Amador County Behavioral Health Department

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Mental Health Service Act

Innovation Component
Three-Year Program & Expenditure Plan
Fiscal years 2006-07, 2007-08, 2008-09

Posting Date: October 14, 2010

Public Hearing: November 17, 2010

Amador County Office of Health & Human Services
10877 Conductor Blvd.
Conference Rooms C & D
Sutter Creek, CA 95685

ACKNOWLEDGEMENTS

Amador County Behavioral Health Department wishes to thank the many consumers and their family members who gave their time and energy to this process. Their words of wisdom and stories of optimism, wellness, resiliency and recovery have shaped every component of this plan.

In addition, the Department wishes to recognize the contributions of the members of the MHSA Steering Committee and representatives of partner agencies and community based organizations who helped guide the development of the planning process and the creation of this plan.

Prepared by Resource Development Associates

Project Team:

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EXHIBIT A

INNOVATION WORKPLAN
COUNTY CERTIFICATION

County Name:	Amador

County Mental Health Director	Project Lead
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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 regulations, 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/Designee) Date Title

EXHIBIT B

INNOVATION WORK PLAN
Description of Community Program Planning and Local Review Processes

County Name: Amador Work Plan Name: MHSA Innovation Plan/ Community-Driven Delivery of Self-Management Practices

Instructions: Utilizing the following format please provide a brief description of the Community Program Planning and Local Review Processes that were conducted as 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)

Overview of the Planning Process

In June of 2009, Amador County Behavioral Health Department (ACBH) embarked on a planning process for four separate components of MHSA including Workforce Education and Training (WET), Prevention and Early Intervention (PEI), Capitol Facilities and Technological Needs (CFT), and Innovation. The planning team, comprised of George Sonsel, former Director of Behavioral Health, Lynn Thomas the MHSA Coordinator, and Resource Development Associates, a consulting firm with established Mental Health planning expertise, utilized a participatory framework to encourage community buy-in, while leveraging information and resources across all four MHSA components. Planning for multiple components of MHSA allowed for a deeper, more comprehensive understanding of community workforce needs and training deficits, and the development of a more refined community vision for behavioral health systems change.

Key elements of the Innovation Community Planning Process have included:

- Convening a diverse MHSA Steering Committee
- Conducting outreach for focus groups and community meetings at Family Resource Centers, Senior Centers, Wellness Centers, ESL (Spanish-speaking) classes, homeless services, public schools and preschools.
- Conducting community education on each component, including the unique features of the Innovation Component
- Conducting discovery phase: community assessment of needs and assets through Key Informant Interviews, focus groups and community meetings with special emphasis placed on contacting representatives of underserved rural residents, Latinos and non-English speakers, Jackson and Ione Miwok tribal representatives, seniors, transitional age youth (particularly youth aging out of foster care), and LGBTQQ advocates.
- Development of Innovation Strategies in small group roundtables with representatives from the Behavioral Health Department, consumers and family members
- Prioritization of Innovation Strategies through a community-wide meeting
- Approval of Innovation Strategies by the MHSA Steering Committee
- Development and Public Review of Innovation Component Plan

Oversight and Review: Stakeholder Steering Committee

Amador County's MHSA Steering Committee members represent a broad range of stakeholder groups including mental health and public health providers, child care, schools and child protective services, court and probation, consumers of mental health services and their families. Three MHSA Steering Committee meetings gave participants the opportunity to provide guidance, review draft plans, and ensure alignment with workforce needs and MHSA goals. All Stakeholder Steering Committee meetings were open to the public.

Stakeholder Participation Totals

Almost 370 community members participated in the Innovation planning process. The table to the right illustrates the diversity of participants' gender, ethnicity and age. Information in the table reflects only those who chose to share information collected on sign-in sheets and demographic forms. Demographic forms were distributed at all events and reviewed continuously to help guide the planning effort.

Total Innovation Participation Based on total meeting sign-ins
366 sign-ins; 321 demographic forms submitted
49 consumers of mental health services
63 family members of consumers
47 consumers and family members
7 transitional age youth (18-25 years)
91 older adults (60+)
232 female, 85 male and 4N/A
272 Caucasian/White, 10 Hispanic/Latino, 2 other Asian, 10 Native American, 23 mixed-race/other, 4 N/A

For a more detailed description of the Community Planning Process, please see Amador County's Workforce Education and Training Plan. Note, while planning activities for PEI, WET, CFTN and INN occurred simultaneously, stakeholders received specific instruction on each component. For example, please see the attached PPTs that were delivered to over 100 community members at project kickoff, 60 stakeholders at the community prioritization meeting, and to stakeholders at the final public hearing.

