

### MHSA Program Component INNOVATION

- Completely New Program**
- Revised Previously Approved Program**

**Program Number/Name:**

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

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

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

Glenn County has had several school threat situations in each of the past three years. In addition, there is a high incidence of suicidal ideation amongst children and youth, and a high incidence of bullying in our schools. When these significant events occur, the school staff feel helpless and do not have a specific plan of action to resolve the threat or manage the behavior.

We have held an extensive planning process in preparation for our MHSA 3-Year Plan and new Innovation Plan. Stakeholders were involved throughout the planning stages, development of the Innovation Plan, and will be involved in evaluation process. Stakeholders included youth, adults, older adults, veterans, persons in the AOD recovery community, family members of persons in the AOD community, and persons with lived experience and their family members.

Our services are youth and family driven and focus on wellness, recovery, and resilience. Over the past 10 years, we have collected indicators of wellness, recovery, and resilience for children, youth, families, adults and older adults through our Risk Resiliency Tool. This data has provided us with important information on identifying key risk factors and measuring the development of resiliency skills through treatment. Youth and families were involved in the development of these tools, the individual wellness reports produced, and evaluation activities. Similarly, youth and families are involved in the development of the Innovation Planning, evaluation, and lessons learned.

An MHSA stakeholder survey was also collected during our three-year planning process. The results of this survey this year found that youth, families, and adults reported that suicidal behavioral and school safety, including threats and bullying, were important issues to address in our MHSA Plan. During TAY stakeholder focus group, youth reported that school threats, suicidal ideation, and bullying were significant issues in the schools and that the schools did not respond to these incidents. Participants in the adult stakeholder focus group reported that they were bullied as children, and some reported that they became bullies in response to the bullying behavior. They reported that suicidal behavioral and bullying in our schools was a serious issue.

Currently, when an incident occurs at a local school, the school staff may call police, the mental health crisis line, or probation, depending upon the situation or the person's familiarity with one of the agencies. There is no standard protocol for collaboration, who to call and when to call. As a result, multiple agencies may respond to a situation. There is also no protocol for following up with the youth to ensure that the incident is resolved or that the youth is linked to services. There is no coordinated approach to ensure that the situation is not repeated.

Our new Innovation project adapts an existing evidence-based practice utilized by Los Angeles County and others to meet the needs our small, rural county, and evaluate whether this modification obtains desired outcomes. The Innovation project will focus on developing a collaborative process and team to respond systematically to these critical incidents, including school threats, suicidal behavior, and/or bullying. There are models that have been effective in Los Angeles and other large cities, but these models need to be modified to meet the needs of a small rural community. In this county, there are only a few staff at each agency who perform several different functions. We have limited resources and long distances a between towns with very limited public transportation. As a result, the small number of staff at our partner agencies creates a need to expand collaboration across the agencies. For example, different people may participate for any give incident, depending on who is working that day, or that shift. In the LA model, there is a dedicated team of individuals who only respond to incidents – that is their full-time job! Our modification of this LA model evaluates the result of expanding the team and collaborative efforts to respond in a timely, consistent manner to incidents.

Our Innovation project will identify 1-2 staff from each of the following agencies: mental health, probation, law enforcement, and the schools, to be the key members of the team. These individuals will collaborate together to respond quickly, efficiently, and consistently to crisis and critical event situations. This collaborative team will be called a System-wide Mental Health Assessment Response Treatment (SMART) Team. The SMART Team will respond to situations across the county and will conduct a comprehensive mental health and crisis evaluation to determine what is most effective in each situation, with protocols developed to help respond and evaluate the outcome of each situation. However, to ensure an effective collaborative process, enhanced collaboration will be support, so any persons responding to the incident will effectively implement the response protocol.

In an effort to further improve outcomes for the children and youth involved in these incidents, the SMART Team will also follow-up with each student, classroom, teacher, and/or family member, to deliver brief therapy and assess the need for additional follow-up services. When a student needs ongoing treatment, the SMART Team will link the individual to ongoing mental health, co-occurring treatment, or probation services to follow-up periodically to ensure the incident is fully resolved.

