

EXHIBIT A

INNOVATION WORK PLAN
COUNTY CERTIFICATION

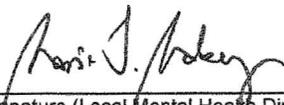
County Name: Riverside County

County Mental Health Director	Project Lead
Name: Jerry Wengerd	Name: Bill Brenneman
Telephone Number: 951-358-4500	Telephone Number: 951-358-4563
E-mail: wengerd@rcmhd.org	E-mail: bhbrenneman@rcmhd.org
Mailing Address: 4095 County Circle Drive Riverside, CA 92503	Mailing Address: 4095 County Circle Drive Riverside, CA 92503

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)

7/19/10

Date

ASST.
Mental Health Director

Title

Exhibit B

INNOVATION WORK PLAN

Description of Community Program Planning and Local Review Processes

County Name:	Riverside County
Work Plan Name:	Recovery Learning Center

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)

This is the second phase of planning around Innovation, as Riverside County previously submitted, and was approved, for a Recovery Arts Core Innovation Project in September 2009. During this current Community Planning Process, the Department reintroduced the Innovation Guidelines as well as the mission and purpose of the component. An overview of the Department's programs and the impact of shrinking funding resources (due to the current budget crisis) was also provided. Considering the learning objectives of Innovation and in light of the on-going fiscal concerns, the discussion centered on the need to continue to transform the mental health system toward a recovery-oriented model, but at the same time look at alternative models that may prove to be more effective, efficient, cost-effective or help to build capacity. We wondered: 'How can we continue to move Riverside's recovery transformation forward in a careful fiscal environment while also improving positive outcomes?'

Presentations and orientations were conducted and input was elicited from the MHSA Planning Committees (including Children's, TAY, Adult, and Older Adult), as well as the Mental Health Board. Not only did this allow the Department to gain perspective by age span, but representation was present from each of the three geographic regions as well, which led to regional input and diversity. To ensure that input was also received from the under represented ethnic populations, the Ethnic Disparities Committee was also solicited to provide perspectives from their culturally specific communities (including Hispanic, African/American, Native American, Asian and Pacific Islanders).

Simultaneous to the aforementioned process, a Consumer Leadership Group conducted a series of planning meetings in conjunction with the Department's Director of Consumer Affairs. This group consisted of mental health

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consumers, consumer providers, Peer Support and Senior Peer Support Specialists. The Department was fortunate in that the consumer group was comprised of rich multi-cultural heritage and linguistic diversity including: Hispanic, Native American, African American, Asian American, LGBTQ, Substance Abuse, Homelessness, and one American Sign Language Peer Support Specialist. The group was convened to brainstorm truly consumer-driven methods and approaches to mental health services that can be implemented in the context of learning and that would meet stakeholders' request to further Riverside's recovery transformation, while at the same time addressing the critical need of shrinking budgets and services.

The group worked autonomously and suggested that existing services, although consumer enhanced, could be more impactful if completely consumer-driven. The group wondered if creating and piloting a multi-cultural and linguistic peer led recovery center and offering it as an alternative level of care within the existing Mental Health delivery system would address both our stakeholder's desire to further Riverside's recovery transformation as well as on-going fiscal concerns. Could a peer led program move Riverside's recovery transformation further, create positive outcomes, and meet the growing concerns over fiscal challenges?

Their exploration and ideas not only coincided with the MHSA goals of delivering recovery and culturally competent oriented services, but the themes that were generated out of the MHSA Planning Committee's. These themes included more consumer-operated services, use of WRAP principles, increases in consumer/family supports and services being delivered in non-traditional settings, and in culturally and linguistically appropriate manners.

The Consumer Leadership Group continued exploring and developing aspects of this potential pilot by narrowing the purpose, looking at contributions to learning and proposed outcomes. They in turn held a cooperative community meeting/focus group to ensure thorough stakeholder inclusion to the project by Homeless Shelter and Peer Center Representatives, Board and Care Providers and Mental Health multicultural, multi-linguistic consumers in recovery.

