

NEW/REVISED PROGRAM DESCRIPTION
Innovation

County: Orange

- Completely New Program
- Revised Previously Approved Program

Program Number/Name: INN 02-002 Religious Leaders Behavioral Health Training

Date: April 2, 2014

Complete this form for each new INN Program. For existing INN programs with changes to the primary¹ purpose and/or learning goal, please complete the sections of this form that are applicable to the proposed changes. If there are no changes in the applicable section, please state "No Changes."

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

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

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

Increased access to services: Surveys reveal that some individuals would rather turn to family and friends for help with mental health problems first, religious leaders second and lastly to mental health professionals. Most religious leaders have little to no formal training on mental health issues. A promising direction to increase access to mental health care, reduce stigma and improve community collaboration is to bring a behavioral health training, such as Mental Health First Aid, to the religious community.

This project is designed to increase access to mental health services by introducing formal behavioral health training into the religious community, which will thereby:

- Increase the number of lay persons trained in basic mental health practice skill sets
- Increase access to mental health services through religious communities

There have been other efforts to educate the religious community on addressing mental health in ministry but no documented project with the targeted purpose of training religious leaders to become trainers themselves combined with Peer Specialist case management supportive services. Training the trainer will multiply the reach into religious communities and in turn increase advocacy and opportunities for consumers to access professional mental health resources and services. A team of Peer Specialists will staff this project to assist with trainings and any case management for consumers needing referrals/linkages to County and community mental health services and resources.

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

Description of the INN Religious Leaders Behavioral Health Training Project: (Participant = Religious Leaders)

This project is designed to increase the access to mental health services and referrals that consumers receive within their religious communities. This project will use a train the trainer technique where, a certified behavioral health training program will be used to train religious leaders in Orange County on behavioral health interventions and practices with basic skills sets including, but not limited to: basic listening, suicide prevention and supportive skills. The religious leaders that are trained will receive certification to in turn, train other religious leaders and congregants in the religious communities with these basic behavioral skill sets. The number of religious leaders and congregants that can be trained by each religious leader during and long after the project's end is exponential, as is the number of consumers that can potentially be helped by those trained individuals.

This project will target a variety of 30 faith based organizations and religious establishments to recruit their leaders to receive basic behavioral health training. It is proposed that one leader from each of the recruited organizations will be

¹ The term "essential purpose" has been replaced with the term "primary purpose" for INN.

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trained in basic behavioral health interventions and practices to become certified trainers themselves. These 30 leaders will in turn each hold three trainings per year (with up to 20 people per training) to utilize and maintain his/her certification. Potentially, up to 1800 lay people in various religious organizations will be trained in basic mental health interventions and serve as a gateway to refer those in need to professional services as appropriate.

This project is proposed to be contracted out to a community agency. The contractor may propose and select a mental health certification program that meets the terms of the contract. One example of an existing mental health certification program with a train-the-trainer component, which the contractor may or may not choose, is Mental Health First Aid (MHFA). The MHFA train-the-trainer program requires individuals to complete an intensive five day (32 hours) training program offered by the program's national authorities in order to obtain trainer status and certification. The train-the-trainer trainings are interactive and typically include a written exam and evaluated presentation prior to certification. Train-the-trainer training topics include how to present the program and teach the evidence-supported treatment, intervention and self-help strategies; overviews of learning styles; teaching strategies; and addressing diverse communities in addition to the mental health curriculum in the core certification courses.

For reference, an example of a train-the-trainer certification program, such as MHFA, specifies: "The MHFA Instructor training is held over five days and is taught by two authorized MHFA trainers connected to at least one of the Mental Health First Aid – USA Authorities. Courses typically run from 9am-5pm each day of the program, with dedicated time on day three for independent preparation for presentations delivered on days four and five. The first two days of the program are an interactive overview of the core 8-hour course, where instructor candidates get to see expert trainers model the full course content. The third day reviews the background of the program, target audiences reached, marketing ideas, training tips & tricks, and expectations & privileges for instructors. Day three provides ample opportunity for the group to discuss the program & brainstorm how to best deliver and market it the course, and ask instructor-related questions. During the last two days of the training, each participant will present an assigned 30-40 minute portion of the 8-hour MHFA course to the group. Trainers will conduct an individual evaluation of each participant in addition to the peer feedback provided. Participants are expected to be active in providing peer reviews on days four and five (Mental Health First Aid, 2009)".

