomona students with ADHD. "Bob," "John," and "Ted" were three project participants who were struggling to get through their Engineering program. Although bright and highly motivated, they lacked the knowledge and skills to effectively manage the impact of ADHD on their personal and academic functioning. At the end of the 5-part series, Bob, John, and Ted began a study group with each other and applied the knowledge and skills gained from the program.
As a result, Bob placed on the Dean's List for the first time ever in his college career. John was able to get out of disqualification status and moved back in with his wife, and together they began attending marital counseling in order to better understand how they can manage the impact of John's ADHD on their marriage and family life. Ted's performance in his classes improved so significantly that one of his professors personally inquired about the program interventions that had evidently contributed to Ted's dramatic change in academic performance.

Early Intervention Programs (PEI funded)

PEI-02: Older Adult Wellbeing
and
PEI-03: Transition-Aged Youth Wellbeing

Both the Older Adult Wellbeing and the Transition-Aged Youth Wellbeing programs are comprised of two projects: Peer to Peer Counseling and Support Groups for the specific ages.

PROGRAM: Peer-to-Peer (P2P)

OVERVIEW

The Peer to Peer Counseling program, an early intervention program, trains volunteers from the Tri-City area who want to learn how to provide support to peers who are in emotional distress. Once trained, peer counselors can offer both individual and group counseling, and additional support through linkages to age- and culturally-appropriate resources.

ORIGINAL RATIONALE

Originally, this project focused on providing peer to peer services to transition aged youth and older adults. Data gathered during CSS planning suggested that, in Tri-City area, 71% of young people ages 16-25 who live below 200% of the federal poverty threshold and who suffer from severe emotional disturbances or serious and persistent mental illness are receiving no mental health services. Moreover, suicide is a significant risk for this population. In addition, delegates documented a large gap in mental health services for older adults (60 years and older) who comprise almost 16% of the total population in the Tri-City area, and the fast growing population in both Claremont and La Verne.

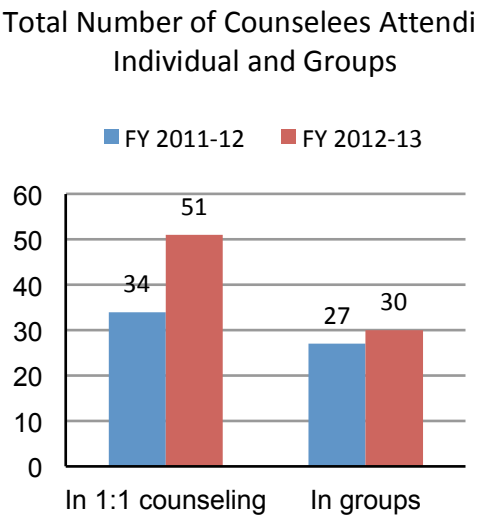
NOTES ON DEVELOPMENT • PROGRESS • LEARNING

While TCMHS continued its aggressive outreach to the two original populations—older adults and TAY—there has been significant demand for peer-to-peer counseling services for intergenerational exchanges. Given this demand, TCMHS expanded the program in FY 2013-14 to also include adults as peer counselors to TAY and Older Adults.

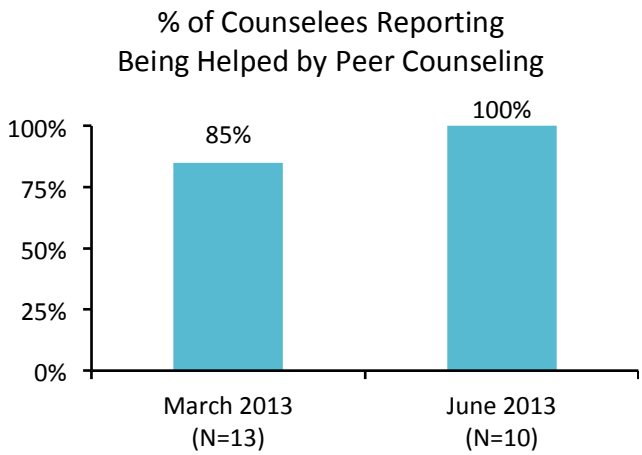
There are 31 trainees in the 2013-2014 cohort of peer counselors. The evolution of the recruitment and selection of peer counselors reflects the learning curve of program staff. Volunteers must be connected with the three cities in some manner (e.g. as a resident, student, etc.), and they must be willing to commit to weekly training sessions and remain with the program for a minimum of nine months. Collaboration and integration with other programs is important for outreach and recruitment, for training and support, and for appropriate matching between peer counselors and counselees.

While anecdotal data show program benefits to both the counselees and the peer counselors, TCMHS continues to be challenged by getting the data to answer: “Is anyone better off?” TCMHS will explore using the peer counselors to increase the response rate to surveys.

HOW MUCH DID WE DO?



IS ANYONE BETTER OFF?



IS ANYONE BETTER OFF: SUCCESS STORIES

After losing a significant relationship of over thirty years, Joe (not his real name) felt alone in the world. Having a peer counselor has helped him connect and begin to reclaim his place in the world and in his own life.

The young woman felt lost as she struggled to find employment and begin the process of moving out of her parents' home. She sought out peer counseling and with her peer volunteer navigated the path of learning how to look for a job. She is now employed. She is in a committed relationship. Now, with the blessings of her parents, she will begin looking for her own apartment. She thanks the steadfast patience and presence of her peer volunteer as the 'steady rock' during what might have become a tumultuous time. The peer volunteer commented that her counselee helped her feel a greater sense of her own worth and capacity.

COST PER PERSON ESTIMATE FOR FY 2012-13: $1859.37 ($150,609/81)

PEI-06: NAMI Community Capacity Building Program

OVERVIEW

The NAMI Community Capacity Building Program consists of two projects: Parents and Teachers as Allies (PTAA) and the Inter-Faith Collaborative on Mental Health (ICMH). Parents and Teachers as Allies provides in-service trainings for school professionals and families to help participants better understand the early warning signs of mental illnesses in children and adolescents. The intention is that this training will help teachers and family members learn how best to intervene so that youth with mental health treatment needs are linked with services. The Inter-Faith Collaborative on Mental Health provides outreach, education and training opportunities to faith organizations, which are often a first point of contact when individuals and families seek assistance. Among other activities, the Collaborative conducts outreach efforts, longer seminars and conferences, and engages a Steering Committee throughout the year.

ORIGINAL RATIONALE

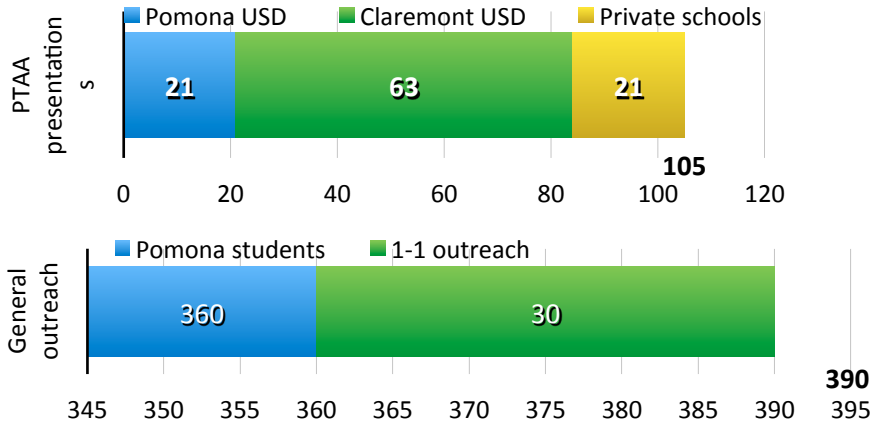
Schools and faith-based organizations are natural centers for seeking mental health support. In addition, they are often multicultural and diverse in their membership. Through this project, NAMI-Pomona Valley Chapter provides education, training, and support to help school personnel and faith-based community members become better able to accept, identify, assist and guide persons and families who are at risk of and/or experiencing mental illness in their lives.

NOTES ON DEVELOPMENT • PROGRESS • LEARNING

In the Parents and Teachers as Allies program, it was difficult to get teachers to attend after-school sessions without a stipend to pay for in-service time. To address this challenge, staff and delegates recommended, and the TCMHS Board approved, increasing the FY 2013-14 budget to include stipends for teachers. In a follow-up survey conducted nine months after PTAA, 92% of respondents say they retained the information, and 50% report referring others to mental health resources.

The main challenge encountered by the Interfaith Collaborative was the need for additional support and engagement to achieve its intended impact. Consequently, TCMHS redirected some of the Community Wellbeing Program funds to add another staff member to support this effort (and the Stigma Reduction program).

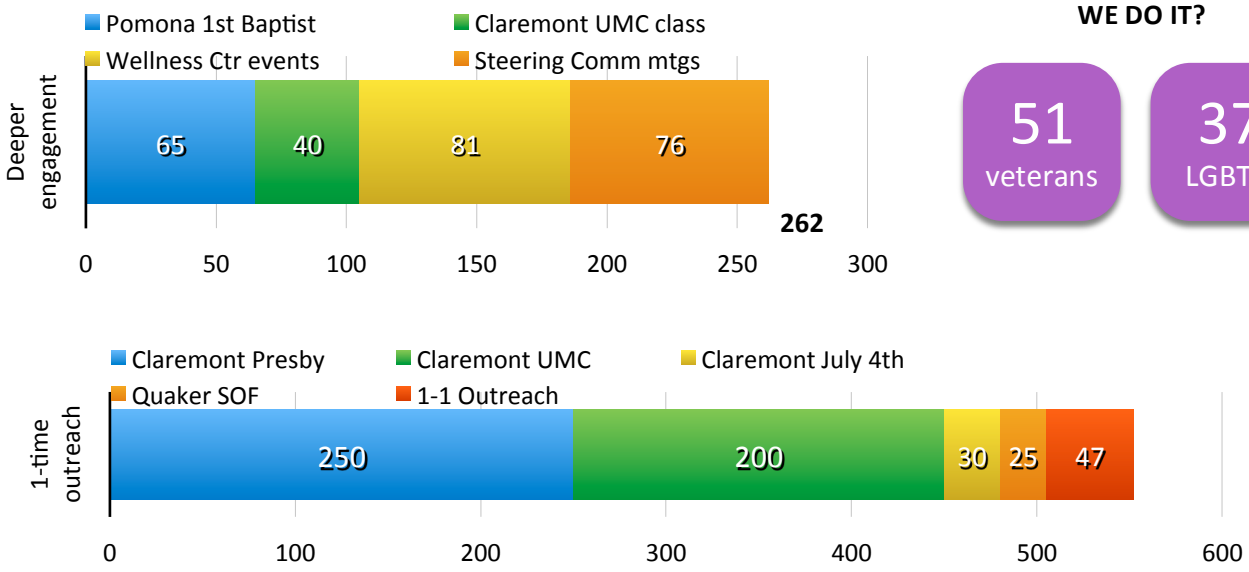
PTAA: HOW MUCH DID WE DO?



HOW WELL DID WE DO IT?

92% of participants report improved knowledge 9 months after taking PTAA training

ICMH: HOW MUCH DID WE DO?



HOW WELL DID WE DO IT?

51 veterans

37 LGBTQ

IS ANYONE BETTER OFF: SUCCESS STORIES

Parents and Teachers as Allies (PTAA): As a result of PTAA presentations in Pomona Unified School District, sixteen monolingual Spanish-speaking parents requested and completed additional education regarding mental illness in children. This prompted the first Spanish NAMI Basics class in the Tri-City area. All sixteen parents completed the six-week training and felt that the course helped them understand what their children are experiencing and equipped them to more effectively parent them.

Interfaith Collaborative On Mental Health (ICMH): An Islamic faith community active in the ICMH referred a young Muslim man for treatment. He presented with untreated bi-polar disorder, suicidal ideation and impaired decision making. Now, he is stable through medication and therapy and enjoying tremendous improvement in his interpersonal and family relationships.

PEI-07: Housing Stability Program

(formerly known as "Building Bridges between Landlords, Mental Health Providers and Clients")

OVERVIEW

The Housing Stability Program is an early intervention program designed to help people with mental illness maintain their current housing or find more appropriate housing. Program staff members work with clients, mental health service providers, landlords, and property managers to secure housing placements, mediate conflicts, and strengthen relationships.

ORIGINAL RATIONALE

Stable housing is a necessary foundation to be able to create wellbeing and support a person's mental health. Once homeless, it is difficult to provide interventions towards mental health and wellbeing without first finding stable housing. TCMHS began this program in January 2012. The intention was to find ways to work with landlords in a cooperative manner, reduce stigma towards mental illness, and prevent evictions and homelessness.

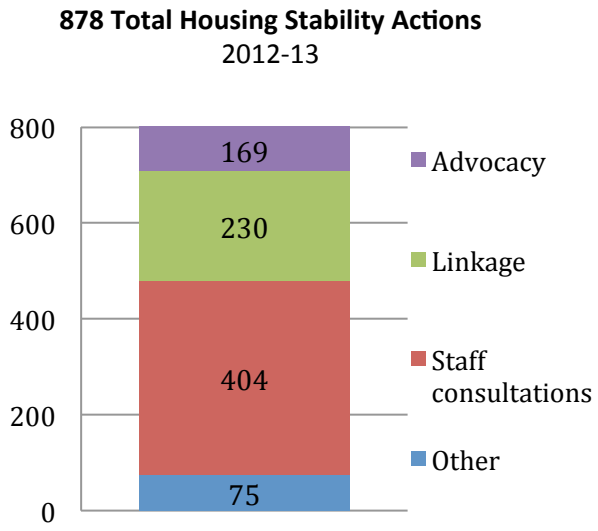
NOTES ON DEVELOPMENT • PROGRESS • LEARNING

TCMHS works to prevent homelessness by going to where the housing is (with landlords and property management companies) and addressing the needs of housing providers, in addition to consumers. Landlords need responsible and reliable tenants and are willing to work with "good tenants" to keep them in housing. TCMHS developed a "good tenant" training that addresses landlord expectations, rights and responsibilities. Those tenants who finish the training can now receive a certificate of completion from the Apartment Association of the Greater Inland Empire (AAGIE). In addition, TCMHS clinicians are trained to integrate questions regarding housing into their regular conversations with consumers, in order to identify potential eviction issues earlier and intervene.