Public Comment, Draft Review and Public Hearing

A draft of the Innovation Plan was posted on the County MHSA website on October 14th, 2010. Emails announcing the posting were sent to the County MHSA Stakeholder list (270 individuals) and paper-based copies were posted in the Behavioral Health lobby, County Administration, Sierra Winds Wellness Center, County Public Library and Family Resource Centers. On November 17, 2010, Amador County Mental Health Advisory Board hosted a public hearing on the proposed Innovation Plan. Twelve individuals attended the meeting, including 5 Mental Health Board members. Following a PowerPoint presentation on the plan, and public comment, the Board voted unanimously (5 in favor, 0 opposed) to submit the plan to the Amador County Board of Supervisors for approval. The following were substantive comments about the proposed plan:

Question: *How will we know if the wellness trainers are delivering services with fidelity to the selected self-management models?* Response: The proposal includes the hiring of a coordinator and oversight by a community-based steering committee as well as an external evaluator. The evaluator, with support from the coordinator and steering committee, will develop a practice checklist for use by the wellness trainer. The checklist will detail the practice components and techniques and will be completed by the wellness trainer at the end of each session in order to monitor implementation and adherence to common practices. Results will be reviewed for consistency of reporting and adherence.

Comment: *I think it is important to establish strong partnerships with the faith community for this project.*

Many in this community have become increasingly committed to supporting the target population. Response: Yes, absolutely. We will want to have faith leaders on the Steering Committee. They will be instrumental in identifying wellness trainers as well as parishioners who could benefit from the techniques. Also, many of the techniques described in this plan are adaptions from traditional prayer practices, such as reciting the rosary, meditation, etc. The connection between spirituality and mental health is a vital for many community members, and this project will seek to develop the relationship between the Behavioral Health Department and faith leaders--as well as between the Department and other community leaders.

Question: *Will this project go out to bid? Will there be an RFP?* Response: No, this will be an internal position for two reasons: 1) departmental oversight and 2) our hope is that this project will help bridge relationships between community based organizations and the Department.

EXHIBIT C

Innovation Work Plan Narrative Date: 01/12/2010

County: AMADOR
Work Plan #: INN-01
Work Plan Name: Community-Driven Delivery of Self-Management Practices

Purpose of Proposed Innovation Project (check all that apply)

X **INCREASE ACCESS TO UNDERSERVED GROUPS**
INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
PROMOTE INTERAGENCY COLLABORATION
INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

Amador County is predominantly rural in nature, which imposes limitations on mental health service delivery. Throughout the MHSA planning process, Amador County stakeholders referred to the many challenges faced by residents from the most geographically isolated areas of the county who live with untreated traumatic stress and related difficulties (e.g., anger, depression, dysregulated affect, substance use disorders). Posttraumatic stress and other forms of anxiety are prevalent among multiple populations in the county, including emergency responders, returning veterans, and survivors of abuse. Additionally, heavy reliance on volunteer fire departments has resulted in a number of community members who experience trauma as a part of their volunteer services. Because many of these residents do not meet medical necessity, they are restricted from accessing public mental health services. Due to limited income, many are also unable to access private-pay providers. For those who meet medical necessity, geographically isolation, lack of comprehensive public transportation, stigma, and deep-rooted mistrust of publically funded mental health services act as considerable barriers. On the provider-side, difficulties with successful recruitment and retention of mental health professionals translates to a limited number of qualified, culturally-competent clinicians. This means few private-pay providers available for those who can afford the service, and even fewer qualified clinicians able to meet the growing needs of the public health sector. Amador County therefore faces both barriers related to access and capacity.

However, the rural nature of the County also provides for unique community resources that can be engaged in the promotion and delivery of alternative treatments in community-based settings. As a result of the planning process, a base of community members emerged who expressed commitment to providing peer-led self-management interventions to those suffering from posttraumatic stress disorder (PTSD) and related psychological distress. Amador County therefore proposes to design and implement a four-year community-driven Self-Management Program, in which volunteer wellness trainers provide self-management services to consumers throughout the county in existing community-based settings, with coordination and support from Amador County Behavioral Health (ACBH). Unlike existing community health worker programs that are primarily staffed by paid workers and serve an educational and service connection function in the field of physical health, the Self-Management Program will be distinct in that it will be staffed by volunteers trained in specific mental health-related practices who will deliver the services directly to the consumer in community-based settings; it will be an effort driven by the community and coordinated by the county behavioral health system; and it will include volunteers representing diverse educational and occupational backgrounds. While each component described above may have been incorporated in some community health worker programs, taken together, the model is an innovation and a

direct response to community needs and assets. The Innovation Project aims to determine if such a model can increase access to services, particularly for those who are currently underserved by the existing network.

EXHIBIT C

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create 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.

This proposed Innovation will examine how an organized network of volunteer wellness trainers, county-based coordination and support, engaged consumers and family members, and a set of promising self-management techniques can combine to create a robust model for community-driven mental health service provision. While the techniques themselves may have an established evidence-base, the method of implementation represents an innovation in service delivery that capitalizes on existing community expertise and resources. It is believed that the model, which is an adaptation of existing community health worker programs, will have the potential for empowering consumers and family members and expanding access to services across the county's broad geography.