The outcome of the planning meetings resulted in full agreement that a consumer-driven service delivery model would move Riverside's recovery transformation forward but also led to unanimous agreement around a central question: Would piloting a consumer led, alternative model increase the quality of services and create positive outcomes such as increases in consumer self-reliance, self-determination, wellness, lasting and improved overall self-concept and less dependence on the mental health system? Our stakeholders believed these to be the central tenants of good recovery practice and wanted to see these outcomes as a part of Riverside's

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transformation. These stakeholders entitled such a consumer-drive mental health service delivery model, The Recovery Learning Center (RLC).

The Leadership Group was integral in establishing the learning goals of The RLC pilot which revolve around determining if peer-provided services have better service adherence than traditional clinics, the effectiveness of recovery coaches and WRAP applications and the impact of peer-centered and driven services as a primary treatment modality. These are described in more detail within the body of the Work Plan narrative (Exhibit C).

Please note that other needs did surface through the planning process such as ideas related to Older Adult services and integrated health and mental health approaches. Due to the complexity of combining all of these concepts into one submittal, our stakeholders agreed to move forward with the RLC while taking additional time and resources to refine and develop the other initiatives.

To ensure optimal opportunities were provided for stakeholder input to this plan, the RLC draft proposal was circulated to county clinics, county libraries and posted for 30-days on the Department's website. The Draft Innovation Plan and Feedback Forms were available in both English and Spanish (Spanish is the only threshold language in Riverside County). A Public Hearing followed the 30-day comment period with Spanish translation services available.

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

The entities involved in the stakeholder process included consumers, consumer providers, Peer Support Specialists, homeless shelter and peer center representatives, board and care providers, family members, parent partners, family advocates, community-based organizations, social services, health department, NAMI, and representatives from underserved cultural groups through the Ethnic Disparities Committee such as Hispanic, Native American, African American, Asian-Pacific Islander, and LGBTQ communities.

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. Indicate if none received.

The RLC Innovation Project was posted for public review and comment from June 3, 2010 through July 7, 2010 on the Department's website and distributed to County clinics and libraries as well as presented to the Stakeholder Leadership and MHSA Committees. A Public Hearing was held on July 7, 2010 by the Mental Health Board and all community input and

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comments were reviewed with the MHB Executive Committee to determine if changes to the project(s) are necessary. All input and comments, are documented and included as Attachment A to this proposal.

During the review of input and comments by the MHB Executive Committee, no substantive changes to the plan were identified and they recommended no change to the Innovation – Recovery Learning Center Project proposal. As part of the discussion process during the review, the following recommendations were provided as considerations to be given to the Implementation Team.

- a. Strong consideration be given to providing evening and ‘off hour’ and/or on-call (Warm Line) capabilities.
- b. Preference be given to hiring clinicians that have lived experience (peer experience).
- c. There is a strong interest in TAY services at these RLCs.
- d. Consideration be given to providing part time positions, which allow for more flexible transition into the work force for peers.
- e. If located in an existing MH Clinic facility, the RLC should have a separate entrance if possible.

In addition, the Department consulted with CIMH staff, prior to and during the open comment period, who provided review and technical assistance. As a result, the narrative has been modified with clarifying points and direction.

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Date: 7/19/10

County: Riverside

Work Plan #: INN-02

Work Plan Name: Recovery Learning Center

Purpose of Proposed Innovation Project (check all that apply)

- 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).

As Riverside County continues to learn from recovery transformation, our stakeholders have provided feedback on the successes and challenges of recovery's practical application into our service delivery. Though we have made notable changes, our stakeholders have stated that they want to see our service delivery become even more consumer-driven and our service outcomes to be more directly related to consumer-led interventions.