The SMART Team offers a change in the response to crisis situations in the schools. The SMART Team will offer a collaborative team of staff from relevant agencies to train, screen, intervene, and provide case management and monitoring to identify and manage any potential threats to our schools and/or community. In addition, the SMART Team will provide

community-wide crisis response, clinical case management, and follow-up services. This comprehensive team will also utilize evidence-based practices to offer suicide assessment and prevention, train school staff on bullying prevention, and provide the clinical services needed to address any identified issues.

The barriers to implementing this collaborative team in the past has been a shortage of staff, especially for probation and law enforcement; high caseloads; and limited time to develop the collaboration and protocols needed to systematically respond to critical incidents. These Innovation dollars will help fund the capacity to plan, design, create, implement this new collaboration and evaluate the effectiveness of the shared collaboration. While this program creates a more complex process, it is essential to make this change from existing models (that have designated staff) to ensure success in this rural community. Ongoing data will help us to determine the effectiveness of the collaboration, as well as modify the design to continually enhance program effectiveness.

Collaboration across agencies is difficult to measure and may fluctuate, depending upon management, funding resources, key events, and individual incidents. With this understanding, we will measure collaboration across our agencies using a tool used by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) and the University of South Florida to evaluate collaboration in Children’s System of Care agencies and other federal grant projects. This Interagency Collaboration Activities Scale (IACAS) will be distributed to partner agency staff at the beginning of the project and annually. This survey asks the question: “To what extent does your organization SHARE with other child serving agencies?” A number of variables are measured, including funding, services, facility space, data, program evaluation, and staff training.

By measuring perception of these collaborative activities over time, we will be able to evaluate the success of our project. Through the project, we will improve how our collaborative agencies share funding, space, data, evaluation, training, participation on committees, case reviews, and formal written agreements.

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

This Innovation Project will make a change to the evidence-based practice model by developing a collaborative response team to specifically address school and community crises, for this small rural community. The SMART Team will be available throughout the county to address many of the key issues identified on our MHSA surveys and in our focus groups. The SMART Team will respond to all community crisis situations; conduct school threat assessments; identify situations of bullying; and provide follow-up treatment, brief therapy, and case management services, as needed. If an individual and/or family needs ongoing treatment, they will be linked to relevant services and/or behavioral health services through a warm handoff, when appropriate.

The learning goal of this project is to assess the effectiveness of this collaborative team approach, using limited resources. We will adopt a proven model of response to use in the schools, to address school threats and bullying incidents. We will evaluate the effectiveness of this enhanced collaboration, to determine the effectiveness when agency staff may differ, with each crisis situation, depending upon the time of day, or shift. The expected learning outcomes will be to understand the collaborative process, training needs of all team members, and success in resolving crisis situations, school threats, bullying, suicide prevention, and treatment strategies. SMART Team members will be available to triage each situation, provide the needed services, and link the individual and/or family to ongoing supportive services, as needed.

We will utilize mental health staff, Youth Peer Mentors, law enforcement, probation, and school staff to create the collaborative team that promotes a safe environment for schools and our communities. An active evaluation process will assess the collaboration between team members and the schools, and the timeliness of response and resolution of the incident.

The collaboration between team members will be measured by using the IACAS to survey partner agency staff at the beginning of the project and annually. By asking agency staff to describe how their organization shares different indicators with other child serving agencies, we will have information from both managers and staff on a number of variables including funding, purchasing of services, facility space, data, program evaluation, and staff training.

By measuring perception of these collaborative activities over time, we will be able to evaluate the success of our project. Through the project, we will improve how our collaborative agencies share funding, space, data, evaluation, training, participation on committees, case reviews, and formal written agreements.

We will also evaluate individual outcomes for youth and family, to assess the effectiveness of ongoing follow-up, treatment, and recidivism. Each individual and/or family who needs ongoing follow-up services will be enrolled in our evaluation activities. These activities will provide the needed information to track individual outcomes over time to assess the effectiveness of the program.

On a system level, we will evaluate the effectiveness of the Glenn rural collaborative model, using more people with few resources, and determine what works, and how our learning can be applied to other small county programs.