Self-Management Practices

Self-management strategies are varied and may include: writing down or talking about problems; contacting or visiting with friends; exercising; praying/meditating; creative endeavors; practicing good nutrition; and engaging in self-advocacy (Rogers & Rogers, 2004). In the research literature, self-management is most often used to refer to three types of activities: 1) self-directed readings (e.g., self-help books, online resources); 2) groups (e.g., Alcoholics Anonymous); and 3) alternative or complimentary therapies. All emphasize the role of consumers as the central determinants of their own health and wellbeing, and aim to increase confidence so that individuals can more effectively cope with chronic conditions (Holman & Lorig, 2004). The emphasis on self-efficacy, which is reinforced through the use of peer networks, has made it a pillar of the consumer and peer movements (Sterling, von Esenwein, Tucker, Fricks, & Druss, 2010; Velente, Okamoto, Pumpaung, Okamoto, & Sussman, 2007). While most often used in the management of chronic physical health issues (von Korff et al., 1998), self-management practices have more recently been imported to the mental health field where they have been used to treat anxiety, depression, and eating disorders (Scheider, 2006). A review of randomized controlled trails found that self-management interventions showed promise as a means of improving symptoms, behavior, and knowledge related to psychological difficulties (Griffins & Christensen, 2006). As such, self-management practices may offer a solution to several problems associated with traditional mental healthcare provision, including consumer disempowerment, stigma, and lack of access to available resources (Schneider, 2006).

Several manualized mental health self-management programs have been developed in recent years, but perhaps the most widely disseminated is Mary Ellen Copeland's *Wellness Recovery Action Planning* known as WRAP (Copeland, 1997). Through the use of presentations, demonstrations, interactive discussions, and related activities, WRAP facilitators assist participants in creating personal ''Wellness Toolboxes'' consisting of simple and easily accessible strategies, including healthy diet, exercise, sleep, and goal setting. These individualized plans also include the identification of ''early warning signs'' and how to effectively manage crisis situations. Several studies have shown that WRAP participants experience significant increases in self-reported knowledge of early warning signs, tools and skills for coping with symptoms, preference for using natural supports, support groups, and other people with mental illness for support, use of wellness tools in their daily routines, and hope for recovery (Cook et al., 2009; Sterling, von

Esenwein, Tucker, Fricks, & Druss, 2010). WRAP services may be offered in either a group or individual format by peer or paraprofessional facilitators trained in the model. Books, pamphlets, and online resources are available to help clinicians, counselors, and peers learn and apply the model (see www.mentalhealthrecovery.com).

Another promising practice, *Mindfulness-Based Stress Reduction* (MBSR) was developed by Dr. Jon Kabat-Zinn in 1979 as a systematic application of mindfulness techniques to assist with problems related to stress. MBSR has proven to be highly effective in diminishing stress, anxiety, and depression, and has proven effective in lessening the ill effects of stress on heart disease, cancer, chronic pain, skin ailments, asthma, and many other health conditions (Grossman, et al., 2004). Participants learn to use guided meditations and gentle movement exercises to develop insight into inner sources of healing. Facilitators also provide psycho-education and individualized support. Between sessions, participants enhance their practice through the completion of homework assignments (e.g. meditation practice, readings, etc.). Mindfulness may be taught to consumers in a group or individual format by facilitators trained in the practices. Numerous books, videos, and audio resources are available for facilitators and individual practitioners. Additionally, resources developed by Dr. John Briere are available online (www.johnbriere.com) and provide specific applications of mindfulness techniques for the identification and management of trauma triggers for those suffering from traumatic stress.

Additionally, Amador County has a number of individuals trained in *Meridian Tapping Techniques* (MTT), a form of acupressure that helps relieve energy blockages caused by physical, mental or emotional trauma. Techniques include touching and tapping on acupressure points with two fingers and may incorporate having the individual repeat certain phrases to help focus attention. While there is limited research examining the efficacy of MTT, some mental health practitioners have suggested that the techniques empower individuals to self-sooth rather than relying on professionals for soothing, thus promoting self-reliance and increased resilience in the face of life's traumas and stressors. Individuals trained in MTT help consumers learn the correct tapping points, guide consumers through tapping sequences (or 'rounds'), and assist with identifying beneficial phrases. Books, manuals, and online resources are available (see www.howtotap.com). Techniques may be taught to consumers by individuals trained in the practices.

Collaborative Service Delivery Model

Amador County proposes to harness the self-identified volunteer person-power to implement the Self-Management Program. Within the model, volunteer wellness trainers will be trained in variety of self-management practices and will provide services directly to individuals throughout the county in existing community-based settings. In order to ensure adequate training and support to volunteers, MHSA funds will be used to hire a Program Coordinator who will work within Amador County Behavioral Health (ACBH). In this community-county collaboration, ACBH will provide a central home for all training and coordination activities. MHSA funds will also be used to: 1) provide transportation stipends to the wellness trainers, and 2) produce and distribute program outreach materials in English and Spanish. Existing MHSA investments in a traditional *promotores* program, Wellness Centers for youth and adults, interventions for troubled families and other programming will be leveraged to provide referrals to the Self-Management Program. Wellness trainers will work with local contacts throughout the course of the program to tailor outreach and engagement strategies. Information gathered about specific community needs will be communicated to the ACBH Coordinator who will ensure that training content and structure is based on the identified needs.