Transformational philosophy, evidence based research, and our own community stakeholder processes have all emphasized both the interest and the success of consumer run services. The integration of lived-experience practitioners into service delivery has been an evolution, especially as we continue to master the transformation from the traditional medical model into the more holistic, recovery based system. The initial MHSA phases have focused on the addition of consumer run services into the existing mental health services system. Yet, our stakeholders have spoken:

- "We need to have people who have been through the recovery process running the process."
- "We need to have people who are actively participating in their own recovery running the process."
- "We need peers in recovery running the process."
- "I have learned the most from people with a diagnosis. To really get the recovery picture, you have to get it from someone who has experienced it."
- "Staff needs personal experience to best serve consumers."
- "We need more Peer Support Specialists."
- "I would like to see a program that was run by peers and it would be a WRAP clinic."

The intent of the MHSA and recovery practice is to create a new service delivery model, one that is "consumer-driven", not just consumer-enhanced. Peer run centers typically function only for support and offer socialization, vocational, and

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consumer education. In order to address our stakeholders' desire to have a more consumer-driven, mental health delivery system, we wondered if developing mental health services that were envisioned, developed, and led by peer practitioners would best meet this concern.

Under the leadership of our Director of Consumer Affairs, a peer leadership forum was convened to brainstorm questions and ideas that would creatively address how Riverside could better meet our goals of truly consumer-driven mental health services. This leadership forum included consumers who have worked as Peer Support Specialists in the public mental health service system, volunteers, peer community leaders, and consumer stakeholders. This consumer group believed that the development of a peer-operated mental health services clinic would be the next step in our recovery evolution and brought their proposal to Riverside County as a recommended pilot. They called this innovative service model, the Recovery Learning Center (RLC). The full design of the RLC including program philosophy, physical plant, structure and service delivery were envisioned by people with lived-experience who are dedicated to improving the lives of consumers.

As Riverside's Peer Leadership explored their ideas around the development of the RLC, other central concerns also developed. Would such a peer led program also improve service outcomes? Would it also address growing fiscal concerns at this time of tenuous budgets and funding?

We wondered if the RLC would increase the quality of services, including better outcomes such better treatment adherence and participation, improved consumer self-reliance, self-determination, and wellness, as well as create lasting and improved overall self-concept and less dependence on the mental health system.. By establishing a program rooted in recovery philosophy and operated by people with lived-experience, we want to explore if the RLC will improve these positive outcomes and address cost saving budgetary concerns when compared to our existing service delivery model.

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, section 3320. (suggested length – one page)

Riverside County currently has three Peer Run Support and Resource Centers; these centers typically provide mental health recovery education and support as well as socialization and anti-stigma advocacy. Unlike the concept of The RLC, these centers are “outside” of the consumer's clinic treatment and consumers are referred to them for peer support. These services are complimentary to services provided by the Riverside County Department of Mental Health, and facilitate and

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promote recovery and empowerment of mental health consumers, but are not at the center of the consumer's mental health treatment.

We envision that the RLC will offer Riverside County consumers a new choice: a mental health services delivery model designed with consumer staff delivering services at the center of the delivery model. The RLC was planned around the development and implementation of a Wellness Recovery Action Plan (WRAP) and is intended to demonstrate and coach recovery, empowerment, and personal responsibility. Riverside County consumers who choose the RLC as their service provider will be called center members. It is anticipated that each member will complete a minimum of eight-week personal WRAP tailored to an initial goal.

WRAP, pioneered and promoted by Dr. Mary Ellen Copeland of the Copeland Center, "was developed by a group of people who had been dealing with difficult feelings and behaviors for many years, people working to feel better and get on with their lives" (Copeland Center). WRAP is designed to empower consumers to take responsibility for their own recovery and develop a proactive plan to stay well and lead productive lives.

All additional RLC services, including traditional clinic services, will serve as supports to achieve WRAP goals. WRAP has traditionally been utilized as an adjunct, or complementary program to an existing clinical treatment plan. Developing mental health interventions that center on WRAP goals is a fundamental change in mental health service delivery. Such a service design was considered "innovative" by Mr. Mathew Federici, Executive Director of The Copeland Center who has observed mental health service delivery across the country as he presents WRAP to mental health organizations throughout the United States.