The project will be staffed with a team of Peer Specialists to provide assistance to the religious leaders with the trainings and consumer referrals/linkages to County and community mental health resources. The Peer Specialists will handle all coordination, scheduling and administrative support for the religious leaders to both enroll in the trainings as well as when they provide the trainings. Additionally, the Peer Specialists will offer case management and supportive services to consumers in the congregations as needed and referred by the religious leaders or congregant trainees.

It is expected that the religious leaders will announce their certification and trainings to their congregation/community as an effort to outreach support and services for the project.

Each trained religious leader will be asked to keep documentation of number of people they train as well as number of individual mental health referrals given out to congregants for the duration of the project.

The issue and learning goal addressed:

The learning contributions from this project involve studying the collaboration between the religious and mental health communities. Having this type of support available in the religious community breeds a supportive environment which provides a unique opportunity to engage consumers and/ or their family members to address mental health issues that they might not otherwise have had exposure to. The goal of having more religious leaders and religious community members trained in mental health basics is in no way to replace professional mental health support, but rather to assess the person for risk of harm or suicide, listen non-judgmentally, give reassurance, and help to encourage identified consumers to seek and access professional mental health support as applicable and needed, increasing access to mental health services. The physical presence of a trained individual not only increases and eases access to resources and services, but also helps display the support of the religious community to help de-stigmatize mental illness. This integration of mental health services demonstrates to consumers, that the religious community recognizes and values these services.

Expected learning outcomes:

Learning outcomes will assess if training religious leaders to be certified behavioral health trainers will result in:

- Increased participant's understanding of mental health
- Increased number of lay persons, specifically in various religious communities, trained in basic mental health practice skill sets
- Increased access to mental health services through religious communities

Bringing certified behavioral health training to religious communities introduces practices that have been highly successful

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in other non-mental health contexts. Behavioral health training programs such as, "Mental Health First Aid", have a proven track record in various settings including but not limited to: religious settings, primary care, corporations, business communities, schools, law enforcement, corrections, nursing homes as well as the general public. Interactive basic behavioral health training presents an overview of mental illness and substance use disorders and builds an understanding of issues, interventions and treatment. Those who take the course will learn skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social and self-help care (2009, National Council for Community Behavioral Healthcare). This infusion of behavioral health training to the religious communities, specifically the religious leaders and the congregations willingness to engage in this project, will contribute to answering the question of whether such an ongoing collaboration is feasible and beneficial as a long-term partnership between the religious communities and the field of mental health.

Data capturing training completion rates, mental health referrals and linkages will be collected to measure the impact of introducing behavioral health training to the religious communities. The number of individuals trained by each religious leader will be tracked and reported. All identified participants and their "trainees" (other religious leaders and congregants) will be tracked for completion of behavioral health trainings. Every participant and additional trainees will be given a pre/posttest to assess increase in mental health awareness after the training. Additionally, any referrals/linkages provided by the Peer Specialist will be tracked and documented.

Meets MHA definition of Innovation:

This project integrates best practices/approaches that have been developed within mental health communities through a process that is inclusive and representative of unserved and underserved individuals within the religious communities. This project empowers religious leaders to become certified trainers which gives each trained leader the ability to continue training other leaders and congregants long after this project's end.

The Train-the-Trainer approach is a widely acknowledged practice successfully used across many disciplines. This training approach assigns one experienced trainer to train a larger group of new trainers; the new trainers, in turn, have the ability to train an unlimited numbers of others. There are many benefits of recruiting leaders internally from the religious community to become trainers. Internal trainers can be more effective because they have a deeper understanding of the religious culture, congregants, perceptions, and a pulse on the religious community at large. This familiarity can increase the learner's retention and understanding of the training material (Hill I, Palmer A, Klein A, et al. Assessing the Train-the-Trainer Model: An Evaluation of the Data & Democracy II Project. 2010).

This project is important as the reach into the religious communities will be exponential and limitless with the train the trainer approach to bring mental health awareness into the religious communities. Consequently, stigma will be reduced and consumers who naturally turn to their religious communities will be encouraged to access and utilize professional mental health services as applicable and needed.

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

This Innovations Project supports and is consistent with the General Standards identified in the MHA and Title 9, CCR, section 3320, as demonstrated by the following:

Community Collaboration: Specifically the project promotes collaboration of the religious community, the mental health field, and County/community mental health resources. The Peer Specialists staffing the project will work with religious leaders to provide referrals and linkages for consumers to a range of mental health education and services available within County as well as through community partners.

Cultural Competence: When introducing mental health to different religions and cultures it will important to know how the different religious denominations and cultures have historically/culturally viewed mental health. Presentations will have to give considerations to any existing biases and work with the religious leaders to address and reduce stigma supporting thoughts and practices. Having religious leaders from the community, train as trainers, will promote religious cultural sensitivity.