The project will be structured to unfold in multiple stages over the course of four years:

- Planning Period (6 months): During the start-up phase, a part-time Program Coordinator will be hired to work within ACBH. The coordinator will facilitate the development of a community-based Self-Management Program Steering Committee. The committee will be made up of, at minimum, an ACBH consumer, Sierra Wind Wellness Center representative, a volunteer fire fighter or other emergency responder, an older adult, a transitional age youth aging out of foster care, a member of the Native American community, a representative from the Latino community, a mental health service provider, a member of the National Alliance on Mental Illness (NAMI) and other interested members of the community. The structure and governance of the committee will reflect that of current Amador County committees and advisory boards. The Steering Committee, with the assistance of the Program Coordinator, will: 1) review county services and community resources; 2) identify communities in greatest need; 3) identify self-management practice training opportunities and assessment instruments); 4) develop an implementation plan; and 5) obtain support from community leaders. These leaders will also be asked to help identify potential wellness trainers (for a total of ten to 12 volunteers) and help secure venues (sites like the Family Learning Centers have been proposed as ideal venues for self-management service provision because they offer both trusted brokers and a familiar setting). The independent evaluator will develop and/or identify relevant program measurement and tracking tools. During the planning period, the Coordinator will recruit and screen volunteers, and conduct initial team-building activities.
- Service Implementation (Years 2 - 4): With guidance from the Steering Committee, the Program Coordinator will design and implement ongoing trainings, individual wellness trainer consultation, and a wellness trainer support group. Because several of the techniques that the Steering Committee might recommend and that volunteers may wish to practice require adherence to practice guidelines, the Program Coordinator will be in charge of bringing in the appropriate trainers and scheduling the activities in accordance with wellness trainer availability. For example, if MBSR is selected, the training may follow the recommended 28 hour (8 week) training model. In addition to training in the selected toolbox of self-management practices, wellness trainers will receive ongoing training in confidentiality, mandated reporting, cultural competence, and identification of severe mental illness requiring more intensive intervention. Trainings will also focus on developing volunteer confidence and understanding principles of client choice and of wellness, recovery and resiliency.

  Key to the success of this program will be the capacity of the Coordinator to provide ongoing support and encouragement to the trainers and strengthen relationships between the trainers and the Behavioral Health staff. The Program Coordinator will also work with the wellness trainers to conduct community outreach, working with existing MHSA programs and local service providers to identify participants. Outreach materials will be developed to promote the program and encourage consumer self-referral. Once wellness trainers reach competence in the self-management practice(s), they will be sent out into the community to interface with local contacts and provide direct service to consumers (i.e. teach self-management practices to individuals and groups in the community). Wellness trainers will also participate in departmental cross-training activities, sharing their knowledge of the self-management practice(s) with ACBH staff (e.g., the Integrated Recovery Teams/IRTs). The Steering Committee will be kept abreast of all developments as the program is rolled out; this information will be documented, reviewed, and used to make decisions about adaptations/revisions to the service delivery model.

  The Program Coordinator will be involved in all aspects of the program. He/she will: 1) facilitate the

development of a community-based Self-Management Program Steering Committee; 2) assist the committee in finalizing all implementation planning and coordinate all committee meetings; 3) coordinate initial and ongoing recruitment and retention of wellness trainers; 4) take the lead in designing and implementing the wellness trainer training program, including ongoing case consultation and support group; 5) contribute to community outreach efforts, including the development of outreach materials; 6) assist wellness trainers in making appropriate behavioral health service referrals for program participants requiring more intensive intervention; 7) assist with the collection of program evaluation data; and 8) facilitate the dissemination of program findings. In order to support the volunteer wellness trainers, ongoing case consultation will occur on a regular basis (e.g., weekly or bi-weekly individual group case review sessions, followed by a wellness trainer support group. During these activities, the Program Coordinator will have the opportunity to gauge trainer engagement and help address identified challenges/barriers. While a minimum one-year commitment to the program will be encouraged, a protocol for early withdrawal will be developed and will be reviewed with each wellness trainer entering the program. Outreach and identification of potential wellness trainers will be ongoing. Peers, family members, and individuals representing ethnic and linguistic minorities will be encouraged to become wellness trainers.

- Evaluation Year (Year 4): While evaluation will take place throughout the course of the program, the final year will be spent assessing the project in its totality to measure both the outcome and the process. The objective will be to examine the ways in which the model was: 1) able in engage and retain a diverse group of volunteer wellness trainers; 2) able to train the wellness trainers in selected self-management practices; 3) able to deliver services; 4) increase access for underserved groups; and 5) lead to positive consumer outcomes. Should the project provide positive outcomes, particularly for previously unserved and underserved individuals, the Evaluation Year can also be spent assessing how best to continue the program with alternate sources of funding.

This work plan is consistent with the General Standards identified in the MHSA, and emphasizes the following principles:

- Community Collaboration: This program was developed based on community input regarding the need for alternative treatment strategies offered in community-based settings, and community members committing to deliver services to consumers themselves. The program is built upon collaboration between ACBH, community volunteers, and consumers. It can only be implemented with full the participation of the community volunteers (i.e. wellness trainers) and the community-based settings.
- Cultural Competence: The program is designed to meet the needs of the community in a collaborative fashion that capitalizes on both county and community expertise and resources. Expanding mental heath service capacity will act to reduce disparities in access, especially for those whom stigma and geographical isolation play considerable barriers. ACBH staff working with the program shall be culturally-responsive to wellness trainer and consumer needs. Individuals selected to act as volunteer wellness trainers will reflect the cultural and ethnic diversity of the population(s) to be served. Special attention will be given to recruiting Native American and bilingual-bicultural Latino wellness trainers. All staff, Steering Committee members, and wellness trainers will receive on-going cultural competence training. Wellness trainers will also receive specialized training on

working with diverse populations and applying the self-management practice(s) in a culturally-responsive fashion.