Our consumer leadership forum initially conceived that the only requirements for program participation would be a willingness to learn and apply WRAP and to make a personal commitment to the member's own recovery. The program will be designed in a three-tiered structure, each tier lasting 4 months, totaling 1 year. Each tier would be progressive and build upon the other, starting with a foundation of recovery, to re-evaluating and changing goals upon greater skill development, and concluding with "giving back" or mentoring other members who are just starting the program. A RLC alumni group would not only serve as on-going support for the Recovery Learning Center graduates, but also as the mentoring pool for new members. The three tiers will be adjusted to meet the cultural and linguistic needs of the diverse multicultural population. The core cultural and linguistic elements for different ethnic and cultural groups will be developed as the program evolves. A part of our discovery will include how to create flexibility into the WRAP application so that it best meets the quality outcomes for a diversity of members.

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The peer staff at the RLC will serve as recovery coaches who will not only model recovery and assist consumers with creating individual recovery plans, but will also coach consumers to develop the wellness skills that are necessary to apply that plan as a living tool. Each member will have a recovery coach who will provide the member with individual coaching. Though research indicates that consumers with peer sponsors have shown greater adherence and follow up to program participation (Powell, Hill, Warner, & Yeaton, 2000), these studies focused on peer support and not on peers coaching WRAP application. We would like to know if adding individual coaching to WRAP development and implementation would result in the better application of the WRAP leading not only to better service outcomes but to the reduction of self-stigma and improve a member's overall self-concept.

We envision offering multicultural and multilinguistic ancillary services at the RLC that will support a member's WRAP. These ancillary services will include medication management provided by a psychiatrist and nurse, preferably who also have lived experience, and will commit to utilizing the member's WRAP as the central tool of service delivery. We also want to explore the benefit of incorporating additional holistic approaches such as yoga, breathing and mindfulness techniques, and meditation activities, as well as working with native and traditional healers within cultural communities.

The RLC concept will be implemented in two sites, one an urban free-standing clinic and the other integrated into a rural clinic. Each provides an opportunity for consumers to choose an alternative to traditional services where they take responsibility for their own recovery plan and choose their own goals and services with the assistance of a Recovery Coach who is a Peer Specialist.

Having two sites allows the Department to compare two applications of the model – one as an alternative separate clinic within a region and one as a division of an existing clinic. Determining effectiveness of the two applications will guide the best means of implementation for any future RLC programs and identify implementation challenges in a new site versus an existing site. This means testing out a regional model including a choice of clinics service models versus transforming an existing clinic site into two side by side service models with flow between the divisions based on consumer choice. Because of geography and smaller populations a two clinic model is not practical in all parts of the county so a variation of the organizational model delivery model must be tested as well as the overall service concept.

We believe that the RLC will exemplify a transformed service delivery model and an alternative to the traditional Department clinic, but will also serve as a proactive influence in transforming the culture of the mental health profession. Instead of persuading practitioners to accept the new direction of peer led services, we envision that the RLC will also provide a training foundation for

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behavioral science graduate students as they develop their careers in public mental health service.

To accomplish this, embedded in the RLC will be the Student Academy, a field placement site for multicultural diverse graduate students in behavioral science disciplines who need practice hours to fulfill their degree requirements. These students, under the supervision of licensed professionals, will provide individual and group therapy to RLC members, when consumers request it as a part of their WRAP. Not only will students receive the instruction required to become competent practitioners, but students will also integrate into a peer-driven program that will develop the peer-collaborative and partnership perspective that will shape their careers. We want to explore if developing this professional staff-consumer partnership at this early stage of practitioner development would influence practitioner perspective on welcoming recovery into their practice philosophy. We believe that this new generation of practitioners will have a foundation of recovery that will become the standard of practice as they grow into their professions and work settings.

This Innovation project supports and is consistent with the General Standards identified in the MHSA and Title 9, section 3320.