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

The SMART Team model of collaboration and timely response to critical incidents support and is consistent with the MHSA General standards. We will develop, measure, and test an approach to small county collaboration that works in a rural county, adopting a proven model to use in the schools to address school threats and bullying incidents. This community collaboration will strengthen our multi-agency partnerships, develop opportunities to share funding, service planning, evaluation, and celebrate positive outcomes.

Our services will be culturally-competent and available in English and Spanish. As we work closely with the schools to reduce school threats and bullying, we will also offer supportive services to high-risk youth and their families. If the family is monolingual Spanish, we will have bilingual, bicultural clinicians available to offer services in their primary language.

We will continue our long tradition of client- and family-driven services, as evidenced by having paid Peer Youth Mentors on our SMART Team. The Peer Mentors help support high-risk youth to develop resiliency skills and support them to have a voice in developing client-driven treatment and services. In addition, we will utilize staff to support families to be active participants in their services and enhance resiliency skills for both the youth and the family, while reducing risk factors.

We have a strong history of delivering mental health services that focus on wellness, recovery, and resilience. Our Harmony House Wellness Center was developed with MHSA CSS funding and modeled after our Transition Age Youth Center, which was started in 2005. Both centers support recovery and wellness and have paid and volunteer Coach and Peer Mentor positions working actively with individuals. The SMART Team will help promote collaboration and integrated services in the schools and with allied agencies.

We utilize a Risk/Resiliency Tool which measures key risk factors and resiliency factors for children, youth, and families. We utilize this tool at admission and every six (6) months. Progress on developing resiliency factors is shared with youth, families, and staff through an Individual Wellness Report. This information helps to guide services to develop resiliency skills over time.

We initiated the development of the SMART Team to develop and test an enhanced collaboration across multiple agencies in our community to systematically respond to crisis and critical mental health events in the schools, and promote and create safe environments to meet the needs of unserved and underserved individuals in our community. The enhanced collaboration with our primary allied agencies will offer a full range of services and develop a comprehensive prevention, intervention, and evaluation program to reduce depression, suicide, bullying, and school threat situations. The evaluation activities will test the effectiveness of this collaboration using the modified SMART Team approach to resolve school threats and reduce the impact of suicide, violence, and bullying on our schools and communities.

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

We anticipate that we will serve 25 Children (ages 5-15) and 20 Transition Age Youth (ages 16-25). It is expected that we will serve approximately 25% Hispanic, 70% Caucasian, and 5% other race/ethnicity groups. Approximately 50% will be females. The majority of youth will speak English. We anticipate that approximately 5% of the individuals or family members utilizing the SMART Team will identify Spanish as their primary language.

*3. Describe the total timeframe of the program. In your description include key actions and milestones related to assessing your Innovation and communicating results and lessons learned. Provide a brief explanation of why this timeline will allow sufficient time for the desired learning to occur and to demonstrate the feasibility of replicating the Innovation.*

We will develop, implement, and evaluate the effectiveness of the modified SMART Team's collaboration across the three-year time period. This period will allow ample time to hire and train staff; develop and test standard tools for threat assessments and timely response to crisis and critical events; and develop and test protocols for responding to the bullying behavior. We anticipate that we will start to implement components of this program within the first three months of funding; however, full implementation and collaboration of services will occur by the end of the first year. This strategy will allow two additional years to fully implement and study the effectiveness of this approach and share our learnings with other counties.

Evaluation activities will be developed in the first three months, and collected and analyzed monthly. Evaluation outcomes and lessons learned will be shared with the SMART Team and at the Behavioral Health System Improvement Committee, MHSA Committee, and the Management and Planning Team monthly meetings. In addition, we will share our experience of collaboration in a rural county, so other counties will be able to implement similar strategies, within their limited resources.

After the three-year timeframe, the success of the project will be determined through the evaluation activities and stakeholder input. If deemed successful, the project will be transitioned it to another category of MHSA funding, such as PEI.