- Consumer and Family Driven Mental Health System: This program is dependent on the ongoing involvement of community volunteers (which may include past mental health service consumers and family members) in the wellness trainer role. It also depends on the willingness of community members to receive self-management services. Consumers will have the power to accept, reject, and/or select the type of self-management service they receive. For example, while one wellness trainer may offer a consumer MBSR services (based on that wellness trainer's training, comfort level with the practice, etc.), the consumer may be more interested in MTT. If the wellness trainer is unable to provide MTT, he/she will be trained to connect the consumer with another wellness trainer with that particular expertise. Additionally, if consumers begin to request a new self-management practice, that information will be communicated to the Program Coordinator and Steering Committee and will be considered for inclusion in future training plans. Consumer feedback and satisfaction will also be collected throughout and will be used to guide outreach and service delivery.

  Family members may play a vital role in supporting their loved ones to learn about and use the self-management techniques. The volunteers will be trained to include family members, when invited by the individuals requesting services. Additionally, stakeholders during the planning process specifically requested that family members of people with severe mental illness be outreached to and invited to learn about self-management techniques, because the stress associated with supporting their loved one's recovery can be mitigated by such techniques.

  Community members, including at least one ACBH consumer and a member of NAMI, will sit on the Steering Committee that will be in charge of: 1) selecting the self-management practice(s); 2) developing, monitoring, and refining the service delivery model; 3) overseeing the evaluation process and making recommendations based on findings; and 4) planning any future expansion. In addition, results of mid-year evaluations will be made available to the Mental Health Board and to community partners on the Continuous Quality Improvement Committee, while results of the yearly (12-month) evaluations will be distributed widely allowing ample opportunity for stakeholders to offer input at the program, consumer, family, staff, and community levels. When participants request family participation, volunteers will be encouraged to teach them about the techniques as well.

- Wellness, Recovery and Resilience Focus: This program increases resilience and promotes recovery and overall wellness for those living with PTSD and related psychological distress through the provision of self-management practices provided by trusted members of the community in community based settings. The program is designed to strengthen consumers' ability to drive their recovery and effectively manage their symptoms. Self-management services will be offered and provided to consumers without requiring that they engage in any other ACBH services. Specifically, the services may be accessed without having to engage in any traditional psychological or psychiatric consultations or treatments. Only those consumers who present with severe mental illness, or who express interest in receiving adjunctive traditional therapies, will be referred to available services. Thus, consumers will be empowered to own their wellness options.

EXHIBIT C

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)

While new mental health practices will be introduced to the county as part of the Innovation Project (i.e. the self-management practices), the true innovation will be the approach used to deliver the services. This project will contribute to learning by exploring how a unique collaboration between the community and ACBH can produce a robust model for community-driven mental health service provision. The project will assess whether and how the unique factors of an organized network of volunteer wellness trainers, county-based coordination and support, engaged consumers, and a set of promising techniques can combine to create a successful delivery mechanism. The framework for the service delivery model may be seen as an adaptation of existing health worker programs. The proposed model will include: 1) the use of volunteers to deliver the service directly to consumers; 2) the inclusion of a group of providers (i.e. wellness trainers) that represent diverse occupational and education backgrounds (e.g., fire fighters, pastors, etc.); 3) a focus on the provision of self-management practices; and 4) the commitment to community-driven development and implementation. While individual components may be present in existing community health worker programs, the proposed model was designed to meet the specific needs of Amador County residents and will continue to evolve in response to Streering Committee and stakeholder feedback. The service delivery model, incorporting these unique characterstics, will be at the core of the program evaluation.

Such a delivery model is significant for Amador County because it could provide a method for turning county specific challenges into resources. Amador has a small, geographically dispersed population that is unlikely to seek traditional mental health services due to stigma, mistrust and geographic isolation. Further, the current funding realities have severly curtailed the spectrum of mental health services available to its residents. Finding a method of overcoming these barriers, empowering consumers to own their wellness options, and expanding access to services across the county's broad geography could radically redefine the nature of service delivery. A commitment to developing a local community-driven service delivery model is proposed as an investment in the broader mental health system of care. Lessons learned about the delivery model will be used to guide future county-wide efforts. Specifically, it is hoped that the model can be replicated in the future to meet the needs of geographically isolated residents suffering from other mental health conditions, including depression and substance use disorders.

The Innovation Project seeks to analyze the ways in which and the degree to which this unique collaborative service delivery model achieves its goals. Key questions the project will attempt to answer include:

- Process
    - How and to what extent was the model able to engage and retain a diverse group of volunteer wellness trainers?
    - How and to what extent was the model able to train the wellness trainers in the selected self-management practice(s)?
    - How and to what extent did the model contribute to participation by community leaders in

building a more robust behavioral health system?