- Client Driven: The RLC is consumer designed and developed, and will be implemented by multicultural diverse consumer staff functioning as Peer Support Specialists. WRAP and peer coaching interventions are the foundation of the project with other clinical services augmenting the members' WRAP goals. The consumers' goals drive the service delivery.
- Family Driven: RCMH employees Family Advocates, family members who have lived-experience within the public mental health service system, and who now serve to educate and assist other family members. Family Advocates facilitate family member groups in county clinics; this will include the facilitation of family groups at the RLC. RLC family groups will serve as a foundation of understanding of the role family members have in supporting consumers' WRAP, of collaboration with consumers and RLC staff, and as a link between consumer services and family support. Additionally, family members will have key stakeholder roles in the evaluation of RLC implementation.
- Wellness, Recovery, and Resilience Focused: WRAP is an action plan for Wellness and Recovery and WRAP is at the heart of this service delivery model. Every RLC member must commit to a WRAP as a part of his or her participation. Because the Recovery Learning Center is consumer-operated, the tenants of peer-designed programs – wellness, recovery, and resiliency – are inherent in both mission and implementation. The Recovery Learning Center was conceived by Riverside's peer leadership as "recovery in action".

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- Cultural Competence: At the heart of recovery intervention is understanding and embracing the unique cultural and linguistic perspectives of each consumer. Because WRAP is individually developed by each member, then each member's service delivery will reflect that person's own world view. We will partner with our multicultural group stakeholders on how to best outreach and refer a diverse membership to the RLC. We also will actively explore how to adapt WRAP to meet the needs of a culturally diverse membership. Hiring a multicultural and multilingual diverse, peer staff will be a personnel goal. All peer staff will be trained by Recovery Innovations, a program that emphasizes cultural competency as an integral component of recovery interventions. Developing cultural competency skills to provide services to culturally and linguistically diverse members will be the core of the training program.
- Integrated Service Experience: Peer run services have traditionally been viewed as ancillary to standard clinical services or as a compliment to services and provided by peer-run centers. The Recovery Learning Center is a comprehensive mental health service delivery program centered on peer-run recovery activities but also includes medication management and psychotherapy when needed. Consumers receiving services will have full access to all Recovery Learning Center resources that support their WRAP.
- Community Collaboration: By integrating the Student Academy into the Recovery Learning Center, multiple southern region colleges and universities will collaborate with Riverside County through field instruction agreements. Collaborative instruction will also be exchanged as schools integrate the recovery oriented curriculum necessary to develop practitioners and to provide academic support to the Recovery Learning Center students and staff. We will also partner with existing multicultural communities and cultural and ethnic specific agencies to connect members to other cultural appropriate support services or cultural traditional healing practices, including our current peer support centers which offer housing, employment, and socialization assistance that could benefit a member's WRAP.

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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)

Though research indicates that consumers who are served by programs that were developed and implemented by peers have shown better healing outcomes, greater levels of empowerment, shorter hospital stays, and fewer hospital admissions (Dumont & Jones, 2002), we wondered if these outcomes could be enhanced. These studies were based on peer services that supported traditional, medical model treatment plans. We wondered: What would these outcomes look like if peer-driven services were at the center of the delivery model, and not simply added as an enhancement?

At this stage of the mental health service delivery transformation, peer designed and driven services have been ancillary to traditional clinic services. The RLC introduces an adapted mental health approach to service delivery model by centering service on peer intervention and WRAP. Even though the elements of the program have been previously implemented in other forums, they have not been composed together as represented by the RLC model. All other clinic services will be utilized as resources to actively apply WRAP in consumers' daily lives. Based upon our review of the research, to best of our knowledge, this model of mental health service delivery has never been tried before.

Though empirical evidence demonstrates the benefit of peer support as a best practice, the evidence to support such a peer-centered and peer-driven service as a primary treatment delivery model is lacking.

The Primary Learning Goals:

1. To determine if consumer-driven services have better service adherence and mental health outcomes than traditional clinic models.
2. To determine if this consumer-driven service delivery model will reduce internalized stigma related to mental illness and improve members' self-concepts.
3. To determine if adding recovery coaches to WRAP application increases the effectiveness of WRAP application

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4. To determine if integrating professional learning into a peer-centered atmosphere will transform the treatment philosophy of the mental health practitioner into a greater welcoming of recovery and consumer-led services.