The services most in demand fall into four categories: advocacy, linkage, staff consultations and other. Advocacy efforts help clients in removing barriers that hinder progress towards self-sufficiency. This assistance is usually in the form of a phone call, accompanying a client to appointments or filing case complaints to public/social service entities. Linkage services connect clients to resources that assist to stabilize and maintain housing status, such as mental health, health, clothing, and public transportation resources. Staff consultations typically involve meeting with staff from TCMHS and external agencies to help clients develop housing plans and goals, such as increased self-sufficiency, skills and income. Other includes miscellaneous services requested by clients—e.g., services to help home maintenance.

HOW MUCH DID WE DO?

282 total people served 2012-13



IS ANYONE BETTER OFF? In FY 2012-13:

40 people secured housing

12 people stayed in housing for ≥ 6

6 people avoided evictions

IS ANYONE BETTER OFF? A SUCCESS STORY

In August 2012, Janet and her significant other began suffering severe medical conditions that led to unemployment. Soon after, both adults and their teenage daughter became homeless. TCMHS helped Janet secure a 120-day hotel voucher and determined that the family would be eligible for the Shelter Plus Care program. Staff worked with the family to complete the application, and it was approved.

Housing staff began talking with a landlord that worked with TCMHS previously. Given her recent eviction and unemployment, Janet had bad credit. The landlord agreed to overlook her credit and past eviction and discount the security deposit. Staff helped Janet connect to other services and supports.

The family's wellbeing is improving. The daughter now receives services through the TAY FSP program, and the family is participating in the Therapeutic Community Gardening program. Just recently, Janet was offered a full-time administrative position with medical benefits.

COST PER PERSON ESTIMATE FOR FY 2012-13: $613.23 ($172,931/282)

PEI-08: Therapeutic Community Gardening (TCG)

OVERVIEW

The Therapeutic Community Gardening project helps participants decrease their isolation and experience mental health benefits through participation in gardening and horticultural group therapy programs. The focal populations for this program are unserved and underserved ethnic populations, veterans, school-aged children and their families, and youth transitioning out of foster care. Focusing on early intervention, this program provides services to people who do not yet meet medical necessity or who are not eligible for Medi-Cal. For some people, the community garden becomes a place to reconnect with their family's heritage of working the land; for all participants, the community garden is a setting where otherwise isolated people come together to work, learn, and share. Program participants not only engage in peer support activities supported by professional staff; they also experience the satisfaction of producing something meaningful—healthy food— that contributes to their wellbeing and the wellbeing of their families.

ORIGINAL RATIONALE

TCMHS developed the Therapeutic Community Gardening program to provide early intervention services and supports to people who are at significant risk of serious mental health issues, but who are unable or as yet unwilling to access formal mental health services.

NOTES ON DEVELOPMENT • PROGRESS • LEARNING

In FY 2012-13, we expanded the program in several ways. First, we added a second gardening site, this one next door to TCMHS offices. Second, we expanded outreach and engagement efforts to increase participation in the program. We are specifically targeting PEI priority populations, and people who are in recovery to help them sustain their progress.
The principal challenge confronting the program is capacity. With one staff person, the program is essentially at capacity. To engage more people, we will hire one more staff person and explore other strategies—e.g., training long-time participants as volunteer leaders who may be able to assume some program responsibilities. The program is also limited by the number of gardening sites available. We continue to search for additional land in the three cities area.

HOW MUCH DID WE DO?

# of Outreach/Engagement Presentations

47
Focus groups/ TCG presentations 2012/13

# of People Served

19
individuals served 2012/13

9
families served 2012/13

IS ANYONE BETTER OFF: SUCCESS STORIES

Over the past year, we have seen positive responses in program participants that resulted directly from their involvement in the program. A gentleman who joined the program in April 2013, initially expressed skepticism as to whether he had the ability to garden and grow plants. He was homeless and out of work. Over time, he learned how to plant tomatoes, eggplants, squash and melons. As months passed he became more verbal and engaged with peers in program groups. Meanwhile, other TCMHS program staff worked with him to secure housing. As a result of rendered support from the TCMHS on multiple levels, this client "grew" in many areas of his life and continues to do so.

Two mothers who are current TCG participants (along with their children) discovered they are neighbors and their children attend the same school. One of the mothers recently moved to Pomona and had almost no friends in the area. Now both families visit one another at home during the week, and join each other for family celebrations.

COST PER PERSON ESTIMATE FOR FY 2012-13: $2,739.38 ($150,666/55: 19 individuals + 36 people in families)

Innovation Programs (INN funded)

INN-01: Modified Cognitive Enhancement Therapy

OVERVIEW

Cognitive Enhancement Therapy (CET) is a recovery-oriented, evidence-based practice. It assists individuals diagnosed with schizophrenia and schizoaffective disorders in developing and enhancing their mental capacities. Enhanced capacities include an increased self-awareness that encourages self-directed social interactions, greater psychosocial functioning and wellbeing. Clients diagnosed with schizophrenia and schizoaffective disorders can improve their mental stamina and active information processing and learn to function better with and around other people. The treatment lasts 48 weeks and includes weekly computer sessions, 1:1 coaching and social-educational group sessions. Through this Innovation Project, TCMHS is testing a modified version of CET to include individuals diagnosed with bi-polar disorder.

ORIGINAL RATIONALE

Medication and treatment options are available in the three cities of Claremont, La Verne and Pomona, and these strategies help individuals diagnosed with schizophrenia and bipolar disorder more effectively manage their symptoms. These treatment options, however, do not address the underlying cognitive impairment associated with these illnesses. Addressing cognitive impairment is central to a person's recovery and ability to function effectively in life. If a modified version of CET can be introduced into TCMHS's system of care and proven to be effective in addressing underlying cognitive impairment, it can improve significantly the system's overall ability to support successful processes of recovery.

NOTES ON DEVELOPMENT • PROGRESS • LEARNING

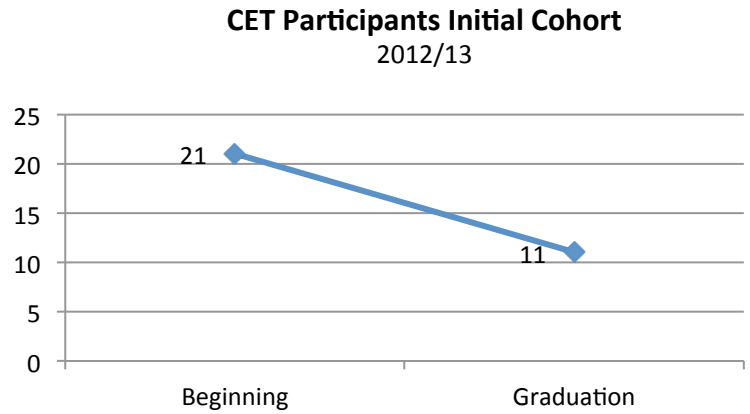
In the original Innovation Plan, CET would be modified to include individuals diagnosed with bi-polar disorder and adapted for use with monolingual Spanish speakers. However, the number of monolingual Spanish speakers eligible for CET was too small to do the modification.

Two well-attended meetings have been held to review lessons learned. Participants included individuals enrolled in CET, TCMHS staff, family members of participants, potential enrollees and community members. Initial observations include:

- A hypothesis that the social support that comes with participation in CET may be as important as the treatment itself;
- Of the 21 people who started one of the two CET cohorts, only 11 people (52%) completed the program. Feedback from participants revealed that the treatment period was too long;
- Interested potential participants have long waiting periods since new cohorts only begin annually; and,
- CET addresses cognitive functioning, but not the symptoms of the respective disorders.

Staff members organized a barbecue picnic and formal graduation ceremony to celebrate participants' completion of the CET sessions.

HOW MUCH DID WE DO?



2 certified CET coaches with 2 more to be certified in early 2014

IS ANYONE BETTER OFF: SUCCESS STORIES

- A CET participant who had been previously ostracized by her community because of her mental health issues was able to rejoin her community. She now volunteers at a school in her community.
- Several participants were able to let go of personal items they had previously needed to help them feel safe in the world.
- Most participants were able to form meaningful friendships with others in the CET group.

COST PER PERSON ESTIMATE FOR FY 2012-13 (assumes 16 FTE clients): $19,857.81 ($317,723/16)

INN-02: Integrated Care Project

(formerly known as Integrated Services)

OVERVIEW

The Integrated Care Project aims to create a model of integrated care among providers with a shared commitment to recovery and wellness.

The project currently engages people representing 12 physical health, mental health and substance abuse providers in the Tri-City area, including formal leaders, medical providers, receptionists, administrative staff, and individuals who receive services.

The focus is to strengthen relationships and create shared understanding and knowledge among participants in order to transform existing policies and procedures toward a more fully integrated system of care. Put differently, the project seeks to identify and challenge existing paradigms that fragment care among providers of physical health, substance abuse and mental health services.

ORIGINAL RATIONALE

Most counties have systems to facilitate working across health and substance abuse departments, e.g., regular cross-departmental meetings. TCMHS as a Joint Powers Authority has not had similar facilitative structures. This project intends to create formal opportunities to bring together representatives from physical health, substance abuse, and mental health systems in service of creating a truly integrated system of care.

NOTES ON DEVELOPMENT • PROGRESS • LEARNING

Twelve organizations across the physical health, mental health, and substance abuse treatment fields came together as partners in this effort. Initial activities included:

- Creating a mission statement, model of integrated care, new project title, logo and website;
- Identifying individuals who receive services across multiple organizations/sectors;
- Developing relationships that support a “warm hand-off” so that individuals from one organization can receive services from another partner organization;
- Tracking referrals across the multiple organizations;
- Developing common protocols;
- Collecting data from individuals who receive services from the partner organizations; and
- Implementing shared training of staff across partner organizations.

The Affordable Care Act, which includes requirements for collaboration across the health service fields, was finalized since the implementation of this project. This project may generate learning that can benefit other organizations that have not yet begun to connect across practice fields, and it may provide skills and connections for partner organizations that will help them comply with new regulations.

HOW MUCH DID WE DO?

IS ANYONE BETTER OFF: SUCCESS STORIES

An older adult enrolled in a Full Service Partnership incurred unusually high treatment costs due to alcoholism. Through this project, TCMHS staff members initiated a warm hand-off to American Recovery Services and enrolled her in a two-month substance abuse treatment using additional funding from the Integrated Care Project. This individual is now making great progress on her recovery. For example, she now takes medications, lives on her own, volunteers as a support group leader and participates in a pre-job training program.

After a popular young man at a local school died from an accidental drug overdose, the Children's Department immediately responded to a school official's request for assistance by contacting staff from the Integrated Care Project. TCMHS teamed up with the National Council on Alcoholism and Drug Dependence to provide grief counseling and drug prevention training to students and school staff members. Through this experience, the Integrated Care Project members established the goal for more active drug prevention activities.

New Proposed Innovation Projects

Exhibit A: Innovation Work Plan County Certification

County Name: Tri-City Mental Health Services

Local Mental Health Director	Program Lead
Name: JESSE H. DUFF	Name: RIMMI HUNDAL
Telephone Number: (909) 623-6131	Telephone Number: (909) 784-3016
E-mail: jduff@tricitymhs.org	E-mail: rhundal@tricitymhs.org
County Mental Health Mailing Address: 1717 N. Indian Hill Boulevard, Suite B Claremont, CA 91711	

I hereby certify that I am the official responsible for the administration of public community mental health services in and for said County and that the County has complied with all pertinent regulation, laws and statutes for this Innovation Work Plan. Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code Section 5891 and Title 9, California Code of Regulations (CCR), Section 3410, Non-Supplant.

This Work Plan has been developed with the participation of stakeholders, in accordance with Title 9, CCR Sections 3300, 3310(d) and 3315(a). The draft Work Plan was circulated for 30 days to stakeholders for review and comment and a public hearing was held by the local mental health board or commission. All input has been considered with adjustments made, as appropriate. Any Work Plan requiring participation from individuals has been designed for voluntary participation therefore all participation by individuals in the proposed Work Plan is voluntary, pursuant to Title 9, CCR, Section 3400(b)(2).

All documents in the attached Work Plan are true and correct.

Signature (Local Mental Health Director)	Date	Title
Jesse H. Duff	8/28/14	Executive Director

Exhibit B: Description of Community Program Planning and Local Review Processes

County Name: Tri-City Mental Health Services
Work Plan Name: Innovation

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted a part of this Annual Update.

1. Briefly describe the Community Program Planning Process for development of the Innovation Work Plan. It shall include the methods for obtaining stakeholder input. (suggested length – one half page)

Beginning in September 2013, TCMHS engaged stakeholders in a seven-month program review, evaluation, and planning process of the current CSS, PEI, and INN projects. Through this review, workgroups identified potential themes for learning and future Innovation projects. During the January 2014 meeting, TCMHS formed three additional workgroups to explore these themes and develop potential Innovation projects which are included here as the Proposed Innovation Plan. The stakeholders endorsed these proposed Innovation projects during the March 2014 meeting.

To assist stakeholders in understanding the MHSA requirements for an Innovative program, we provided them an orientation packet which included information on MHSA, its five plans, a glossary of terms and acronyms, and a summary of the requirements for Innovation projects. We discussed at length the concept of a "learning edge" and held multiple meetings led by professional facilitators who redirected conversations back towards the learning emphasis of this plan.

2. Identify the stakeholder entities involved in the Community Program Planning Process.

TCMHS is committed to ensuring a broad stakeholder and community engagement process in developing all of its MHSA plans. Stakeholder perspectives include individuals who receive services; seniors, adults, and families with children with serious mental illness; community providers; leaders of community groups in unserved and underserved communities; persons recovering from severe mental illness; representatives from the three cities of Claremont, La Verne and Pomona; veterans; representatives from the local school districts; primary health care providers; law enforcement representatives; mental health, physical health, and drug/alcohol treatment service providers; faith-based community representatives; representatives from the LGBTQ community; representatives from LACDMH and other county agencies; and many others. Because these Innovation projects were developed as part of the full discussion of the Three-Year Plan, the list of participants and their demographic profiles are the same.

Attachment A includes the sign-in sheets from the public hearing. Attachment B lists the demographics of those who were invited to participate in the planning process and public hearing. Attachment C is a summary of all the comments received at the public hearing; no changes were made to this plan based on comments from the public hearing.