Client and Family-Driven Mental Health System: This project encourages and gives access to the religious community, including consumers and family members, to a better understanding of mental health, and increased access to services. The religious leaders will encourage congregants, especially consumers and family members, interested in learning more about mental health to enroll in the trainings.

Wellness, Recovery, and Resilience Focused: This project is focused on wellness, recovery and resilience. It

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increases and eases access to mental health education and resources with the expectation that increased understanding of mental health will help to destigmatize mental illness in the religious communities. The training in this project teaches the religious community to focus on the consumer's strengths and the development of resilience in the promotion of recovery and total wellness.

Integrated Service Experience: This project provides an integrated service experience for participants, as they will have immediate access to a Peer Specialist to assist with County/community mental health referrals and linkages. Inherently, this project creates an integrative service experience connecting the religious communities and mental health systems.

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

(Participant = Religious Leaders)

Target population: This project will target a variety of 30 faith based organizations and religious establishments to recruit their leaders. It is proposed that one leader from each of the recruited organizations will be trained in behavioral health basic interventions and practices. In turn, the number of additional religious leaders and congregants that can be trained by the participant religious leaders is exponential.

Served: This project will train, 30 religious leaders annually

Demographics:

It is the intention of the project to recruit adult religious leaders from a variety of denominations throughout Orange County. The trainings will be offered to Transitional Age Youth and adult congregants from each religious organization and will reflect the cultural and linguistic needs of each group.

3. Describe the total timeframe of the program. In your description include key actions and milestones related to assessing your Innovation and communicating results and lessons learned. Provide a brief explanation of why this timeline will allow sufficient time for the desired learning to occur and to demonstrate the feasibility of replicating the Innovation. Please note that the timeline for your Innovation Program can be longer than the period for which you are currently requesting Innovation Component funds.

The Religious Leaders Behavioral Health Training Innovations Project is proposed to be contracted out. It is proposed that service delivery will run 2 ½ years; program evaluation will take place throughout the duration of the project with a decrease in trainings during the final year and increase in summative analysis and evaluation at the project's end, for a total of 3 years dedicated to this project. At the project's end, based on the evaluation, a continuation plan will be developed and a different funding source identified.

It is expected that this time frame will allow Orange County Department of Behavioral Health sufficient time to assess the progress of this Innovations Project, make any necessary adjustments, and communicate the contribution to learning to the community, stakeholders, and other interested Counties and State agencies.

Months 0-3:

It is expected that the first three months of the project will be spent with county management staff working with contractors that want to implement this project. Following the completion of contractual arrangements with a provider and hiring of the staff, the project will simultaneously train Peer Specialists (consumer/family members) staffing this project and recruit a variety of religious leaders to receive the behavioral health train-the-trainer certification. A certified behavioral health training program will be selected for the train-the-trainer project. Recruitment will occur through outreach, networking and presentations to local religious groups and individual contacts.

Month 6:

At six months, the Religious Leaders Behavioral Health Training Project will have enrolled 15 religious organizations, each with 2 identified religious leaders to enroll in the 5 day train-the-trainer courses. The 15 trained participants will prepare and begin to offer trainings for their congregants. The Peer Specialists staffing this project will handle all scheduling, coordination and administrative aspects of the trainings that are provided to the religious leaders and by the religious leaders. Outreach material/project brochures will have been created and distributed.

Year 1:

At year one, the project will have an additional 15 religious organizations, each with an identified religious leader enrolled

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in the 5 day train-the-trainer courses. Year one will conclude with a total of 30 various religious organizations participating in the project and a total of 30 trained religious leader participants. Each trained religious leader will conduct three trainings for congregant members within a year of receipt of their trainer certification.

Program evaluation will continue throughout the duration of the project, as data is collected. Quarterly programmatic reviews will give the project team opportunities to identify any policy or procedural changes needed to refine the project and services. Data on religious leader training enrollment, religious leader training completion, number of trainings provided by the religious leaders, number of individual trainees trained by the religious leaders, pre/posttest mental health awareness surveys, and referrals/linkages will continue to be collected for the duration of the project. The project will be revised based upon recommendations that come out of reviewing the annual outcome analysis.

Year 2:

An additional 30 religious organizations, each with one identified religious leader enrolled in the 5 day train-the-trainer courses. Year two will conclude with a total of an additional 30 religious organizations and an additional 30 trained religious leader participants. Each trained religious leader will conduct three trainings for congregant members within a year of receipt of their trainer certification.