5. To identify and compare implementation challenges and impact on existing clinic services and culture when the RLC is built into a current clinic versus free-standing center within a region.

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: September 2010 / October 2013

Dates	Activities
September 2010	Anticipated DMH/OAC approval.
October – November 2010	Identify and develop RLC infrastructure and further refine model; develop evaluation methodology, surveys, and measurement tools; partner with universities to secure identified graduate students for field placements within the Student Academy
December 2010	Hire multicultural and multilinguistic RLC staff; train staff; identify and select outcome measures; set up Information Management System to track outcome data.
January 2011	Orient graduate students to field placement; identify RLC referral format; begin schedule of service delivery.
February 2011	Begin implementation of services. Begin evaluation data collection. Pre to post data will be collected continuously according to protocol. Focus group or survey data on implementation process will be collected every three months for the first nine months of implementation.
June 2011	Review first round of evaluation data and complete preliminary report. Make adjustments as needed with guidance from data collected.
September 2011	Develop a comprehensive annual report identifying the strengths and weaknesses of the program thus far, year one (lessons learned). Annual report will also include next round of evaluation data collected. Thereafter, evaluation updates will be completed on a bi-monthly schedule.
October 2011	Meet with MHSA Planning Committees, Mental Health Board, and community stakeholders to present the report.
September 2012	Develop a comprehensive annual report identifying the strengths and weaknesses of the program, year two.

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October 2012	Meet with MHSA Planning Committees, Mental Health Board, and community stakeholders to present the report.
September 2013	Develop a comprehensive annual report identifying the strengths and weaknesses of the program, year three.
October 2013	Meet with MHSA Planning Committees, Mental Health Board, and community stakeholders to present the report to determine the future of the model. End of project.

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.

Measurement of the Primary Learning Goals:

1. To determine if consumer-driven services have better service adherence and mental health outcomes than in the current service delivery system: Outcomes will be measured by comparing a member's current and historical service data as well as members' self-reports.
2. To determine if this consumer-driven service delivery model will reduce internalized stigma related to mental illness and improve members' self-concepts: Participants will receive a pre- and post- evaluation measure designed to identify degrees of self-esteem, self-efficacy, and self-stigma. Pre-to-post data will be analyzed to determine any changes in consumer's self-stigma and/or self-concepts.
3. To determine if adding recovery coaches to WRAP application increases the effectiveness of WRAP application: At program graduation, members will be surveyed on their knowledge and understanding of WRAP concepts and application. Non-RLC department consumers who have participated in WRAP groups without recovery coaches will also be surveyed. Analysis will include a comparison between the two groups on knowledge and understanding of WRAP concepts and application
4. To determine if integrating professional learning into a peer-centered atmosphere will transform the treatment philosophy of the mental health practitioner into a greater welcoming of recovery and consumer-led services. Students will receive a pre- and post- field placement evaluation measure designed to identify knowledge and attitudes toward recovery concepts. Pre-to-post data will be analyzed to determine any changes in attitudes toward recovery and/or knowledge of recovery concepts.
5. To determine the most effective method for delivering this innovative model, implementation at two different clinic sites will be tested. The RLC established at an existing clinic will be compared to the RLC that will be

Exhibit C

offered at a free standing separate clinic. This analysis will focus on identifying and comparing implementation challenges, differences in consumer outcomes, and impact on existing clinic services and culture.

Both qualitative and quantitative data will be utilized to capture information about program implementation including; service data and open-ended survey or focus group information. Measures for consumer self-stigma and measures of clinical staff treatment philosophy from both site applications will also be compared.

The RCDMH Research and Evaluation Unit will work closely with the RLC team to develop the evaluation tools, methods to monitor outcomes and develop reports identifying progress as well as program strengths, weakness, and areas of development.