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

We will collect data on both client level outcomes and measure the effectiveness of the Innovation Project and sources of collaboration. Client level outcomes will include the number of children and TAY referred; number served; number of crisis response situations and school threat assessments; outcomes of each critical incident; and ongoing need for follow-up services. The number of individuals receiving ongoing case management and numbers referred for ongoing services will be measured. In addition, key events such as the number of suicide attempts, school threats, referrals for bullying, and crisis response situations will be measured. Program effectiveness will measure the collaboration activities of the allied agencies prior to development of the SMART Team, and ongoing collaborative activities as the SMART Team is implemented.

The collaboration between team members will be measured by using the IACAS to survey partner agency staff at the beginning of the project and annually. By asking agency staff to describe how their organization shares different indicators with other child serving agencies, we will have information from both managers and staff on a number of variables including funding, purchasing of services, facility space, data, program evaluation, and staff training.

By measuring perception of these collaborative activities over time, we will be able to evaluate the success of our project. Through the project, we will improve how our collaborative agencies share funding, space, data, evaluation, training, participation on committees, case reviews, and formal written agreements.

Our evaluation activities will be developed and implemented with guidance from our System Improvement Committee and oversight by the Glenn County Mental Health, Alcohol and Drug Commission. Outcomes and lessons learned will be shared with the SMART Team and at the Behavioral Health System Improvement Committee, MHSA Committee, the Management and Planning (MAP) Team monthly meetings, and at regional and/or statewide meetings that involve other small, rural counties.

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

In addition to MHSA funding, we will utilize Medi-Cal revenue, whenever possible, to support the SMART Team, as well as funding ongoing mental health treatment services delivered to youth and family members identified through the SMART Team activities.

6. Please provide projected expenditures by each fiscal year during the program time frame, including both the current and future funding years. Please also describe briefly the logic for this budget: how your proposed expenditures will allow you to test your model and meet your learning and communication goals.

Project: SMART Team

Estimated Project Costs (Total per Year):

- Year 1: \$341,964
- Year 2: \$234,624
- Year 3: \$239,756

This Innovation Project utilizes a proven model to develop a comprehensive, innovative, mentoring program to address the need for a threat prevention and management program in our county. The SMART Team will respond to all community crisis situations, conduct school threat assessments, identify situations of bullying, and provide follow-up treatment, brief therapy, and case management services, as needed. If an individual and/or family needs ongoing treatment, they will be linked to appropriate services and/or behavioral health services through a warm handoff, when appropriate. Extensive evaluation activities will provide an assessment of project effectiveness and client-level outcomes achieved as a result; outcomes and lessons learned will be shared through established staff and stakeholder meetings. Expenditures will support this model; ensure that we are able to fully implement the project; and allow us to conduct supervision, evaluation, reporting, and dissemination activities.

After the three-year timeframe, the success of the project will be determined through the evaluation activities and stakeholder input. If deemed successful, the project will be transitioned to another category of MHSA funding, such as PEI.

A detailed budget for the Innovation Project (Years 1 – 3) is included below.

<b>INNOVATION PROJECT – YEAR 1 NEW ANNUAL PROGRAM BUDGET</b>					
<b>A. EXPENDITURES</b>					
	<b>Type of Expenditure</b>	<b>County Mental Health Department</b>	<b>Other Governmental Agencies</b>	<b>Community Mental Health Contract Providers/CBO's</b>	<b>Total</b>
1.	Personnel	249,855			249,855
2.	Operating Expenditures	51,729			51,729
3.	Non-recurring Expenditures	0			0
4.	Contracts (Training, Consultant, Contracts)	4,098			4,098
5.	Evaluation	20,000			20,000
6.	Work Plan Management	0			0
7.	Other Expenditures (Admin)	16,282			16,282
	<b>Operating Reserve</b>	<b>0</b>			<b>0</b>
	<b>Total Proposed Expenditures</b>	<b>341,964</b>			<b>341,964</b>
<b>B. REVENUES</b>					
1.	New Revenues				
	a. Medi-Cal (FFP only)	137,135			137,135
	b. State General Funds	0			0
	c. Other Revenues	298			298
	<b>Total Revenues</b>	<b>137,433</b>			<b>137,433</b>
<b>C. TOTAL MHSA FUNDING REQUESTED</b>		<b>204,531</b>			<b>204,531</b>