- How and to what extent did the volunteers, community leaders and behavioral health staff work together to address persistent community mental health needs?

- Outcome
  - Was the model able to increase access to underserved and previously disenfranchised individuals?
  - Did the model have a positive impact on participant outcomes?

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.

Implementation & Completion Dates: February 2011 – June 2014 (3.5 yrs.)

Month	Year	Activity	Outcome/Deliverable
Feb.	2011	Anticipated OAC approval; Program contract procurement Initiate project; Hire ACBH Program Coordinator	Approved plan Signed contract Staff member on board
March-April	2011	Establish Steering Committee Steering Committee: 1) Identification of self-management practice(s) and assessment methodology; development of program implementation plan; obtain support from community leaders	Committee established Practice(s) and instruments identified; materials and trainers secured; targeted outreach to community leaders Community invited to April Steering Committee meeting (attendance and response documented by independent evaluator)
May	2011	Identify wellness trainers and community-based venues	Ten to 12 community members accepted into program as wellness trainers and venues secured via MOUs
May-June	2011	Program Coordinator: Train wellness trainers in model	Training initiated (attendance documented)

		Program Coordinator and wellness trainers: Begin outreach and participant recruitment	Outreach materials created and distributed throughout county
July	2011	Initiate Self-Management Program services (SERVICE PROVISION INITIATED)	1st year of service implementation
Dec.	2011	Conduct mid-year Program Evaluation	Collect, analyze and report participant data
Jan.	2012	Steering Committee review mid-year evaluation, distribute to stakeholders, and develop plan for relevant revisions moving forward	Reports distributed; community feedback collected; recommendations made and documented
June	2012	Conduct End of Year Evaluation	Collect, analyze and report process and participant (current and follow-up) data Independent evaluator to conduct focus groups, key informant interviews
July	2012	Steering Committee review Year 2 Evaluation, distribute to stakeholders, and develop plan for relevant revisions moving forward Begin 2nd year of Self-Management Program services (YEAR 2 SERVICE PROVISION)	Reports distributed; community feedback collected via open community meetings and written feedback mechanisms; recommendations made and documented; discussed with ACBH administrators
Dec.	2012	Conduct mid-year Program Evaluation	Collect, analyze and report participant data
Jan.	2013	Steering Committee review mid-year evaluation, distribute to stakeholders, and develop plan for relevant revisions moving forward	Reports distributed; community feedback collected; recommendations made and documented
June	2013	Conduct Year 3 Evaluation; Strategic Planning Retreat; sustainability planning	Independent evaluator to conduct focus groups, key informant interviews, review pre- and post-treatment data

July	2013	Steering Committee review Year 3 Evaluation, distribute to stakeholders, and develop plan for relevant revisions moving forward Begin 3rd year of Self-Management Program services (YEAR 3 SERVICE PROVISION)	Reports distributed; community feedback collected via open community meetings and written feedback mechanisms; recommendations made and documented; discussed with ACBH administrators
Dec.	2013	Conduct mid-year Program Evaluation	Collect, analyze and report participant data
Jan.	2014	Steering Committee review mid-year evaluation; determine future steps and prepare for project conclusion; disseminate findings and plans	Reports distributed; community feedback collected; recommendations made and documented
June	2014	Conduct Final Outcome and Process Evaluation Project conclusion Steering Committee: Wrap-up and recognitions	Final Outcome and Process Evaluation Report with client outcome data and process data related to the service delivery model; results shared with stakeholders and ACBH administrators

Evaluations at six-month intervals throughout implementation will allow the program to measure the effectiveness of both the service delivery model and the self-management strategies. Continuous measurement will also allow for learning to occur as early as Year 1.

EXHIBIT C

Project Measurement

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

Amador County proposes to design and implement a community-driven Self-Management Program with the specific aim of determining whether and how an innovative community-county collabortive service delivery model can successfully increase access to needed mental health services. The project will assess whether

and how the model was able to: 1) engage and retain a diverse group of volunteer wellness trainers; 2) train the wellness trainers in the selected self-management practices; 3) increase participation by community leaders in building a more responsive and robust behavioral health system; 4) increase the degree to which volunteers, community leaders and behavioral health staff work together to address persistent community mental health needs; 5) increase access for underserved groups; and 6) support positive participant outcomes.

Process Evaluation

1. To assess whether and how the model was successful in engaging and retaining a diverse group of volunteer wellness trainers, the project proposes to follow wellness trainers over the course of their involvement. The project will collect demographic and retention data. Wellness trainer satisfaction will also be assessed at six-month intervals throughout the course of the project via questionnaires and on a yearly basis via interviews or focus groups.
2. To assess whether and how the model was successful in training wellness trainers to administer the self-management practices, data corresponding to participation in training, knowledge gained, and confidence will be gathered and analyzed. Volunteers will complete pre and post questionnaires and participate in interviews or focus groups.
3. To assess whether and how the model was able increase participation by community leaders in building a more responsive and robust behavioral health system, the project will collect and analyze data on steering committee participation and demographics, successful referrals to other Behavioral Health services; and degree of community leaders satisfaction with Behavioral Health responsiveness to community needs. Community leaders will be interviewed on an annual basis to determine what was aspects of the project were most and least useful in connecting individuals to available supports.
4. To assess how the model was able to engage community leaders, volunteers and behavioral health staff in working together to address persistent community mental health needs, the project will collect and analyze data pertaining to steering committee participation, assessment, planning and follow-through. Interviews and/or focused discussion groups with stakeholders will help understand opportunities to build relationships and break down barriers to collectively serving the public interest.