Riverside County stakeholders will have ample opportunity to learn about the RLC's progress and outcomes. Following the guidelines and principles of the MHSA, Riverside County Department of Mental Health (RCDMH) includes community members and stakeholders in every step of implementation and review, including the development of evaluation measures. Annual reports are presented to all MHSA age group committees and the Mental Health Board. In addition, a Consumer Advisory and Review Committee will be established to provide feedback and recommendation on RLC implementation, development, and activities.

Leveraging Resources (if applicable):

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

Services provided at the RLC that meet Medi-Cal billing requirements will be submitted for reimbursements. Workforce Education and Training unit staff will serve as support and back-up to the RLC personnel. All employed recovery coaches will have met hiring criteria as Peer Support Specialists; many who have received their pre-employment training through a Community Services and Supports (CSS) contract with Jefferson Transitional Programs, a local peer-run support organization.

Additional leverage through local university MSW and MFT programs will include securing a regular pool of graduate students for field placement as well as a cooperative relationship on clinical training. Adding student clinicians through cooperative agreements with schools allows for expanded services and contributions to learning for both the consumer and the student.

Exhibit D

Innovation Work Plan Description (For Posting on DMH Website)

County Name

Riverside County

Annual Number of Clients to Be Served (If Applicable)

1,200 Total

Work Plan Name

Recovery Learning Center

Population to Be Served (if applicable):

The Recovery Learning Center (RLC) will provide services to Transition Age Youth, Adults, and Older Adults with serious emotional disorder and/or serious mental illness. It will also provide supports to individuals with co-occurring substance abuse disorders. It is anticipated that priority populations will include unengaged homeless individuals, high users of services (those from acute-inpatient settings, outpatient crisis services). Adults referred through the criminal justice system and Hispanic populations and other underserved cultures.

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

The intent of the MHSA and recovery practice is to create a new service delivery model, one that is “consumer-driven”, not just consumer-enhanced. Peer run centers typically function only for support and offer socialization, vocational, and consumer education. Developing a mental health services center that is envisioned, developed, and led by peer practitioners is the necessary innovation to truly transform philosophy into service.

The Recovery Learning Center (RLC) will be that peer center. The RLC was conceived and designed by a peer leadership forum which included consumers who have worked as Peer Support Specialists in the public mental health service system, volunteers, peer community leaders, and consumer stakeholders. This consumer group proposed development of a peer-operated mental health services clinic and brought their proposal to Riverside County as a recommended pilot.

Consumers who are served by programs that were developed and implemented by peers have shown better healing outcomes, greater levels of empowerment, shorter hospital stays, and fewer hospital admissions (Dumont & Jones, 2002). The full design of the RLC including program philosophy, physical plant, structure and service delivery were envisioned by people with lived-experience who are dedicated to improving the lives of consumers.

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The RLC will increase the quality of services, including better outcomes, by designing consumer developed mental health services from inception to service delivery instead of offering ancillary peer services which is the current standard of practice. By establishing a program rooted in recovery philosophy and operated by people with lived-experience, the RLC will not only allow for a unique learning experience for consumers, but will also serve as a transformational influence in the overall mental health services system.

Exhibit E
Mental Health Services Act
Innovation Funding Request

County: Riverside County

Date: 5/20/2010

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	Recovery Learning Center/Student Academy	\$6,489,510		\$1,622,377	\$4,055,944	\$811,189
2							
3							
4							
5							
6							
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25							
26	Subtotal: Work Plans		\$6,489,510	\$0	\$1,622,377	\$4,055,944	\$811,189
27	Plus County Administration		\$650,066				
28	Plus Optional 10% Operating Reserve		\$713,958				
29	Total MHSA Funds Required for Innovation		\$7,853,534				