<b>INNOVATION PROJECT – YEAR 2 NEW ANNUAL PROGRAM BUDGET</b>					
<b>A. EXPENDITURES</b>					
	<b>Type of Expenditure</b>	<b>County Mental Health Department</b>	<b>Other Governmental Agencies</b>	<b>Community Mental Health Contract Providers/CBO's</b>	<b>Total</b>
1.	Personnel	171,276			171,276
2.	Operating Expenditures	35,194			35,194
3.	Non-recurring Expenditures				
4.	Contracts (Training, Consultant, Contracts)	2,346			2,346
5.	Evaluation	11,731			11,731
6.	Work Plan Management				
7.	Other Expenditures (Admin)	14,077			14,077
	<b>Operating Reserve</b>				
	<b>Total Proposed Expenditures</b>	<b>234,624</b>			<b>234,624</b>
<b>B. REVENUES</b>					
1.	New Revenues				
	a. Medi-Cal (FFP only)	117,312			117,312
	b. State General Funds				
	c. Other Revenues				
	<b>Total Revenues</b>	<b>117,312</b>			<b>117,312</b>
<b>C. TOTAL MHSA FUNDING REQUESTED</b>		<b>117,312</b>			<b>117,312</b>

<b>INNOVATION PROJECT – YEAR 3 NEW ANNUAL PROGRAM BUDGET</b>					
<b>A. EXPENDITURES</b>					
	<b>Type of Expenditure</b>	<b>County Mental Health Department</b>	<b>Other Governmental Agencies</b>	<b>Community Mental Health Contract Providers/CBO's</b>	<b>Total</b>
1.	Personnel	175,022			175,022
2.	Operating Expenditures	35,963			35,963
3.	Non-recurring Expenditures				
4.	Contracts (Training, Consultant, Contracts)	2,398			2,398
5.	Evaluation	11,988			11,988
6.	Work Plan Management				
7.	Other Expenditures (Admin)	14,385			14,385
	<b>Operating Reserve</b>				
	<b>Total Proposed Expenditures</b>	<b>239,756</b>			<b>239,756</b>
<b>B. REVENUES</b>					
1.	New Revenues				
	a. Medi-Cal (FFP only)	119,878			119,878
	b. State General Funds				
	c. Other Revenues				
	<b>Total Revenues</b>	<b>119,878</b>			<b>119,878</b>
<b>C. TOTAL MHSA FUNDING REQUESTED</b>		<b>119,878</b>			<b>119,878</b>

**D. BUDGET NARRATIVE – INNOVATION PROJECT**

**A. Expenditures**

1. **Personnel** – This line item includes salaries and benefits for the following positions: a) 0.10 FTE Coordinator; b) 1.0 FTE Mental Health Case Manager; c) 1.0 FTE Sr. Mental Health Counselor; d) 0.5 FTE Adult Coach; e) 1.0 FTE Peer Mentor; and 0.25 FTE Sheriff. Expenditures in this category are based on current County Personnel Salary tables.
2. **Operating Expenditures** – This line item includes facility costs, such as rent, and other operating expenses including communications, office supplies, utilities, IT, and janitorial costs. Expenses also include ongoing client supports, medications, food, housing, etc. In addition, dissemination of lessons learned to other counties and interested stakeholders is included. Expenditures are based on historical costs.
3. **Non-recurring Expenditures** – No expenditures are included in this category.
4. **Contracts (Training, Consultant, Other Contracts)** – This line item includes the project’s portion of general mental health contracts.
5. **Evaluation** – This line items covers project evaluation, which will provide an assessment of project effectiveness and client-level outcomes achieved as a result.
6. **Work Plan Management** – No expenditures are included in this category.
7. **Other Expenditures** – This line item includes administration costs associated with the project.

**B. Revenues**

1. **New Revenues** – Revenue is estimated from Medi-Cal and other funding sources.