Outcome Evaluation

4. To assess whether the model was successful in increasing access to underserved and previously disenfranchised consumers, the project proposes to collected service utilization data.

5. To assess whether the model was able to positively impact participant outcomes, the project proposes to follow and assess participants over a ten to 12 month timeframe using standardized self-assessment tools.

Review:

Stakeholders, via the Steering Committee, will be involved in the design of the service delivery model, the project's assessment methodology, and implementation plan. They will also be directly involved in reviewing all project evaluation products. Results of mid-year (six-month) evaluations will be presented to the Steering Committee, wellness trainers, and ACBH staff for feedback and problem-solving. These

reports will also be distributed to the Mental Health Board and to community partners on the Continuous Quality Improvement Committee. Results of the yearly (12-month) evaluations will be presented first to the stakeholders listed above, then distributed via the ACBH information sharing and collaboration process to the Amador County Board of Supervisors. The reports will also be posted on the ACBH website, at the Sierra Wind Wellness Center, the Family Development Centers, and other community sites. The Steering Committee will also hold open community meetings on a yearly basis to generate feedback and recommendations. This process will provide ample opportunity for stakeholders to offer input at the program, consumer, family, staff, and community levels.

Leveraging Resources (if applicable)

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

- Volunteer wellness trainers;
- Local network of Volunteer Fire Departments;
- CSS investment in Integrated Recovery Team (IRT) Capacity Building to provide training for project stakeholders;
- Tod Doris, certified Anger Management Trainer and local expert in Veterans and PTSD recovery;
- Susan McMorris, community member and owner, Wellness by choice Self Management Strategies; and
- Mental Health America for meeting space and assistance with outreach via the Sierra Wind Wellness Center.

Exhibit D
Innovation Work Plan Description
(For Posting on DMH Website)

County Name:
Amador County

Work Plan Name:

Community-Driven Delivery of Self-Management Practices

Annual Number of Clients to be Served: 80

Population to Be Served (if applicable):

The Self-Management Program will target adults (individuals 18 and over) suffering from untreated traumatic stress and related difficulties (e.g., anger, depression, dysregulated affect, substance use disorders) living throughout the county. Services will be voluntary, but will specifically target those individuals currently not accessing mental health services due to ineligibility, lack of trust in the public health system, and/or geographic isolation.

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

The Self-Management Program will provide peer-led supportive services to 80 adult residents of Amador County suffering from untreated posttraumatic stress a year. The program will offer these services at existing community-based settings throughout the county through a collaborative partnership between community members and Amador County Behavioral Health (ACBH).

The focus of this proposed Innovation Project will be to examine how an organized network of volunteer wellness trainers, county-based coordination and support, engaged consumers and family members, and a set of promising self-management techniques can combine to create a robust system of community-driven mental health service provision. While the self-management services themselves may have an established evidence-base, the method of implementation represents an innovation in service delivery that capitalizes on existing community expertise and resources. The model may be seen as an adaptation of existing health worker programs that includes: 1) the use of volunteers to deliver the service directly to consumers; 2) the inclusion of a group of providers (i.e. wellness trainers) that represent diverse occupational and education backgrounds (e.g., fire fighters, pastors, etc.); 3) a focus on the provision of specfic self-management practices; and 4) the commitment to community-driven development and implementation. While individual components may be present in existing community health worker programs, the proposed model was designed to meet the specific needs of Amador County residents and will continue to evolve in response to Streering Committee and stakeholder feedback. It is believed that the model will have the potential for empowering consumers and expanding access to services across the county's broad geography.

EXHIBIT E

Innovation Funding Request (FY 2010/11 – 2012/13)

Mental Health Services Act
Innovation Funding Request

County: Amador County

Date: FY 2010-2011 to 2012-2013 (2.5 Years)

	Innovation Work Plans		Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	1	Self-Management Program	$283,620				
2							
3							
4							
5							
6							
7							
8							
9							
10	Subtotal: Work Plans		$283,620	$	$	$	$
11	Plus County Administration		$35,133				
12	Plus Optional 10% Operating Reserve		$31,875				
13	Total MHSA Funds Required for Innovation		$350,628				

Exhibit F

Innovation Projected Revenues and Expenditures (2010-2011)

County: **Amador** **Fiscal Year:** **2010/11**

Work Plan #: 1

Work Plan Name: Self-Management

New Work Plan ☑

Expansion ☐

Months of Operation: 01/2011-06/2014

MM/YY - MM/YY

07/2010-06/2011

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Yearly Expenditures				
1. Personnel Expenditures	25,000			$25,000
2. Operating Expenditures	33,620			$33,620
3. Non-recurring expenditures				$0
4. Training Consultant Contracts	13,000			$13,000
5. Work Plan Management				$0
6. Total Proposed Work Plan Expenditures	**$71,620**	**$0**	**$0**	**$71,620**
B. Yearly 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. Yearly Total Funding Requirements	**$71,620**	**$0**	**$0**	**$71,620**

Prepared by: _____ Date: _____

Telephone Number: _____

INNOVATION WORK PLAN BUDGET NARRATIVE (2010-2011)

Summary:
The funding request for Fiscal Year 2010-2011 represents the initial start-up (5 months of project implementation).