Exhibit F

Innovation Projected Revenues and Expenditures

County: Riverside County

Fiscal Year: 2010 - 2013

Work Plan #: _____

Work Plan Name: Recovery Learning Center/Student Academy

New Work Plan

Expansion

Months of Operation: 10/10 - 06/13

MM/YY - MM/YY

	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers	Total
A. Expenditures				
1. Personnel Expenditures	5,417,219			\$5,417,219
2. Operating Expenditures	2,294,852			\$2,294,852
3. Non-recurring expenditures	464,000			\$464,000
4. Training Consultant Contracts				\$0
5. Work Plan Management			0	\$0
6. Total Proposed Work Plan Expenditures	\$8,176,070	\$0	\$0	\$8,176,070
B. Revenues				
1. Existing Revenues				
2. Additional Revenues				
a) MediCal	1,686,560			\$1,686,560
3. Total New Revenue	\$1,686,560	\$0	\$0	\$1,686,560
4. Total Revenues	\$1,686,560	\$0	\$0	\$1,686,560
C. Total Funding Requirements	\$6,489,510	\$0	\$0	\$6,489,510

Prepared by: Roize Basallo
 Telephone Number: (951) 358-4562

Date: 5/20/2010

**RIVERSIDE COUNTY MHSA INNOVATIONS
BUDGET NARRATIVE
RECOVERY LEARNING CENTER/STUDENT ACADEMY
FY 2010 - FY 2013**

	Budget Amount
A. Expenditures	
1. Personnel Expenditures Estimated 32 months of salaries and county benefits for 27.25 new program FTEs. Staffing consists of 2.0 FTE Mental Health Services Supervisor, 2.0 FTE Clinical Therapist, 2.0 FTE Senior Mental Health Peer Specialist, 16.0 FTE Mental Health Peer Specialist, 1.25 FTE Staff Psych IV, 20.FTE Licensed Vocational Nurse, and 2.0 FTE Office Assistant. Position fulfillment is not limited to full time staff, but could also include part time staff. An additional 26.0 new program FTEs will be staffed as voluntary student interns.	\$5,417,219
2. Operating Expenditures Estimated 32 months of program rent, utilities, building maintenance, equipment rent, communication services , travel, transportation, general office expenditures such as postage, printing, and supplies, medication costs, and program overhead charges such as liability, malpractice, property, and insurance.	\$2,294,852
3. Non-recurring expenditures Estimated cost of equipping new program staff, as well as voluntary student interns, and acquiring and or expanding current office space. These costs will include workstations, computers, printers, telephones, and tenant improvements.	\$464,000
4. Training Consultant Contracts	\$0
5. Work Plan Management	\$0
6. Total Proposed Work Plan Expenditures	\$8,176,070
B. Revenues	
1. Existing Revenues	\$0
2. Additional Revenues a) MediCal New program generated Medi-Cal revenue.	\$1,686,560
3. Total New Revenue	\$1,686,560
4. Total Revenues	\$1,686,560

C. Other	
1. County Administration All general and regional overhead allocated to the new program, including the Fiscal Unit, Program Support, IT Services, Human Resources, and County Support Services.	\$650,066
2. Optional 10% Operating Reserve Additional 10% Operating Reserve requested to fund the new program.	\$713,958
4. Total Other	\$1,364,024
D. Total Funding Requirements	\$7,853,534

**RIVERSIDE COUNTY'S DEPARTMENT OF MENTAL HEALTH
INNOVATION PROJECT TIMELINE:**

Riverside County Department of Mental Health (RCDMH)'s Recovery Learning Center/Student Academy Innovations project is anticipated to require Innovation funding for a period of five years starting FY 2010/11 – FY 2014/15 at an estimated total cost of \$13,484,422. RCDMH will be initially requesting \$7,853,534: \$2,305,202 from FY 2008/09, \$2,755,100 from FY 2009/10, and \$2,793,232 from FY 2010/11 Planning Estimates. It is estimated that these funds will support the first 3 years of the project. The following years will be funded using prior unspent Innovation funds and/or future Innovation planning estimates. The first year Design & Development Phase, is projected to cost \$2,495,553. The second year's Testing Phase is estimated at \$2,645,117. The next thirty months (two and a half years) will be the Learning Phase at a projected cost of \$6,918,651. The final sixth months, known as the Communication of Results Phase, is estimated to cost \$1,425,101.