For many years, TCMHS has made a concerted effort to reach out to underserved communities by adopting a community organizing approach and building one-on-one relationships with key leaders within those communities. As a result, many of them respond to our general calls for participation in the stakeholder process, and our staff also identify specific populations to whom more personalized contact is required. Our stakeholders are invited continuously to participate in every aspect of TCMHS governance and operations including board membership, commission membership, policy development, plan implementation, and budgeting.

3. List the dates of the 30-day stakeholder review and public hearing. Attach substantive comments received during the stakeholder review and public hearing and responses to those comments. Indicated if none received.

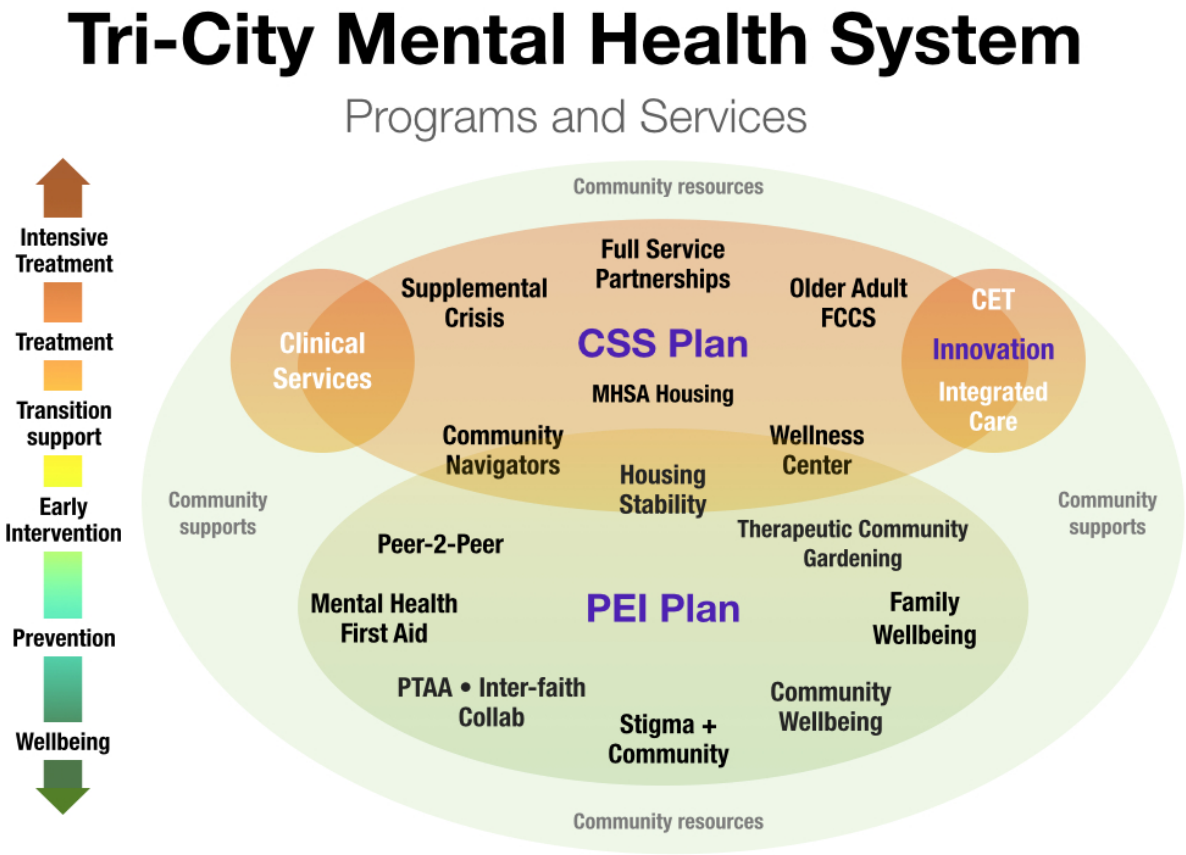
This addition to our Innovation Plan is included as part of TCMHS's Annual Update and Three-Year Program and Expenditure Plan, which was posted on April 21, 2014, and the required 30-day review process ended on May 20, 2014. Staff circulated a draft by making electronic copies available on TCMHS's website and providing printed copies at various public locations (such as at the Wellness Center, libraries, etc.). Several methods of collecting feedback were available such as phone, fax, email, mail, and comments at the public hearing.

The public hearing was scheduled for May 22, 2014. The Mental Health Commission recommended the Three-Year Program and Expenditure Plan including planned Innovation Programs for approval, and the Governing Board approved the Three-Year Program and Expenditure Plan at this meeting.

Attachment A includes the sign-in sheets from the public hearing. Attachment B lists the demographics of those who were invited to participate in the planning process and public hearing. Attachment C is a summary of all the comments received at the public hearing; no changes were made to this plan based on comments from the public hearing. Attachment D is a summary of the recommendations stakeholders identified as areas for each program's improvement and opportunities for greater collaboration between programs and between additional stakeholders, and it was from this process that potential Innovations projects were identified and developed into this plan.

Introduction to Exhibit C's Innovation Work Plans

Tri-City Mental Health Services (TCMHS) takes an innovative approach throughout all of its MHSA planning efforts in order to transform our system of care to the recovery model. Unlike traditional models where intensive, publicly-funded services are the main focus of the system of care, TCMHS's role in the system of care is critical but not exclusive. Rather, the system of care is made possible by the three cities' community's own capacity to care for its members without relying exclusively on expanded services provided by TCMHS. Therefore, in this system of care, TCMHS supports the community's capacity to care for its members and only provides services when necessary. Our approach can be visualized using the following map of the emerging system of care and the MHSA investments that have been made to date:



This Innovation Plan was conceived as another component of this system of care in which we continue to build the capacity of both TCMHS and the three cities' communities to support mental health and recovery. The three Innovation work plans provided here represent areas of learning that we believe can increase community capacity significantly, improve services, and transform the system of care. We believe that these projects, while time-limited, will provide a wealth of information that can inform our ongoing efforts through CSS and PEI.

Exhibit C: Cognitive Remediation Therapy Program (CRT)

Date: **April 21, 2014**
County: **Tri-City Mental Health Services**
Work Plan #: **3**
Work Plan Name: **Cognitive Remediation Therapy Program**

Primary Purpose of Proposed Innovation Project

Increase access to underserved groups
X Increase the quality of services, including measurable outcomes
Promote interagency collaboration
Increase access to services

Briefly explain the reason for selecting the above purpose.

The purpose of this project is to increase the quality of available services including measurable outcomes for people with psychosis and psychotic features including post-traumatic stress disorder, depression, schizophrenia, schizoaffective disorder, and bipolar disorder. The project integrates two existing evidence-based practices, Cognitive Enhancement Therapy and Cognitive Behavioral Treatment for Psychosis (CBTfP), that elsewhere are administered independently, each addressing one part of a client's interrelated cognitive impairment and psychotic symptoms. This project tests an approach to treating the whole person who experiences psychotic illness with an innovative combination of treatments to address both their cognitive impairment and psychotic symptoms.

TCMHS's emphasis on increasing the wellbeing of all community members urges us to consider treatments and approaches that can more directly allow individuals with psychosis to live productive, connected, and meaningful lives. Our stakeholders express high demand for the potential positive outcomes of this project. Given our experiences modifying Cognitive Enhancement Therapy in a previous round of Innovation funding, this new project explores the potential of faster recovery by creating a combined Cognitive Remediation Therapy Program.

Project Description

Describe the Innovation, the issue it addresses in the expected outcome, i.e. how the Innovation project makes a positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length – one page)

This project builds on what was learned in an earlier TCMHS Innovation project, the Cognitive Enhanced Therapy (CET) form of cognitive remediation. In its original form, CET combines structured group activities, computer exercises completed in pairs, and one-on-one coaching with a trained therapist. Through TCMHS's modified CET project (which continues through March 2015), TCMHS is learning that cognitive remediation can have a positive impact on cognitive functions for clients with psychosis. For example, through paired-learning using computer exercises, participants are able to increase their processing speed, improve their cognition (attention, memory, and problem solving), increase their ability to interact wisely with others, and reduce their anxiety. However, this approach does not address or reduce symptoms of psychosis (e.g. hallucinations, voices, worry-filled thinking style, etc.).

In contrast, Cognitive Behavioral Treatment for Psychosis (CBTfP) offers an evidence-based approach to reduce symptoms, improve personal and social functioning, develop highly effective problem solving strategies, and restore energy and enjoyment in life. CBTfP (currently not offered at TCMHS) is typically more focused on the present, is more time-limited, and is more problem-solving oriented than other therapies. Through CBTfP, clients learn specific skills they can use for the rest of their lives, including identification of distorted thinking, modifying beliefs, relating to others in different ways, and changing damaging behaviors. CBTfP has been tested extensively and has been shown to be effective for a wide variety of emotional and behavioral issues, but it doesn't improve cognitive functioning.

This innovation proposes to combine the two types of treatment approaches to address the client as a whole person, supporting and accelerating their progress toward wellness. The educational approach that is embedded in the program helps participants cope with the self-stigma that can often be associated with mental illness, helps them move toward self-acceptance, and become realistically hopeful about their recovery.

TCMHS has learned through its work with CET that many clients do not meet the program's strict eligibility requirements because they may have active use of alcohol or other drugs; do not meet IQ and reading level requirements; or do not have the required transportation and/or family support. By establishing simpler eligibility requirements, this project explores the breadth of clients who may still benefit from this combination of treatments. The requirements for participating in this Cognitive Remediation Therapy project are:

- Resident of either Claremont, La Verne, or Pomona
- 18 years of age or older
- Experience of psychosis or psychotic features
- Commitment to the program cycle

We anticipate serving 40-50 clients in the first operational year of this project and an additional 70-85 clients in the second year; the exact number depends upon what we learn about the most effective length of time for the treatments and client demand for the treatments. Participants may or may not be TCMHS clients, and they also may be receiving other services such as Full Service Partnership, other support groups, and/or outpatient psychotherapy (billed separately). In addition, by reducing the time commitment of the program from the CET requirement of 48 weeks, this project will address one of the main barriers to completion for participants, while exploring the impact that is possible through briefer therapy.

This project incorporates all of the essential MHSA General Standards. The emphasis of combining treatments to address the whole person embodies the recovery focus and integrating service experiences, with the intention of increasing the speed of recovery for participants toward their highest potential of wellness. The program design encourages client- and family-driven systems due to our strong consumer and family participation through the Recovery Learning Team which conducts the learning aspects of the project (see Project Measurement description). In addition, CRT encourages community collaboration in that the availability of the CRT services and lessons learned can be shared across the physical health and substance abuse systems through another Innovation project, Integrated Care. Cultural competence is encouraged because we hope that offering these therapies in their combined form and with fewer eligibility requirements will provide greater access to these services and their benefits than previously. Because it adds to clinicians' and consumers' service options for treatments, we also expect that we will be better able to effectively engage and retain individuals of diverse backgrounds. Lastly, the combined practice may better meet consumers' individual needs, preferences, and comfort levels by addressing the full range and variation of the his or her functioning and symptoms rather than just on one aspect of the manifestation of his or her mental illness.

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length – one page)

This project tests a new approach to treating the whole person who experiences psychotic illness with an innovative combination of treatments to address both their cognitive impairment and psychotic symptoms. The project offers progress through recovery for people with severe conditions including schizophrenia and bipolar disorder to attain functioning that is closer to their pre-illness capacity. By combining effective treatments used separately until now, this project tests the possibility of reducing the length of the disorder, leading to improved quality of life for clients.

The changes to existing mental health practices that will contribute to the learning come in at least two aspects:

1. Revisions to the cognitive remediation approaches based on TCMHS learning through the earlier CET innovations project; and,
2. Integration of traditionally separate treatment for the cognitive impairments and psychotic symptoms.

More specifically, we expect to learn answers to the following questions:

- Can this combination of evidence-based practices lead to improved outcomes for cognitive functioning and reduction of psychotic symptoms?
- Can a revised cognitive remediation approach, identified through the earlier innovations project, increase client engagement and retention?
- Can the revised cognitive remediation approach become a positive additional treatment option in the overall system of care available to clients who are not participating in the combined treatment?
- Can the CBTfP methodology become a positive additional treatment option in the overall system of care available to clients who are not participating in the combined treatment?
- Can TCMHS implement a combined cognitive treatment for psychotic disorders in a cost effective way? Are there reimbursement opportunities?
- Can a broader group of participants (with fewer eligibility screens) succeed with the combined treatment?

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length – one page)

Implementation/Completion dates: 9/14-6/17

September 2014 – February 2015: Training and curriculum development, Project Measurement Design

- Lead Therapist participates in training needed to fully develop expertise in both therapies
- Lead Therapist develops curriculum and, together with evaluation staff, designs the project measurement methodology. The curriculum will address the number of sessions, types of sessions, length of participation, topics to be addressed through both aspects of treatment, and other details. The project measurement plan will articulate the measures to be used to assess progress toward the learning objectives, and establish the tools and timeline to be used in that measurement. The plan will likely incorporate a selection of existing pre- and post-measures from both types of treatment, process measures, as well as qualitative approaches to capture learning around implementation.
- Curriculum to draw on extensive cognitive remediation tools and activities available for free on the internet

March 2015 – June 2015: Preparation for launch

- Hire coach/therapists
- Extend time of evaluation consultant to begin preparations for the measurement of this project (The consultant will be shared among the two new Innovation projects and will have been hired already.)
- Conduct training in new curriculum for coach/therapist hires
- Extend training opportunity to existing TCMHS clinical staff to encourage incorporation into ongoing therapy
- Recruit participants from post-CET support group at the Wellness Center, graduates of the WISH pre-volunteer program, interested TCMHS clients and non-client community members
- Develop a pre-test for the project

July 2015 – April 2017: Full implementation

- Begin first cohort of participants (We anticipate four months per cohort with a two-month learning/evaluation period prior to the start of the next cohort. If there is enough demand, we may run multiple cohorts simultaneously and/or adjust the timeline of the length of the cohort to maximize outcomes.)
- Establish a Recovery Learning Team to facilitate learning dialogues among participants and document learning

- Calendar and length of cohorts to be determined during the curriculum development phase. Groups may overlap in timing as appropriate based on capacity of staff and interest of potential participants.