A) Expenditures

1. Personnel Expenditures - $25,000
   - Personnel Expenditures are for a .50 FTE ACBH contracted Program Coordinator; projection includes salary and relevant benefits (5 months during 2010-2011 fiscal year)
     - The project coordinator will bring expertise in mental health and community-based delivery of services. The coordinator will manage the volunteer wellness trainers and all other aspects of the program.

2. Operating Expenditures - $33,620
   - Volunteer transportation stipends ($10,000)
   - Outreach materials ($2,000; reflects initial start-up expenditures that exceed projected on-going costs)
   - Assessment measures/instruments ($2,000; reflects initial start-up expenditures that exceed projected on-going costs)
   - Contracted evaluation ($15,000; reflects initial start-up expenditures that exceed prorated on-going costs)
   - Percentage of normal operating expenses for phones, office supplies, utilities and equipment usage (approximately $4,620 prorated for 5 months, plus initial supplies required)

3. Non-recurring expenditures - $ 0
   - No non-recurring expenditures are anticipated.

4. Training Consultant Contracts - $13,000
   - Consultants brought in to initially train volunteers, the Program Coordinator, and Steering Committee members ($13,000)

5. Work Plan Management - $ 0
   - No contracted management expenses.

6. Total Proposed Innovation Work Plan Budget - $71,620
   - ($71,620 for FY 2010-2011 program costs, $7,028 county administrative fees, and $6,375 operating reserve; total MHSA Funds required for Innovation during 2010-2011 $85,023)

B) Revenues

1. Other Revenues - $ 0
   - There are no revenues for this program.

Innovation Projected Revenues and Expenditures (2011-2013)

Innovation Projected Revenues and Expenditures

County:	**Amador**	**Fiscal Year:**	**11/12 - 12/13**
Work Plan #:	1		
Work Plan Name:	Self-Management		
New Work Plan	☑		
Expansion	☐		
Months of Operation:	01/2011-06/2014		
	MM/YY - MM/YY		
	07/2011-06/2012 and 07/2012-06/2013		

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Yearly Expenditures				
1. Personnel Expenditures	120,000			$120,000
2. Operating Expenditures	66,000			$66,000
3. Non-recurring expenditures				$0
4. Training Consultant Contracts	26,000			$26,000
5. Work Plan Management				$0
6. Total Proposed Work Plan Expenditures	**$212,000**	**$0**	**$0**	**$212,000**
B. Yearly 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. Yearly Total Funding Requirements	**$212,000**	**$0**	**$0**	**$212,000**

Prepared by: _____ Date: _____

Telephone Number: _____

INNOVATION WORK PLAN BUDGET NARRATIVE
(2011-2012 and 2012-2013; projected to 2013-2014)

Summary: The funding requested for Fiscal Years 2011-2012 and 2012-2013 represent the level of funding requested for each year after start-up. Please note that the following figures are presented under the assumption that project costs will remain constant from 2011-2012 through 2012-2013.

Amador County is presently requesting funding for the first three years (FY10/11 – FY12/13), but is projecting that the project will continue through the 2013-2014 fiscal year. During the next annual update, the county will request additional funding to cover the costs of the fourth year. Using the same cost assumptions as years 2011/12 and 2012/13, the cost for all 4 years of this project will be $483,430.

C) Expenditures

1. Personnel Expenditures - $60,000 X 2 years = $120,000
   - Personnel Expenditures are for a .50 FTE ACBH contracted Program Coordinator; projection includes salary and relevant benefits (12 months a fiscal year).
     - The project coordinator will bring expertise in mental health and community-based delivery of services. The coordinator will manage the volunteer wellness trainers and all other aspects of the program.
     -

2. Operating Expenditures - $33,000 X 2 years = $66,000
   - Volunteer transportation stipends ($10,000 a year)
   - Outreach materials ($1,000 a year)
   - Assessment measures/instruments ($1,000 a year)
   - Contracted evaluation ($15,000 per year)
   - Percentage of normal operating expenses for phones, office supplies, utilities and equipment usage (approximately $6,000 per year)

3. Non-recurring expenditures - $ 0 X 2 years = $0
   - No non-recurring expenditures are anticipated.

7. Training Consultant Contracts - $13,000 X 2 years = $26,000
   - Consultants brought in to train volunteers and the Program Coordinator in specific self-management practices ($13,000 year anticipated)

8. Work Plan Management - $ 0 X 2 years = $0
   - No contracted management expenses.

9. Total Proposed Innovation Work Plan Budget - $106,000 X 2 years = $212,000
   - ($106,000 for each year's program costs, $14,054 county administrative fees, and $12,748 operating reserve; total MHSA Funds required for Innovation for each year is $132,802.)

D) Revenues

2. Other Revenues - $ 0 X 2 years = $0
   - There are no revenues for this program.

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