May-June 2017

- Final meeting of Recovery Learning Team
- Final project measurement conducted and documented
- Dissemination of findings through annual stakeholders meetings, approaching CiMH for possible replication, and presentations at conferences

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

Building on the successful model used with the CET innovations project, a Recovery Learning Team (RLT) will periodically assess progress toward addressing the learning questions and will document findings. Other stakeholders will provide feedback to the interim and final learning reports. In addition, the RLT and stakeholders will make a recommendation as to whether and how to incorporate these practices into TCMHS services.

The RLT will be comprised of approximately 10-14 individuals representing the following participants and stakeholders:

- Clinicians implementing the Cognitive Treatment for Psychotic Disorders program and clinicians implementing other available forms of treatments such as Full Service Partnerships;
- Lead Therapist overseeing the project implementation;
- Researcher from a local university;
- Family members;
- Consumers; and,
- Innovation project workgroup members.

With a focus on the learning questions, we will assess and learn from the collected data using the Results-Based Accountability (RBA) processes that TCMHS uses to monitor and evaluate all of its programs. RBA requires us to identify specific measures for answering the questions: "How much did we do?" "How well did we do it?" and "Is anybody better off?" The following are measures to be used in the evaluation, and more may be included as needed:

How much did we do?

- How many participants enrolled in the program?

How well did we do it?

- How many enrolled participants completed the program?

Is anybody better off?

- What measurable changes to participants' cognitive abilities resulted?
- What measurable changes to participants' psychotic symptoms resulted?

In addition, in order to know whether the project is successful enough to recommend to others and/or to continue to invest resources in its development, we will consider the following learning questions and methods of assessment:

- Is the new combination of treatments more successful than each of the treatments alone?
- In what ways is it more successful?
- Why is it more successful (or not)?

- Are there specific components of the combined method that contribute to its success?

To answer these questions, we will rely upon the expertise of the evaluation consultant to conduct the data analysis and advise us on the generalizability of our findings. We expect to compare the participation levels, completion rates, and pre- and post-test results of our combined therapy's cohorts to past TCMHS CET participants as well as the populations in the CET and CBTfP literature available. Although the evaluation consultant will be brought onto this project at the beginning of the implementation phase, TCMHS has the capacity internally to conduct program evaluation and measurement. As such, the Lead Therapist will consider these measurement needs in her curriculum and project measurement design and will be supported by the Manager of Best Practices, as needed.

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

If successful, TCMHS anticipates incorporating these treatments into our menu of available services. As evidence-based practices, they are eligible for Medi-Cal billing. Lastly, by providing a time-limited, effective treatment, this program increases flow through the system of care, opening resources for additional clients to be served.

Exhibit C: Employment Stability Project

Date: **April 21, 2014**
County: **Tri-City Mental Health Services**
Work Plan #: **4**
Work Plan Name: **Employment Stability Program**

Primary Purpose of Proposed Innovation Project

Increase access to underserved groups
Increase the quality of services, including measurable outcomes
X Promote interagency collaboration
Increase access to services

Briefly explain the reason for selecting the above purpose.

In traditional systems, once a person enters mental health treatment and accesses Social Security benefits, he or she is assumed to be out of the employment market; but for some clients, employment is a necessary component of recovery and mental health.

The current job market is challenging for all potential employees and more so for those recovering from serious mental illness. Employers are typically disconnected from TCMHS and available services, and there is a pervasiveness of stigma, including self-stigma. In addition, the state Employment Development Department is downsizing, resulting in less support in the community for those who seek employment. Those who do have jobs face multiple stressors, such as increased work expectations and lack knowledge of the resources available to provide support.

By finding ways to work with employers in a cooperative manner and reduce stigma towards mental illness, we hope to prevent future job loss and increase general-market employment for those who wish to include it in their path to wellness. This project design builds directly on what TCMHS has learned through its earlier work with landlords to sustain housing. Just as TCMHS has made significant progress and gained state and national attention though strong partnerships with landlords, this proposal articulates a path for effective partnerships with employers.

The purpose of this project is to expand and strengthen the system of care by focusing on ways that employers and TCMHS can work together to: 1) identify mental health needs; and 2) provide assistance in ways that allow TCMHS clients and others, including those at risk of serious mental illness, to access or maintain their employment. The project expands on the effective employment support already offered by TCMHS staff and volunteers. It builds beyond the support for employees to work with employers:

- To create a healthier work environment;

- To promote more openness to hiring and retaining employees with mental health challenges; and,
- To support employers when faced with employees who are experiencing significant symptoms of mental distress or illness.

Project Description

Describe the Innovation, the issue it addresses in the expected outcome, i.e. how the Innovation project makes a positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320. (suggested length – one page)

This project seeks to build new relationships, understanding, and activities that will effectively incorporate employers into the system of care. First, the project will take some time to learn the perspectives the people involved. We will engage employers and clients in discussions on topics such as:

- Differences and needs between large and small employers;
- Opportunities to complement Employee Assistance Programs (EAP) when they are offered to employees, or provide useful support and services when they do not; and,
- Challenges and interests of clients who have or want jobs.

Next, the project will break harmful beliefs and barriers in clients' own thinking about employment and address the clients' self-stigma. We will develop an "effective employee" curriculum that addresses issues such as:

- How to relate to and communicate with your boss;
- What employers expect; and,
- What you should expect on the job.

The purpose of this curriculum will be to remove self-stigma and disbelief of potential to be a successful employee, and to build skills that are attractive to employers and help sustain successful employment. Unlike in most supportive employment practices, an initial small cohort of employers will be essential input partners in the development of this curriculum, along with clients who are interested in employment. In this way, we can develop curriculum that speaks to relevant and salient needs and issues of employers and employees today.

Using a wellness-focused approach, the curriculum will be responsive to cultural differences and specific challenges, such as hesitation to ask an employer for accommodation or support for fear of losing the job, or a self-stigmatizing belief that they are not trainable so therefore will not seek opportunities for learning. With a curriculum that addresses employee rights as well as healthy behaviors and responses to power, the project will cut across cultures effectively.

We anticipate reaching 16 employers and 150 employees in the first year, and 30 employers and 300 employees in each subsequent year (a total of 76 employers and 750 employees). It may take a year or more of working with the first small cohort of employers(who can act later as spokespeople to recruit additional participants) before the project team is ready to move

into further activities. The small cohort will design and lead the activities for greatest impact. These actions may include:

- Match graduates of the effective employee curriculum in open positions, delivering employees who are ready to work;
- Provide a trained peer job coach to support the employee at the new job, checking in periodically, and responding when challenges arise;
- Host a free presentation on issues that matter to the employers, such as an attorney addressing reasonable accommodations, while building relationships and incorporating stigma reduction;
- Introduce employers to options for providing special accommodations for mental illness, e.g. providing a benefit of leave time to attend a class at the Wellness Center to reduce stress;
- Encourage employers to connect all employees, not just those placed through TCMHS, to participate in Wellness Center activities of interest to them;
- Provide behind-the-scenes support to employers, e.g. connecting confidentially with a former mental health client who is struggling on the job;
- Conduct training sessions for case managers, other mental health providers and clients on getting and sustaining employment;
- Leverage existing programs including community navigators for the benefit of employers and employees;
- Work with Community Navigators and Mental Health First Aiders to reach out to employers;
- Recruit employers to become Mental Health First Aiders;
- Serve as a model by introducing a career ladder within TCMHS by creating new levels of community support workers.

Finally, TCMHS will expand outreach to additional employers drawing from community groups e.g. Chambers of Commerce, ethnic-focused Chambers of Commerce, Rotary Clubs, economic development groups, professional Human Resource managers, groups at human resource schools. TCMHS may conduct education and outreach workshops at business, civic, or other community events to broaden the audience of employers. The leaders who emerge from the earlier phases will conduct these sessions as it will be more powerful and persuasive for employers to hear about the collaboration with mental health providers and clients from other business owners.

This project moves beyond existing supportive care models by focusing on the training and engagement of *employers* (as opposed to employees) while continuing to encourage clients to take ownership of their employment-seeking process. Of the actions listed above, the elements that are new compared to existing supported employment models are:

- Building a cohort among employers;

- Letting the employers teach us about their own needs in working with, supporting, and sustaining employees;
- Building relationships between employers and TCMHS as partners working toward the same goals;
- Engaging employers themselves in the curriculum design;
- Helping employers see TCMHS as a useful resource that helps them succeed; and,
- Approaching businesses as key partners in an ongoing relationship with TCMHS, not just temporarily when consumers need employment or when employers have positions available.

The project primarily addresses community collaboration in that it seeks to find ways for employers, mental health providers and clients to work together to ensure that people with mental illness can get and sustain appropriate employment. It also seeks to build stronger connections between these parties as a way to bring employers into the community system of care and wellbeing.

To slightly lesser but still notable extent, the project addresses the other essential MHSA elements. The project seeks to integrate employment services into mental health provision by preserving a clients' existing employment or moving them into a more appropriate position for their needs. By aiming at the client's wellness, recovery, and resiliency, the project supports the community's capacity to care for its members. The project also works to create a client-driven system by reducing stigma and creating opportunities for employers, mental health providers and clients to learn and develop strategies together. Similarly, the project supports a family-driven system in that we expect that some employers and employees will be family members of those with serious mental illness, and this project can help connect them to needed resources while reducing stigma. Finally, we believe that the project helps us work toward a more culturally competent system by understanding the business-oriented perspectives of employers, finding effective ways to communicate and work together, and offering opportunities to educate employers and employees on how to address a person's mental health needs and be respectful of his or her cultural norms and practices regarding mental health.

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts. (suggested length – one page)

The project is a change to existing supported employment models, which tend to focus on preparing and supporting the consumer in his or her place of employment. In contrast, this project seeks to understand if mental health service providers can maintain and expand the employment opportunities for people with mental health needs (or find more appropriate ones) by strengthening partnerships among employers, clients, and mental health service providers. It seeks to bring employers into the community system of care.

Some of the questions that can be addressed in the evaluation are:

- What challenges or needs make it difficult for Tri-City area employers to offer jobs to people who have mental health needs?
- What challenges or needs make it more likely that Tri-City area employers will terminate employment or not hire people with mental health needs rather than keeping or hiring them?
- What policies, agreements, services and/or supports before and during employment might make it more likely that Tri-City area employers will offer jobs to people with mental health needs, and work to keep people with mental health needs in their jobs once hired?
- What can TCMHS offer employers to meet their business needs while supporting employees with mental health needs?
- What are effective outreach strategies for building positive, productive relationships with employers?
- What skills and information can TCMHS help our clients exercise and understand about being a “good employee” that serve to build better employer - employee relationships and keep them in appropriate work positions?
- How can mental health clinicians integrate discussion of current or potential employment in their ongoing clinical planning and care?
- Are there specific components of this approach that contribute to its success, particularly when compared to traditional models of supportive employment?

The project seeks to introduce a new mental health practice by developing truly collaborative relationships between employers, clients, and mental health providers.

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication. (suggested length – one page)

Implementation/Completion dates: 9/14-6/17

Phase 1: Engage with an initial pool of employers in conversation about mental health and employment. TCMHS will host a luncheon to explore key questions and possibilities. Beginning with a small group of those with whom TCMHS has an existing relationship and who have an openness to the work, participants will represent a range of professional and non-professional work and may be drawn from:

- Employers who participate in TCMHS job fairs
- Employers who have received placements through TCMHS
- Employers who have a personal experience with mental illness, whether through their family, circle of friends, or on the job
- Clients who are currently employed
- Clients who are looking for a job or who want a job but have stopped looking due to barriers

An evaluation consultant will be identified and hired during the beginning of this phase. He or she will help us develop an appropriate project measurement plan for this project and work with the project director and other TCMHS staff throughout the project to advise with regard to evaluation.

Phase 2: Develop an "effective employee" curriculum that addresses issues such as:

- How to relate to and communicate with your boss
- How to relate to and communicate with your co-workers
- What employers expect
- What you should expect on the job

The evaluation consultant will develop pre- and post-testing on the curriculum to measure learning. Possible indicators of changes to employers' understanding of mental illness in employment may be changes to employment policies, procedures, and protocols that address mental health.

Phase 3: Take action based on these newly formed relationships. It may take a year or more of working with the small cohort of employers, with them acting as spokespeople to recruit additional participants, before the project team is ready to move into further activities. The small cohort will design and lead the activities for greatest impact.

Phase 4: Expand to additional employers drawing from community groups e.g. Chamber, ethnic-focused chambers, Rotary, economic development groups, professional Human Resource managers, groups at human resource schools. TCMHS may conduct education and outreach workshops at business, civic or other community events to broaden the audience of employers.

The evaluation consultant will complete the measurements needed to be able to develop and report significant findings from this project for broader dissemination, including a comparison to the outcomes of other supported employment models.

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

With a focus on the learning questions, TCMHS will assess and learn from the collected data through the Results-Based Accountability process that TCMHS uses to monitor and evaluate all of its programs. RBA requires us to identify specific measures for answering the questions: "How much did we do?" "How well did we do it?" and "Is anybody better off?" The following are measures to be used in the evaluation, and more may be included as needed:

How much did we do?

- Number of employers participating in the initial cohort
- Number of clients participating in the initial cohort
- Number of clients participating in the curriculum program
- Number of contacts required to engage new employers

How well did we do it?

- Number of clients placed in new position(s)
- Number of new participants at the Wellness Center through project referrals
- Number of initial cohort members who participate over time
- Number of new employers engaged by initial cohort members
- Number of participants who complete the curriculum program

Is anybody better off?

- Number of clients placed in new position(s)

In addition, in order to know whether the project is successful enough to recommend to others and/or to continue to invest resources in its development, we will consider the following learning questions and methods of assessment:

- Does improving the collaboration among mental health service providers, employers and employees result in more successful outcomes than traditional supportive employment practices?
- In what ways is it more successful?
- Why is it more successful (or not)?

To answer these questions, we will rely upon the expertise of the evaluation consultant to advise us on appropriate methodologies and measures for this project. However we anticipate that we would track the following indicators to help us assess the contributions of this project's innovation:

- The number of employers willing to participate in the initial cohort

- The number of employers willing to participate in later phases
- The number of employers who are willing to advocate for mental health issues in the workplace
- The number of employees at organizations that participate in the program
- The number of referrals coming from employers or their employees, e.g. to the Wellness Center

While we anticipate that some of this information will be more qualitative, even anecdotal, these are additional indicators that we will use to assess our success:

- When there are new relationships acquired and honest and respectful dialogue is maintained among employers, mental health providers and clients.
- When we are able to bring solutions and agreed upon action plans (e.g. no firing until both parties have tried everything to avoid job loss) to the table.
- When employers can recognize the possibility of mental illness in an employee and reaches out to mental health providers for assistance.
- When TCMHS staff has an understanding of the local employment market and the challenges employers face.
- When we all have a better understanding of what a reasonable accommodation is for a person with mental illness, what are reasonable responsibilities of an employee with mental illness towards the employer, other employees, and business; and what mental health providers can do to facilitate these understandings.

In the first phase of this project, the staff person assigned to this project will have the opportunity to reflect on what he/she is learning about effective outreach to and the perspectives of employers through monthly staff reports and meetings with supervisors. This information will allow TCMHS to make adjustments along the way until it has a critical mass of employers to engage in the second phase of the project. In particular, we are interested in tracking the number of engagements needed before employers are willing to continue the conversation and relationship with us in more depth. We believe that this information can help us better understand when to continue to work at developing these relationships and when we need to move on to other people for conversation.

By the fourth phase of this project, we will document the themes and highlights of our learning exchanges among employers, clients and mental health providers. This phase may also include one-on-one interviews with leaders that emerge from this phase to get more insight into how they view the relationship between us.

TCMHS staff, other mental health providers and employers will be engaged in this assessment work. Other stakeholders can be included by inviting interested agencies, community members, business and civic groups, and associations of human resource professionals. The invitation can come through existing coalitions, word of mouth, and/or a formal invitation to participate.

In addition, an evaluation consultant(who will be shared by both new Innovation projects) will be hired at the beginning of the project to do a thorough assessment of the project and draft the findings for broader dissemination.

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

If this approach proves successful, we will find cost-effective ways to incorporate it into our work. In addition, many of the CSS, PEI and WET programs we have already developed fit in well with supporting this approach, so we expect that the lessons from this Innovation project can be easily absorbed.

Exhibit D: Description for Cognitive Remediation Therapy

(For Posting on DMH Website)

County Name: Tri-City Mental Health Services
Work Plan Name: Cognitive Remediation Therapy
Annual Number of Clients to Be Served (if Applicable): 110-135 total

Population to Be Served (if applicable):

This project will serve approximately 110-135 people with psychosis and psychotic features including post-traumatic stress disorder, depression, schizophrenia, schizoaffective disorder, and bipolar disorder. Participants will be 18 years or older; a resident of either Claremont, La Verne, or Pomona; experiencing psychosis or psychotic features; and willing to commit to the program cycle.

Project Description (suggested length – one-half page): Provide a concise overall description of the proposed Innovation

The project integrates two existing evidence-based practices, Cognitive Enhancement Therapy and Cognitive Behavioral Treatment for Psychosis (CBTfP) that elsewhere have been administered independently, each addressing one part of a client's interrelated cognitive impairment and psychotic symptoms. This project tests an approach to treating the whole person who experiences psychotic illness with an innovative combination of treatments to address both their cognitive impairment and psychotic symptoms. By combining the two types of treatment approaches, TCMHS hopes to support and accelerate the client's progress toward wellness. The educational approach that is embedded in the program helps participants cope with the self-stigma that can often be associated with mental illness, helps them move toward self-acceptance, and to become realistically hopeful about their recovery.

Exhibit D: Description for Employment Stability

(For Posting on DMH Website)

County Name: Tri-City Mental Health Services
Work Plan Name: Employment Stability
Annual Number of Clients to Be Served (if Applicable): 750 total

Population to Be Served (if applicable):

Employers and employees experiencing mental distress or illness will be served by this project. We anticipate involving 76 employers and 750 employees clients over the course of this three-year project.

Project Description (suggested length – one-half page): Provide a concise overall description of the proposed Innovation

The purpose of this project is to expand and strengthen the system of care by focusing on ways that employers and TCMHS can work together to: 1) identify mental health needs; and 2) provide assistance in ways that allow TCMHS clients and others to access or maintain their employment. The project expands on the effective employment support already offered by TCMHS staff and volunteers, building beyond the support for employees, to work now with employers to create a healthier work environment, more openness to hiring and retaining employees with mental health challenges, and successfully supporting employers when faced with employees who are experiencing significant symptoms of mental distress or illness.

Exhibit E: MHSA Innovation Funding Request, FY 14/15

County: Tri-City Mental Health Services Date: July 21, 2014

	Innovation Work Plans		FY 14/15 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	#01	Modifications to Cognitive Enhancement Therapy	$177,581	$0	$58,602	$118,979	$0
2	#02	Integrated Care (previously Integrated Services)	$288,263	$72,066	$72,066	$72,066	$72,066
3	#03	Cognitive Remediation Therapy Project	$137,626	$0	$45,417	$92,209	$0
4	#04	Employment Stability	$203,092	$0	$50,773	$152,319	$0
5							
6							
7							
8							
9							
10	Subtotal: Work Plans		$806,562	$72,066	$226,857	$435,573	$72,066
11	Plus County Administration		$121,000				
12	Plus Optional 10% Operating Reserve						
13	Total MHSA Funds Required for Innovation		$927,562				

Exhibit E: MHSA Innovation Funding Request, FY 15/16

County: Tri-City Mental Health Services Date: April 21, 2014

Innovation Work Plans			**FY 15/16 Required MHSA Funding**	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	#03	Cognitive Remediation Therapy Project	$332,690	$0	$109,734	$222,794	$0
2	#04	Employment Stability	$284,971	$0	$71,243	$213,728	$0
3							
4							
5							
6							
7							
8	Subtotal: Work Plans		$617,499	$0	$180,977	$436,522	$0
9	Plus County Administration		$92,625				
10	Plus Optional 10% Operating Reserve						
11	Total MHSA Funds Required for Innovation		$710,124				

Exhibit E: MHSA Innovation Funding Request, FY 16/17

County: Tri-City Mental Health Services Date: April 21, 2014

Innovation Work Plans			**FY 16/17 Required MHSA Funding**	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	#03	Cognitive Remediation Therapy Project	$332,990	$0	$109,887	$223,103	$0
2	#04	Employment Stability	$289,771	$0	$72,443	$217,328	$0
3							
4							
5							
6							
7	Subtotal: Work Plans		$622,761	$0	$182,329	$440,432	$0
8	Plus County Administration		$93,414				
9	Plus Optional 10% Operating Reserve						
10	Total MHSA Funds Required for Innovation		$716,175				

Exhibit F: Innovation Projected Revenues and Expenditures

County: Tri-City Mental Health Services Fiscal Year: 2014-15 through 2016-17

Work Plan #: INN-03

Work Plan Name: Cognitive Remediation Therapy Project

X New Work Plan

Months of Operation: 09/14 to 6/17

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	531,621			$531,621
2. Operating Expenditures	114,921			$114,921
3. Non-recurring expenditures	4,000			$4,000
4. Consultant Contracts	101,920			$101,920
5. Work Plan Management	223,649			$223,649
6. Total Proposed Work Plan Expenditures	**$976,111**	**$0**	**$0**	**$976,111**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. Medi-Cal	172,966			$172,966
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$172,966**	**$0**	**$0**	**$172,966**
4. Total Revenues	**$172,966**	**$0**	**$0**	**$172,966**
C. Total Funding Requirements	**$803,145**	**$0**	**$0**	**$803,145**

Prepared by: Margaret Harris Date: 7/24/14

Telephone Number: (909) 623-6131 ext. 2308

BUDGET NARRATIVE

County Name: Tri-City Mental Health Services Date: July 24, 2014
INN Work Plan Name: Cognitive Remediation Therapy (CRT)
INN Project #: 03

General

The costs included in this budget covers the initial year period of the work plan beginning September 2014 through June 2015 to train and develop curriculum, hire personnel, and recruit participants, with CTPD services commencing in July 2015 through June 2017.

A. Expenditures

1. Personnel Expenditures—$531,621

   Personnel expenditures include:

   a) Salaries of $416,631 cover the three-year period ending June 30, 2017 and were determined based on Tri-City's job classifications and compensation ranges.

      Positions include:
      - Lead Therapist/Psychologist—.65 FTE in 2014-15 and 1.0 FTE in 2015-16 and 2016-17
      - Clinical Staff—.28 FTE in 2014-15, 1.1 FTE in 2015-16 and 1.6 FTE in 2016-17

   b) Benefits of $114,990 were based on Tri-City's average benefit rate of 27.6% and include all payroll taxes, retirement costs, health insurance and worker's compensation insurance.

2. Operating Expenditures—$114,921

   Operating expenditures include material and supply costs as well as facility and utility costs for the three year period.

3. Non-recurring expenditures—$4,000

   Non-recurring expenditures include computers and cell phones for new staff.

4. Consulting Contracts—Evaluation--$101,920

Tri-City will engage an evaluation analyst consultant for the last two years of the CRT program as it will take one year to develop and design the curriculum and hire staff. Treatment will begin in the second year at which time the evaluation process will begin. The consultant will dedicate .35 FTE to this program for each of these two years at an estimated cost of $70 per hour, or $101,920 in total.

5. Work Plan Management—$223,649

   Work plan management, including ongoing planning, monitoring, data collection and outcome reporting will be conducted by Tri-City employees that have been assigned to this program. Such staff will include the Innovation Coordinator and Best Practices staff who will provide program leadership, quality assurance management, and outcome reporting and will work in coordination with the evaluation analyst consultant. Staff time projected to be spent on this project is:

   Innovations Coordinator—.25 FTE per year
   Best Practices Staff—.05 FTE in 2014-15 and .85 FTE in 2015-16 and 2016-17

6. Total Proposed Work Plan Expenditures—$976,111

   The total proposed work plan expenditures will cover the costs of the plan over the three years as follows:

Fiscal 2014-15	$ 137,626
Fiscal 2015-16	$ 392,690
Fiscal 2016-17	$ 445,795

B. Revenues—$172,965

1. Existing Revenues—None
2. Additional Revenues—Estimated Medi-Cal FFP reimbursement of $172,966
3. Total New Revenues—$172,966
4. Total Revenues—$172,966

C. Funding Requirements—$803,145

Exhibit F: Innovation Projected Revenues and Expenditures

County: Tri-City Mental Health Services Fiscal Year: 2014-15 through 2016-17

Work Plan #: INN-04

Work Plan Name: Employment Stability

X New Work Plan

Months of Operation: 09/14 to 6/17

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	339,068			$339,068
2. Operating Expenditures	66,291			$66,291
3. Non-recurring expenditures	2,000			$2,000
4. Consultant Contracts	135,893			$135,893
5. Work Plan Management	234,581			$234,581
6. Total Proposed Work Plan Expenditures	**$777,833**	**$0**	**$0**	**$777,833**
B. Revenues				
1. Existing Revenues				$0
2. Additional Revenues				
a. (insert source of revenue)				$0
b. (insert source of revenue)				$0
c. (insert source of revenue)				$0
3. Total New Revenue	**$0**	**$0**	**$0**	**$0**
4. Total Revenues	**$0**	**$0**	**$0**	**$0**
C. Total Funding Requirements	**$777,833**	**$0**	**$0**	**$777,833**

Prepared by: Margaret Harris Date: 7/24/14

Telephone Number: (909) 623-6131 ext. 2308

BUDGET NARRATIVE

County Name: Tri-City Mental Health Services Date: July 24, 2014
INN Work Plan Name: Employment Stability
INN Project #: 05

The costs included in this budget covers the three-year period of the project starting in September 2014 through June 2017.

A. Expenditures

1. Personnel Expenditures—$339,068

   Personnel expenditures include:

   a) Salaries of $265,727 cover the three-year period ending June 30, 2017 and were determined based on Tri-City's job classifications and compensation ranges.

      Positions include:
      - Outreach and Employment Supervisor—.5 FTE
      - Navigation/outreach/employment coach—1.0 FTE
      - Community Support Worker—1.0 FTE

   b) Benefits of $73,341 were based on Tri-City's average benefit rate of 27.6% and include all payroll taxes, retirement costs, health insurance and worker's compensation insurance.

2. Operating Expenditures—$66,291

   Operating expenditures for the three years include:

   a) Approximately $10,300 is included for facility costs (allocation of rental space and utilities costs) and $10,700 for equipment and software costs.
   b) Approximately $22,100 will be allocated for job fairs, outreach to employers and training of employers.
   c) Other operating expenses of approximately $23,191 will cover employee supplies, mileage, liability insurance and other miscellaneous expenses.

3. Non-recurring expenditures—$2,000

   Non-recurring expenditures of $2,000 will be expended in the first year for the purchase of computer equipment for new staff.

4. Consultant Contracts—$135,893

   Tri-City will engage an evaluation analyst consultant upon commencement of the Employment Stability program to develop baseline measures and establish the evaluation protocols to be implemented for the program. The consultant will dedicate .35 FTE to this program for each year beginning in the second quarter of fiscal 2014-15 and for the two full years 2015-16 and 2016-17 with a total estimated cost of $70 per hour, or $135,893 in total.

5. Work Plan Management—$234,581

   Work plan management, including ongoing planning, monitoring, data collection and outcome reporting will be conducted by Tri-City employees that have been assigned to this program. Such staff will include the Innovation Coordinator and Best Practices staff who will provide program leadership, quality assurance management and outcome reporting and will work in coordination with the evaluation analyst consultant. Staff time projected to be spent on this project is:

   Innovations Coordinator—.33 FTE in 2014-15 and .75 FTE in 2015- 16 and 2016-17
   Best Practices Staff—.09 FTE in 2014-15 and .35 FTE in 2015-16 and 2016-17

6. Total Proposed Work Plan Expenditures—$777,833

   The total proposed work plan expenditures will cover the costs of the three-year period as follows:

Fiscal 2014-15	$203,092
Fiscal 2015-16	$284,971
Fiscal 2016-17	$289,771

B. Revenues—none

C. Funding Requirements—$777,833

Workforce Education and Training Programs (WET funded)

Workforce Education and Training (WET)

OVERVIEW

Tri-City's WET Plan focuses on improving the effectiveness of people currently providing support and services in the Tri-City area, as well as preparing people for careers in community mental health. Clinical and non-clinical staff, family, community caregivers and volunteers are the primary recipients of the education and training offered through the WET Plan.

ORIGINAL RATIONALE

Two clear needs emerged out of the WET planning process. The first was the need for a systematic and sustained approach to training and learning within TCMHS. TCMHS grew dramatically over the past five years, and it now manages complex and diverse programs that require more formal methods of training and learning. The second was the need for a deeper pool of volunteers and future employees who have a realistic understanding of community mental health. Stakeholders saw significant volunteer opportunities that could be harnessed to support the efforts in the three cities, and they believed that focusing on the training and education of young people entering careers in mental health would help facilitate the shift toward community mental health in the long run.

NOTES ON DEVELOPMENT • PROGRESS • LEARNING

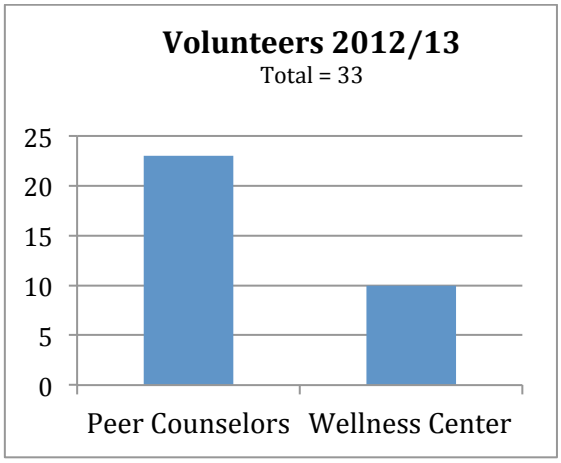
Towards the goal of creating a systematic and sustained approach to training and learning, TCMHS hired WorkingKnowledge to conduct an analysis to see if TCMHS would benefit from an online learning support system. It was determined that TCMHS could build off its existing Summit system more cost-effectively. As part of this analysis, TCMHS completed a staff survey asking for areas where they were interested in learning. Out of that survey came an eight-session writing workshop attended by seven staff. The survey's findings will also contribute to the development of the strategic learning plan.

Towards the goal of creating a deeper pool of volunteers and future employees, TCMHS made many new changes to its volunteer program. It created standardized volunteer process and protocols, added volunteer information on TCMH website, identified key individuals and established outreach with high school/college staff, and attended a United Way volunteer training program. Overall, the volunteer recruitment was refined to provide more information before making the volunteer commitment and to better match the volunteer's interests and strengths to available opportunities. As a result, TCMHS saw an increase in well-prepared volunteers and was able to add Therapeutic Community Garden and Community Navigators as programs ready to accept volunteers.

HOW MUCH DID WE DO? HOW WELL DID WE DO IT?

Increased MH career awareness for 15 high school students; 5 of them became volunteers

17 college student volunteers



IS ANYONE BETTER OFF? TESTIMONIALS

Testimonial #1: I speak two languages, and English is my second language. The TCMHS Writing Workshop changed my way of thinking and writing in English. Mary Baron taught this class differently. All classes were interactive and always had feedback. For the first time, I wrote an essay correctly, and she always motivated us to keep writing and expressing ourselves. We corrected our grammar, and she was always willing to share his professional experience as a writer and as a therapist. In this workshop I learned not only to write in different scenarios but also to improve my grammar and reading. I thank Mary Baron and Tri -City for the opportunity to attend this workshop.

Testimonial #2: After graduating with a Bachelor of Science degree in Psychology, I decided to volunteer for Tri-City while looking for employment. Before volunteering, I knew my help would be appreciated yet believed I would be looked upon as just another volunteer. However, my expectations were far exceeded. Group members always thanked me for the educational information and positivity I shared. I was also reminded by members at Tri City to continue doing a great job. The reciprocation of support from group members at the wellness center inspired me to do more for Tri City Services. For example, under the Peer-to-Peer Counselor program, I was assigned counselees who requested peer support. I also obtained a National Certification in Mental Health First Aid and peer support training from Tri City's very own employees. Throughout my volunteering experience, I bonded with both group members and staff at the Wellness Center. Although I am currently employed full time, volunteering remains important to me. I will be forever grateful to Tri City for the opportunity in providing professional education and training, but most importantly the chance in helping me work toward completing my goal.

Capital Facilities and Technology Programs (CFTN funded)

Capital Facilities and Technology Plan (CFTN)

OVERVIEW

Tri-City's CFTN Plan focuses on creating greater access to technology, to support empowerment for mental health service recipients and providers, and establish a higher level of program monitoring and outcome analysis. Three projects were developed: 1) Improving Electronic Health Records & Systems Enhancement, 2) Consumer and Family Access to Computing Resources, and 3) Program Monitoring and Service Outcome Support. In keeping with key goals of MHSA to modernize and transform the mental health service system, the projects also include training needed to effectively utilize new resources.

ORIGINAL RATIONALE

Four themes emerged out of the CFTN planning process: 1) a need for increased availability of service data; 2) a need for easier methods to gather, collect, and analyze data; 3) a need for data collection for reporting on the impact of mental health and community support services provided throughout the system of care; and 4) a requirement for more interoperability between mental healthcare providers and programs.

The first project seeks to establish a more integrated information system with better infrastructure and modernized administrative and clinical processes such as clinical charts, billing systems, and outcome tracking. The second project will allow placement of computers, technical support and training in easily accessible areas of Tri-City service locations. The third project aims to collect measurable data on existing and new programs to improve our quality of care and identify areas of opportunity.

NOTES ON DEVELOPMENT • PROGRESS • LEARNING

This plan was adopted in May 2013, late into the 2012-13 fiscal year. There were no developments to report on its implementation for 2012-13.

MHSA County Fiscal Accountability Certification

MHSA COUNTY FISCAL ACCOUNTABILITY CERTIFICATION

County: Tri-City Mental Health Services

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

Local Mental Health Director	County Auditor-Controller/City Financial Officer
Name: JESSE H. DUFF	Name: MARGARET HARRIS
Telephone Number: (909) 623-6131	Telephone Number: (909) 623-3161 ext. 2308
E-mail: jduff@tricitymhs.org	E-mail: mharris@tricitymhs.org
Local Mental Health Mailing Address: 1717 N. Indian Hill Boulevard, Suite B Claremont, CA 91711	

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.

JESSE H. DUFF — Local Mental Health Director (PRINT)

Jesse H. Duff — Signature

8/28/14 — Date

I hereby certify that for the fiscal year ended June 30, 2013, the County/City has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's/City's financial statements are audited annually by an independent auditor and the most recent audit report is dated for the fiscal year ended June 30, 2013. I further certify that for the fiscal year ended June 30, 2013, 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 if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

MARGARET HARRIS — County Auditor Controller / City Financial Officer (PRINT)

Margaret Harris — Signature

8/28/14 — Date

Three-Year Program and Expenditure Plan for FY 2014-15 Through FY 2016-17

Funding Summary

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: TRI-CITY MENTAL HEALTH CENTER Date: 4/21/14

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2014/15 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	5,176,281	1,545,651	1,333,277	738,872	2,004,011	
2. Estimated New FY2014/15 Funding	6,883,453	1,721,003	452,690			
3. Transfer in FY2014/15[a/]	0					
4. Access Local Prudent Reserve in FY2014/15						0
5. Estimated Available Funding for FY2014/15	12,059,734	3,266,654	1,785,967	738,872	2,004,011	
B. Estimated FY2014/15 MHSA Expenditures	6,023,213	1,841,452	927,562	278,219	580,158	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	6,036,521	1,425,202	858,405	460,653	1,423,853	
2. Estimated New FY2015/16 Funding	5,941,278	1,485,180	390,808			
3. Transfer in FY2015/16[a/]	0					
4. Access Local Prudent Reserve in FY2015/16						0
5. Estimated Available Funding for FY2015/16	11,977,799	2,910,382	1,249,213	460,653	1,423,853	
D. Estimated FY2015/16 Expenditures	5,831,745	1,745,677	710,124	281,186	0	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	6,146,054	1,164,705	539,089	179,467	1,423,853	
2. Estimated New FY2016/17 Funding	6,073,405	1,518,073	399,728			
3. Transfer in FY2016/17[a/]	0					
4. Access Local Prudent Reserve in FY2016/17						0
5. Estimated Available Funding for FY2016/17	12,219,459	2,682,778	938,817	179,467	1,423,853	
F. Estimated FY2016/17 Expenditures	5,860,132	1,771,582	716,175	179,427	0	
G. Estimated FY2016/17 Unspent Fund Balance	6,359,327	911,196	222,642	40	1,423,853	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	3,461,200
2. Contributions to the Local Prudent Reserve in FY 2014/15	0
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	3,461,200
5. Contributions to the Local Prudent Reserve in FY 2015/16	0
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	3,461,200
8. Contributions to the Local Prudent Reserve in FY 2016/17	0
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	3,461,200

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

Community Services and Supports Component Worksheet

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER

NOTE: TRI-CITY DOES NOT HAVE A BEHAVIORAL HEALTH SUB ACCOUNT-EPSDT REIMBURSEMENT IS PASSED TO TRI-CITY THROUGH LOS ANGELES DMH

Date: APRIL 21,2014

	Fiscal Year 2014/15					
	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 EPSDT*	Estimated Other Funding
FSP Programs						
1. 1a-Child FSP	1,225,009	526,582	388,015		310,412	
2. 1b-TAY FSP	1,138,987	635,160	379,388		124,439	
3. 1c-Adult FSP	2,033,625	1,403,086	629,539			1,000
4. 1d-Older Adult FSP	650,436	395,808	253,628			1,000
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Community Navigators	419,844	419,844				
2. Wellness Center	1,073,177	1,073,177				
3. Supplemental Crisis Support Services	150,538	150,538				
4. Field Capable Services	168,052	168,052				
5. CSS Housing	234,724	200,374				34,350
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration (Includes MHSA Planning Costs)	1,418,607	1,050,592	291,277		76,738	
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	8,512,999	6,023,213	1,941,847	0	511,589	36,350
FSP Programs as Percent of Total	59.3%					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER NOTE: TRI-CITY DOES NOT HAVE A BEHAVIORAL HEALTH Date: APRIL 21,2014

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount EPSDT*	Estimated Other Funding
FSP Programs						
1. 1a-Child FSP	1,254,687	535,308	399,655		319,724	
2. 1b-TAY FSP	1,169,326	650,385	390,769		128,172	
3. 1c-Adult FSP	2,072,597	1,443,058	629,539			
4. 1d-Older Adult FSP	662,719	409,091	253,628			
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Community Navigators	431,112	431,112				
2. Wellness Center	1,065,142	1,065,142				
3. Supplemental Crisis Support Services	152,551	152,551				
4. Field Capable Services	172,853	172,853				
5. CSS Housing	124,236	71,436				52,800
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration (Includes MHSA Planning Costs)	1,275,190	900,809	295,340		79,041	
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	8,380,413	5,831,745	1,968,931	0	526,937	52,800
FSP Programs as Percent of Total	61.6%					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER NOTE: TRI-CITY DOES NOT HAVE A BEHAVIORAL HEALTH Date: APRIL 21,2014

	Fiscal Year 2016/17					
	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 EPSDT*	Estimated Other Funding
FSP Programs						
1. 1a-Child FSP	1,274,163	533,202	411,645		329,316	
2. 1b-TAY FSP	1,182,662	648,153	402,492		132,017	
3. 1c-Adult FSP	2,097,888	1,449,463	648,425			
4. 1d-Older Adult FSP	672,125	410,888	261,237			
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
Non-FSP Programs						
1. Community Navigators	442,659	442,659				
2. Wellness Center	1,096,200	1,096,200				
3. Supplemental Crisis Support Services	155,013	155,013				
4. Field Capable Services	177,862	177,862				
5. CSS Housing	124,603	71,803				52,800
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
CSS Administration (Includes MHSA Planning Costs)	1,260,501	874,889	304,200		81,412	
CSS MHSA Housing Program Assigned Funds	0					
Total CSS Program Estimated Expenditures	8,483,676	5,860,132	2,027,999	0	542,745	52,800
FSP Programs as Percent of Total	61.6%					

Prevention and Early Intervention Component Worksheet

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER

Date: APRIL 21,2014

	Fiscal Year 2014/15					
	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. Community Capacity Building	739,181	739,181				
2. NAMI Community Capacity Building Program	108,002	108,002				
3. Housing Stability Program	200,387	200,387				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Older Adult Wellbeing	69,915	69,915				
12. Transition-Aged Youth Wellbeing	67,138	67,138				
13. Family Wellbeing	95,686	95,686				
14. Therapeutic Community Gardening	239,287	239,287				
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	304,646	304,646				
PEI Assigned Funds	17,210	17,210				
Total PEI Program Estimated Expenditures	1,841,452	1,841,452	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER

Date: APRIL 21,2014

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
PEI Programs - Prevention						
1. Community Capacity Building	722,225	722,225				
2. NAMI Community Capacity Building Program	109,250	109,250				
3. Housing Stability Program	194,186	194,186				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Older Adult Wellbeing	69,948	69,948				
12. Transition-Aged Youth Wellbeing	68,962	68,962				
13. Family Wellbeing	98,168	98,168				
14. Therapeutic Community Gardening	239,743	239,743				
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	228,343	228,343				
PEI Assigned Funds	14,852	14,852				
Total PEI Program Estimated Expenditures	1,745,677	1,745,677	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER

Date: APRIL 21,2014

	Fiscal Year 2016/17					
	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. Community Capacity Building	732,249	732,249				
2. NAMI Community Capacity Building Program	109,893	109,893				
3. Housing Stability Program	196,726	196,726				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
PEI Programs - Early Intervention						
11. Older Adult Wellbeing	71,036	71,036				
12. Transition-Aged Youth Wellbeing	69,023	69,023				
13. Family Wellbeing	99,188	99,188				
14. Therapeutic Community Gardening	242,923	242,923				
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
PEI Administration	235,363	235,363				
PEI Assigned Funds	15,181	15,181				
Total PEI Program Estimated Expenditures	1,771,582	1,771,582	0	0	0	0

Innovation Component Worksheet

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER

Date: APRIL 21,2014

	Fiscal Year 2014/15					
	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. #01 Modifications to Cognitive Enhancement Therapy	194,794	177,581	17,213			
2. #02 Integrated Care (previously Integrated Services)	288,263	288,263				
3. #03 Cognitive Remediation Therapy Program	137,626	137,626				
4. #05 Employment Stability	203,092	203,092				
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	124,038	121,000	3,038			
Total INN Program Estimated Expenditures	947,813	927,562	20,251	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER Date: APRIL 21,2014

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. #03 Cognitive Remediation Therapy Program	392,690	332,528	60,162			
2.	0					
3. #05 Employment Stability	284,971	284,971				
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	92,625	92,625				
Total INN Program Estimated Expenditures	770,286	710,124	60,162	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER Date: APRIL 21,2014

	Fiscal Year 2016/17					
	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. #03 Cognitive Remediation Therapy Program	445,794	332,990	112,804			
2. #05 Employment Stability	289,771	289,771				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
INN Administration	93,414	93,414				
Total INN Program Estimated Expenditures	828,979	716,175	112,804	0	0	0

Workforce, Education and Training Component Worksheet

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER

Date: APRIL 21,2014

	Fiscal Year 2014/15					
	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. A Systemic Approach to Learning and Improvement	187,157	187,157				
2. Engaging Volunteers and Future Employees	50,099	50,099				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	40,963	40,963				
Total WET Program Estimated Expenditures	278,219	278,219	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER

Date: APRIL 21,2014

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. A Systemic Approach to Learning and Improvement	190,074	190,074				
2. Engaging Volunteers and Future Employees	51,188	51,188				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	39,924	39,924				
Total WET Program Estimated Expenditures	281,186	281,186	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER Date: APRIL 21,2014

	Fiscal Year 2016/17					
	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. A Systemic Approach to Learning and Improvement	108,937	108,937				
2. Engaging Volunteers and Future Employees	38,582	38,582				
3.	0					
4.	0					
5.	0					
6.	0					
7.	0					
8.	0					
9.	0					
10.	0					
11.	0					
12.	0					
13.	0					
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
WET Administration	31,908	31,908				
Total WET Program Estimated Expenditures	179,427	179,427	0	0	0	0

Capital Facilities and Technological Needs Component Worksheet

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER

Date: APRIL 21,2014

	Fiscal Year 2014/15					
	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. Improving Electronic Health Record and Systems Enhancement	270,038	270,038				
12. Consumer and Family Access to Computing Resources	48,500	48,500				
13. Program Monitoring and Service Outcome Support	162,726	162,726				
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	98,894	98,894				
Total CFTN Program Estimated Expenditures	580,158	580,158	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER

Date: APRIL 21,2014

	Fiscal Year 2015/16					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
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. Improving Electronic Health Record and Systems Enhancement	0	0				
12. Consumer and Family Access to Computing Resources	0	0				
13. Program Monitoring and Service Outcome Support	0	0				
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: TRI-CITY MENTAL HEALTH CENTER

Date: APRIL 21,2014

	Fiscal Year 2016/17					
	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. Improving Electronic Health Record and Systems Enhancement	0	0				
12. Consumer and Family Access to Computing Resources	0	0				
13. Program Monitoring and Service Outcome Support	0	0				
14.	0					
15.	0					
16.	0					
17.	0					
18.	0					
19.	0					
20.	0					
CFTN Administration	0	0				
Total CFTN Program Estimated Expenditures	0	0	0	0	0	0

Attachment A - Sign-In Sheets from Public Hearing

TRI·CITY Mental Health Services

Public Hearing for MHSA Three–Year Integrated Plan & New Innovation Plan
Palomares Park Community Center
499 E. Arrow Highway, Pomona, CA 91767
Thursday, May 22, 2014, 6:00 p.m. – 8:30 p.m.

Name	Affiliation / Agency	Phone Number	Email Address
Nancy E. Muñoz	Tri-City	909-622-8906	
Zonia Cruz	Tri-City	909542-9538	
Lisa Tran	TCMH	909 623 6131	LTRAN@TricityMHS.org
Luis Garcia	TCMH	909-784-3226	lgarcia@tricitymhs.org
Carol Riddell	Pomona Resident	(909) 837-0183	
Asela Calhoun	Phillips Graduate Institute	(626)-922-0016	amccouce@gmail.com
James R Spaeder	TRI City	909 868 7328	336 Phillips Blvd Apt B
DAVID. GONZALEZ	WELL-CENTER	909-394-1979	NONE
GUADALUPE GONZALEZ	" "	" "	ELLOPINO-@VERIZON.NET
MARY GONZALEZ	" "	" "	
Claudia Arenas	Tri-City	909-762-7192	Daphne1534@Yahoo.com
Elvira Arenas	Tri-City	208 4044047	1196 N Hamilton Blvd

TRI·CITY Mental Health Services

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Name	Affiliation / Agency	Phone Number	Email Address
ARTHUR MARTINEZ	TRI CITY	9099641098	
Gibran Carter	Tri City	9097843171	jcarter@tricitymhs.org
DonWhitney	Tri City	9097843192	DWHITNEY@TRICITYMHS.ORG
Dave Stein	Tricity	909 784-3132	dstein@tricitymhs.org
Robert Marchek	TRy city	(909) 2360884	2295 N. SAN ANTONIO AVE POMONA CALIF 91767
Jessica Bentello	Wellness Center	626 703-3222	jessicabentello@gmail.com
Kim Tso	Consultant	626-710-0707	kimtso@mac.com
Elizabeth Sadlon	consultant	818 6627043	sadlon@mindspring.com
HERIBERTOBEKNAL MARTINEZ	PARTICIPANT	(909) 629-6002	N/A
FELIPE ESPINOZA	TRI CITY	(909) 367-5361	FELIPEESPINOZA32@YAHOO.COM
Jim Holmes	TRi CITY	909-209-	NO PHONE
Rudy Reydeda	TRI CITY		NO

TRI·CITY Mental Health Services

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Name	Affiliation / Agency	Phone Number	Email Address
Remel Gibson	Tri City Member	909-525-5340	
Betsy MacLaren	Tri City mental Health	951-217-7913	
PERLA BORJA	" "	909-985-0166	
Dayetta Williams	" " " "	909 624 4229	
Betsey Coffman	" " " " LWV observer	909 626-1540	
Megansalkeor-Robertson	Tricity	(626)4865326	
Diana K. Robertson	tricity	626486[illegible]26	
Charlene Robertson		6264865326	
Edina Martinez	Governing Board	ON FILE	ON FILE
Barbara Aswad	Tri City	909 4256 7885	b.aswad@
ADNAN ASWAD	" "	" "	" "
Diana Acosta	Tri-City	(909)623-6131	

TRI·CITY Mental Health Services

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Name	Affiliation / Agency	Phone Number	Email Address
Chris Scafzo	Tri-City MHS	909.996.1244	cscafzo@tricitymhs.org
Arny Bloom	Tri City Com		arnybloom@mac.com
Sylvia Whitlock	Tri City Comm		
Michael Robertson	[illegible]	(626) 486-5526	michaelnasyolo[illegible]@gmail.com
Don Perez	TRI-CITY comm	909 625-9159	DPerez19@msn.com
Don Prkuyn	TRI-CITY MH	909 641-8797	Doanjoyce@VERIZON.NET
Kevin Armstrong	Tricity mhs	909/772-8127	
Carlon [illegible]		450-3739	Bo[illegible]oxuu717@hotmail.com
Charlotte Brown	tricity comm	(909) 680-5045	Silkbutterfly222@gmail.com
* SONNY ALINO	TRI CITY/WELLNESS	(909) 623-6131	
Luis Resendez	TCMHS	(909) 766-7302	lresendez@tricity
Yvonne Resendez	Community member		

TRI·CITY Mental Health Services

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Name	Affiliation / Agency	Phone Number	Email Address
Isela Moreno	Tri-city MH	888.436.3246	imoreno@tricitymhs.org
Jonathan Manzo	city Pomona	(909)802-8834	—
Richard Bunce	NAMI Pomona Valley	909-629-3337	dickbunce@verizon.net
[illegible]	Board Member	909 208.6602	rcarder@laverne.edu
MICA OLMOS	TCMHC	909 /984-3015	molmos@tricitymhs.org
Toshi Kuramatsu	TCMHS	909 623-6131	tkuramatsu@tricitymhs.org
Reggie CLARK	VOA	909 - 593.4796	rclark@voala.org
[illegible]			
Maria Castro	Tri city	(909) 398-4047	
Gamaliel Polanco	Tri City	909 242 7610	gpolanco@tricitymhs.org
Gail Remes	C.W.U.	909) 621-9286	gail@phoenixfinancial.biz
Jessica Arellano	TH-city	623-6131	

TRI·CITY Mental Health Services

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Name	Affiliation / Agency	Phone Number	Email Address
Chris Arzalow	Tri-City MHS	9)784-3237	CArzalow@tricitymhs.org
Socorro Bernal	tri city mental		
MARIA Bernal	tri city mental		
[illegible]	TCMHS		
JANIS MSeder	TRI-city	909-784-3024	jseder@tricitymhs.org
Darold Pieper	TCAHH	760-814-1401	dpieper@pieperlaw.com
ROY V. MANGLICMOT	~~382 W. A~~ TRI-CITY	909-865-03-68	382 W. ARTESIA POMONA
Heidi Bonadie	Tri-City	(909) 625-2383	ed@nami.pv.org
Karen m Rosenthal	COA. Claremont	909 626-2045	Karen.kmr@verizon.net
Elizabeth Owens	Tri-City	(909) 784-3022	eowens@tricitymhs.org
Debbie Johnso	Tri-city	909-784-3202	dgohnson@tricitymhs.org
Gooclind Gozen			

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Name	Affiliation / Agency	Phone Number	Email Address
Paul Caprario	Pomona Police	909 620-2122	
Silvia Zavala	Tri-City	909 461-0710	
Ofelia Valencia	Tri-City	626) 404-2068	
Jorge Valencia	Tri-City	626) 404-2068	
Danielle Zavala	Tri-City	909) 461-0710	
Altagracia Vargas	Tri-city	(909) 865 86 13	
Gail Range	Nami	909 263 1109	
Cynthia Angulo	Nami	909	
Stephen Mouton, Psy.D.	SGP Regional Center	909 868-7527	smouton@sgprc.org
Lora Illig	NAMI	909 625-2383	lmi@nami.org
Dawn Van Allen	The Garden	909 738 2435	dawnvanallen@gmail.com
Jude Ann Catayong	Tri City	909623 6131	jcatayong@tricity.org

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Name	Affiliation / Agency	Phone Number	Email Address
Steven Brenner	T.C.G.		
Cindy Arevalo	NAMI PV	630-6676	CNIA31@MSN.COM
Marie Francois	FAP	909-884-2722x223	elmod5@aol.com
Alfredo B. Larios	DMH	213 739-5755	alarios@dmh.lacounty.gov

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Name	Affiliation / Agency	Phone Number	Email Address
Carrie Kennedy	Tri-City MHC	909-762-024	ckennedy@tricitymhs.org.
Cheyenne Stephens	tri-city	—	—
Anne Henderson	PYFM P		
Ellen Taylor			
Vithni Dubois	Sowing Seeds	—	
Tina Brown	Pet	784 3023	tbrown@tricitymhs.org.
Mike			

TRI·CITY Mental Health Services

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Name	Affiliation / Agency	Phone Number	Email Address
Andrea Gordon	Probation	818 374 2001	
Cheryl Berenzy	TCMH	909 625-9159	cmb825@hotmail.com
Toni Lynn Watson	TC Mental Commission	(909) 730-2643	lynnkitty1@yahoo.com
Joe Lyons	City of Claremont TriCity Board		
Gloria Ingram	Resident City of Pomona		glowglo@verizon.net

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Name	Affiliation / Agency	Phone Number	Email Address
Sheila K~~Hughes~~	Tri City Commisson	9096703532	salint4@gmail.com
Monica Valencia	Tricity Delegate	(909) 784-9136	mvalencia@tricitymhs.org
Alex Alonzo	Community Member	(909) 636-6022	alonzo75@yahoo.com
Carolyn Cockrell	Board/Delegate	909 596-6001	carolyn.cockrell@gmail.com

Attachment B - Summary of Outreach and Participation in the Planning Process and Public Hearing

Roster of Participants
Reached Out to and Engaged in the Planning Process and Public Hearing

AAGIE
Americas Job Center
American Recovery Pomona
Angeles who Care
A Place of Comfort
Azusa Pacific University School of Nursing
Austin Kennedy Foundation
Beta Center Food
Brown Memorial Temple
Cambodian Buddhist Society of Pomona
Compassion in Action
Casa Colina Hospital Pomona
Catholic Charities Pomona
City of Claremont Youth Activity Center
City of Claremont, Senior Program
City of La Verne
Library
Pomona Library
City of Pomona Recreation and Community Services Division
City of Pomona Senior Services
Claremont Action For Progress
Claremont Unified School District
Congress Woman Grace Napolitano
Costanoan Rumssen Carmel Tribe Pomona
David and Margaret Home
Department of Children and Family Services L.A.
Department of Mental Health L.A.
Department of Social Services Pomona
Drake Manor
East San Gabriel Valley Coalition for the Homeless
East Valley Community Health Center Pomona
Family Resource Center Pomona
Fist Of Gold Youth Center, Inc So. Pomona
Foothill AIDS Project Pomona
Foothill Transit
Goodwill
Homes of promise
Havenly Homes
Helping Hand Caring Hearts. Pomona

House of Ruth Pomona
Inland Valley Hope Parners
Joslyn Center
Kennedy Austin
La Casita
La Verne City Hall
La Verne Parks and Recs.
La Verne Senior Center
La Verne Youth Action Family
Lincoln Avenue Community Church
Los Angeles Coalition to End Homelessness and Hunger
Los Angeles County Probation Department
Lucas and Hollingsworth Property
Management
Mercy House/Trinity House Pomona
Middlle Land Chan Monastery
Museum of Beginnings
New Life Church
National Alliance on Mental Illness Pomona
National Council on Alcoholism and Drug Dependence Pomona
Pacific Clinics Glendora
Palomares Park Seniors
Phillips Ranch
Pilgrim Place
Pomona Boys and Girls Club
Pomona City Hall
Pomona First Baptist Church
Pomona Homeless Continuum of Care Coalition
Pomona Homeless Outreach
Pomona Inland Valley Hope Partners
Pomona Nieghborhood Center
Pomona Unified School District
Pomona Valley Christian Center
Pomona Valley Hospital Medical Center
Pomona Youth and Family Master Plan
Project Sister Pomona
Project Sister Pomona
Prototypes Pomona
Renaciemento Center
Salvation Army
Service Area Advisory Committee III
Services Center for Independent Living Claremont
St Joseph Catholic Church
St Paul Episcopal Church Pomona

St Annes Transition Housing
Tri-City Consumers and Family members
Temple Bethel
Uncommon Good
United Methodist Church
Unity Church Pomona
Vietnamerican
Vietnamese community of Pomona Valley
Washington Park
Wellness Center
YMCA of Pomona Valley

Planning Process and Public Hearing Outreach by various demographics

Gender:

- Male: 579
- Female: 1,171

Ethnicity:

- Hispanic: 735
- White: 563
- African American: 297
- Asian Pacific Islander: 108
- Native American: 762*
- Other: 35

Age:

- Children, 0-15: 22
- Transition Aged Youth, 16-25: 214
- Adults, 26-59: 1-26
- Older Adults, 60+: 488

Total: 2,500

* The Costanoan Rumsen Tribe extended the invitation to participate by placing the notification in 750 packets that went out to members. We are not able to determine the gender nor age of the recipients.

Attachment C -Summary of Written and Oral Feedback from May 22, 2014 Public Hearing

Summary of Written Feedback
From May 22, 2014 Public Hearing on Annual Plan Update

Participants in the public hearing feedback forms

- Number of feedback forms from tables = 15
- Are hearing about the MHSA plans for the first time = 34
- Have gone to a few meetings about MHSA plans = 29
- Have been substantially involved in the MHSA planning efforts = 21
- (2 sheets were left unanswered for this question)

What we like about the proposed Annual Update

- Want more information in Spanish and more programs in Spanish for Spanish-speaking people
- Employment stability – what about consumers who don't disclose and how will consumers be encouraged to disclose?
- Liked all of the new Innovation programs
- Overlapping and working services together
- Housing is vital and key; need supportive housing in Pomona to be able to be stable
- Alliance for Building Communities will promote relationships and outreach for better relationships
- Employment stability model is huge especially in this economy
- Cognitive Remediation Therapy as step from Cognitive Enhancement Therapy
- Looking at data, looking at selves, looking at replicable aspects
- Like recreation (games, playing cards) at the Wellness Center, like having a place to go and have fun, like outings, new people there
- The focus on the system of care with multiple entry points
- The focus on innovative programs that can test new concepts and keep and grow those that are successful while terminating those that are not
- Liked innovative CRT program derived from the CET experiment
- Liked plan for persons dealing with their psychoses – helping with both thinking skills and disabling symptoms seems more enabling than one emphasis alone
- Helping both employers and employees, coming at problem from both sides
- Helping community leaders to interact with community members to access services
- That they provide a place for people to go
- Community navigators, peer to peer, wellness center
- Stakeholder review
- The research and data prove success
- The Alliance for Building Community is not a top down order – bridging community, "nobody trusts a stranger"
- Is CRT a better fit for the needs of the community

- Employment stability – like the teaching aspect as well as the outreach to the employers to hire.
- It is a good way to get involved in your community
- Community is involved in it
- Everyone comes together to help each other do better.
- I'm motivated for all the information that we received
- Presentations
- Assessments
- Strengthening and building involved with the community
- Use of community strengths and promoters
- The Therapeutic Gardening Center
- Wellness Center
- Employment Stability Program
- Homeless resources
- It works!
- Employment support is great
- Very pleased with programs
- CET evolution to CRT
- Employment facilitation
- Like employment very much
- Separate CRT by diagnoses
- Building on what we learned
- Community building – it can work
- Programs beneficial – especially homeless population
- Employment – makes sense to educate employers, builds well on landlords, might be harder, worth trying, can be better than firing and retraining
- Include churches and any established community leaders, schools, groups
- Building on success of programs in Latin America
- CRT, 6 months is much better than a year

Questions or concerns we have about the Annual Update

- The Wellness Center helped me and my children a lot. Thank you for always being there to help me.
- Which program will serve consumers who have Borderline Personality Disorder?
- Employment – physical or mental
- Do we ask the right questions?
- Is there a budget/funding for the new programs?
- How is liability addressed?
- All three innovations propose integration, more internal for those with psychoses, more external for employers and employees and community leaders with community members

- Keep up the good work and focus on areas that need support; low income, Koreans, Asian community
- Is there help for elderly, homeless people that are alone?
- It is a good plan for the communities
- How can I get involved to participate helping our communities?
- Would Tri-City consider non-traditional mental illness management?
- More people being served with CRT than CET
- Make sure psychiatrists, psychologists and primary care physicians in the surrounding area know about the Wellness Center
- Integration of the various plans in a way to minimize organizational "turf building" by establishing a coordination mechanism
- How to get people to take medications due mainly to stigma and self-stigma
- What is left of "communities?" We have neighborhoods but who do we go to for finding leaders?
- What communication program [unreadable], six programs stay connected and integrate and make sure they don't become turfs
- How can we have impact on older folks, what are the ages of peer providers?
- Does CRT separate consumers by diagnosis so like peers to progress similarly

Other comments we want to share

- I am very happy and grateful and blessed by God for all your help, and I hope you can keep doing this work and help more people because many people need it.
- Reviews of programs – excellent, workable format
- Integrate Alliance with Employment Stability
- Look forward to next year
- Like having a place to do homework and research for school
- How can I receive information for employment?
- Couldn't hear speakers in back half of the room
- Keep up the good work
- Prioritize the communities to be served and helped (such as schools, colleges, churches and worship communities)

Summary of Oral Feedback
From May 22, 2014 Public Hearing

What we like about the proposed Annual Update

- Glad to see that the employment component is getting attention
- Learning a lot through this process, very supportive
- Great innovations, especially CRT and outreach to decrease stigma
- Attention to cultural competency
- Like how CRT will combine the two treatments
- Grateful and pleased with Wellness Center, particularly the outings and recreational programs
- Like how the programs are all linked together so seamlessly
- Like how integrated the community is into the planning process

Questions or concerns we have about the Annual Update

- Remember to engage Chambers of Commerce and City Councils in the employment stability project
- Like to see more focused programs for Latinos
- Who has liability in employer project? (Explained and answered: No liability is incurred since Tri-City is not employing people through the project.)
- More Spanish-speaking programs
- Will there be a separation by diagnoses in CRT?

Attachment D – Summary of Recommendations for Program Improvement

Tri-City MHSA Integrated Plan
Phase One Workgroup Recommendations

During the Phase 1 workgroup deliberations, workgroup members were invited to make no- or low-cost recommendations about how to improve particular programs, as well as recommendations for general system improvements and/or potential Innovation project opportunities. What follows is a summary of the recommendations that emerged from the workgroups. The recommendations are divided into three categories: individual program recommendations; cross program or system improvement recommendations; and recommendations for potential Innovation projects.

Individual Program Recommendations

Community Services and Supports (CSS) Programs • Innovation Projects

1. Full Service Partnerships
   - Keep abreast of Affordable Care Act (ACA) implementation. Note: TCMHS provides Medi-Cal services through a contract with the Los Angeles County Department of Mental Health (LAC DMH). As more people qualify for health insurance plans through the ACA, Tri-City will need to collaborate with LAC DMH to coordinate enrollment and provision of services.

2. Modified Cognitive Enhancement Therapy
   - Reduce the cost and length of treatment while retaining aspects that work—e.g., cognitive enhancement tools and relational skill building in a group setting
   - Share with LAC DMH our lessons learned in resolving CET's billing issues
   - Continue to strengthen linkages for individuals leaving the program
   - **Potential innovation project**: Consider a new project that combines some of the vital and cost-effective aspects of CET—e.g., free cognitive enhancement tools, relational skill building in group settings—with Cognitive Behavioral Therapy for Psychosis (CBTfP). **Background**: Through the CET project we have developed and identified a number of highly effective interventions, including social supports, relational skills, and cognitive enhancement tools. At the same time, CET is very expensive – nearly equal to FSPs but without a match and not fully billable. Moreover, CET does not redress underlying symptoms of mental illness. CBTfP does redress symptoms of psychosis; moreover, about half of Tri-City clients exhibit symptoms of psychosis. A potential Innovation Project would explore how to more cost effectively combine the beneficial elements from the Modified CET program with an evidence-based practice that addresses symptoms like CBTfP.

3. Field Capable Clinical Services for Older Adults
    - Increase "flow," e.g. through defining a time limit for enrollment, increasing transition supports such as peer-to-peer counseling (including cross-generational), and managing warm hand-offs to Wellness Center and Therapeutic Community Gardening

4. Supplemental Crisis Services
    - Consider hiring a part-time staff with fluency in an Asian language – Cost: $20,000/year
    - Provide on-going training with LAC DMH to stakeholders—e.g., school districts, police, others—to help them better access and use crisis services
    - Assess satisfaction and effectiveness through Community Navigator's follow-up
    - Explore options for additional funding support—e.g., ACA funding for school-based health centers, Mental Wellness Act of 2013 funding, reimbursement from LAC DMH

5. Integrated Care Project
    - Strengthen the Integrated Care Project's community leadership and engagement—e.g., by offering leadership training for community leaders, adopting a Promotoras model, engaging stakeholders through the Wellbeing Summit
    - Continue the on-going structures and processes—e.g. meeting support, sharing of resources—that enable effective collaboration among the project partners
    - Invite school districts to participate in the project's Advisory Council

6. MHSA Housing (Permanent Supportive Housing)
    - Use Capital Facilities and Technology Needs (CFTN) funds to support electronic communication and tracking needed for effective community engagement around housing issues

7. Community Navigators
    - Expand the outreach capacity of Community Navigators

Prevention and Early Intervention (PEI) Programs

8. Therapeutic Community Gardening
    - Explore options to increase outreach and engagement—e.g., to other program participants, to faith-based communities

9. Peer-to-Peer Counseling

- Explore options for engaging younger ages (12-16 years old) as peers

10. Housing Stability
    - Explore opportunities for expanding the program (given its cost effectiveness)—e.g., consider shifting housing-dedicated funds, pursue private or foundation support
    - Recruit landlords as anti-stigma spokespeople

11. Mental Health First Aid
    - Continue to provide training materials to MHFA instructors who conduct three free trainings per year in the Tri-City area
    - Continue developing the data system to track: 1) MHFA trainers by city of residence, city of employment, organizational affiliation, and how they learned about the training; and 2) impact data

12. Community Wellbeing Program
    - Continue expanding outreach efforts to engage larger numbers of priority communities
    - Change the program from one-year to two-year grants

Cross-Program and/or System Improvement Recommendations

1. Outreach and engagement
    - Increase outreach and engagement efforts by Community Navigators to support FSPs , Field Capable Clinical Services, and other programs.
    - Increase outreach and engagement efforts across relevant programs targeting particular priority populations—e.g., older adults, unserved and under-served populations, including cultural groups, veterans, LGBTQ, law enforcement, others

2. Cross program integration • Referrals
    - Increase cross-program connections and referrals—e.g., between the Wellness Center and
    - Therapeutic Community Gardening
    - Track referrals to assess impact of outreach and cross-program referral efforts
    - Support staff to better integrate housing goals and support into work with people across the system of care
    - **Potential Innovation project**: Providing effective employment support for people in recovery by "going to where the jobs are—the employers." **Background**: Currently, Tri-City helps individuals prepare for, apply for, and obtain meaningful work through pre-volunteer, volunteer, and employment opportunities. This project will build on the effective engagement of landlords as a model to engage employers who provide

jobs to individuals with mental illnesses. This learning project could build upon but significantly modify the evidence-based practice - Supported Employment model - endorsed by Substance Abuse and Mental Health Services Administration (SAMSHA): http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365.

3. Strengthening transitions to lower levels of care—aka "flow"
    - **Potential Innovation project**: Explore strategies to increase "flow" of participants from high intensity programs—e.g., FSPs, CET, Field Capable Clinical Services for Older Adults (FCCS)—into programs with less intensive levels of professional care. **Background**: Flow is essential for at least two reasons. First, every intensive treatment program strives to help people receiving services achieve the greatest level of independence possible, consistent with their ongoing recovery and wellbeing. Second, intensive treatment programs are the most expensive of all mental health services. Supporting people to transition to less intensive levels of professional care—consistent with their wellbeing—helps ensure we are maximizing the availability and impact of these scarce resources.
    - Train Therapeutic Community gardeners to become peer counselors to help with transitions and expansion
    - Explore how peer support can be used to expand other TCMHS programs and support flow from high intensity to less intensive services and supports

4. Leadership development
    - **Potential Innovation project**: "Next level" leadership development process. **Background**: Create "next-level" leadership development support for people receiving services, volunteers, community leaders and staff to extend the reach of current programs—e.g., TCG, Wellness Center, P2P, Housing Stability, CWB grantees, Interfaith Collaborative.

5. Community engagement • Anti-stigma work
    - Explore opportunities to integrate anti-stigma work into every TCMHS program
    - Explore how to create a broad-based effort to combat stigma and promote support for people with mental illness and their families that coordinates existing efforts and engages key decision makers and community leaders—e.g., school boards, business leaders, Neighborhood Watch captains, etc.
    - Develop Wellbeing Summit as opportunity to deepen engagement with community partners—e.g., Integrated Care Project partners
    - **Potential Innovation project**: Map existing program investments and community partner efforts to identify potential "hot spots" for anti-stigma and/or community building work. **Background**: TCMHS programs now engage people in myriad areas across the three cities. At the same time, we have not engaged a number of

institutional partners—e.g., schools and businesses—as well as we want to. Building on a community building process called “power mapping,” we can map the coverage and relationships of multiple TCMHS programs—e.g., MHFA, Community Wellbeing program, Integrated Care project, Stigma Reduction—to develop a beginning analysis of how we might leverage this work to connect with local schools and other institutions.