Year 3:

Enrollment of new religious leaders will be closed. The first half of the year will include trainings previously scheduled. The final year will be primarily dedicated to program evaluation. All of the project data for the 2 ½ years of project service will be analyzed and reported formally to document the outcomes and lessons learned from this project. This report will be prepared for the MHSO Oversight and Accountability Commission, community, stakeholders and any other County/State agencies interested in project outcomes and lessons learned from this Innovations Project.

Orange County MHSO Innovation Coordination, project staff will conduct workshops presenting the results to the County public stakeholders as well as at statewide and national conferences, as requested. Our hope is to be able to disseminate research findings, encourage the replication of successful approaches and continue the Religious Leaders Behavioral Health Training project using other funding sources.

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

Evaluation plan to measure the results, impacts and lessons learned:

Project evaluation will occur throughout the duration of the project with final summative analysis conducted during year 3. All participants and subsequent trainees will be tracked for completion of mental health training courses. Any referrals/linkages to mental health services/resources will be tracked and reported on a monthly basis. Mental health awareness pre/posttests will be given before and immediately after any mental health trainings.

To examine the benefits of mental health training, this project will collect and compare data from the 2 ½ years of the project and analyze two generations of data. Generation 1: pre/posttests mental health awareness surveys of the identified participant (religious leaders) will assess if the trainings increase mental health knowledge for the religious leaders. Tracking referrals/linkages given by the religious leaders after their trainings, compared to self-reports of referrals/linkages given prior to the training, will assess if the training changed their behavior when dealing with mental health issues. Generation 2: pre/posttests mental health awareness surveys of the congregant trainees (those individuals who receive training from the religious leaders) will assess if the trainings increase their mental health knowledge. Tracking referrals/linkages given by the trainees after their trainings, compared to self-reports of referrals/linkages given prior to the training, will assess if the training changed their behavior when dealing with mental health issues.

Outcomes measures:

Performance outcomes will be measured by intake and enrollment data, self-assessment surveys and interviews. This project will collect data that will help evaluate the utilization and effectiveness of the training program. Enrollment and completion of train-the-trainer and general training numbers will be tracked. Each religious leader and subsequent trainees will be given a survey and a pre and post mental health awareness survey to gauge their increase in knowledge about mental health compared to those religious leaders who did not participate in the project. Each religious leader and those trained will be asked to keep track of mental health referrals and linkages given out. After the project's end, if the County chooses to continue these services, the project work plan will explore and consider transition to CSS funding and/or other funding sources.

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Additional data to be tracked will include: the number of religious leaders trained, the number of congregants trained by each religious leader and direct referrals/linkages to mental health education, programs and services.

It is expected that participants of the project who enrolled and completed behavioral health training would show improvement in the following areas, as measured by self-assessment tools:

1. Religious Leader Participants will show an increase in understanding/awareness of mental health, as evidenced by an increase in mental health awareness survey scores.
2. Trainees (those trained by the Religious Leaders) will show an increase in understanding/ awareness of mental health, as evidenced by an increase in mental health awareness survey scores.
3. Participants and trainees will report increased referral/linkage to County/community mental health services and resources, as evidenced by self-report data logs.

Measurement Tools: OCHCA Mental Health Awareness Survey, referral/linkage data

The data from participant pre and post Mental Health Awareness Surveys will be used to measure increase in knowledge. Self-report tracking logs will be used to assess the number of referrals/linkages given out.

Outcomes evaluation:

The Innovation Advisory subcommittee of the Orange County MHSA Steering Committee (which includes consumer and family member representation) will review and provide input on the draft assessment procedures before the procedures are finalized. Following data collection and analysis, the Innovation Advisory subcommittee will review the project results and provide their assessment of the achievement of learning objectives.

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

N/A

6. Please provide a budget narrative for total projected costs for the entire duration of the Innovation Program, and also provide projected expenditures by each fiscal year during the program time frame, including both the current and future funding years. (For Example, Program 01- XXXX, the entire project is \$1,000,000. The first year projected amount will be \$250,000, the second year projected amount is \$250,000, the third year is \$250,000 and the fourth year is \$250,000.) Please also describe briefly the logic for this budget: how your proposed expenditures will allow you to test your model and meet your learning and communication goals.

The projected total budget for this project is \$1,087,115: including one month in the 2013-2014 fiscal year for administration; three years of project services (FY 2014-2017).

FY 2013-2014 administration projected amount is: \$10,805; The first project year projected amount is \$429,032; the second project year projected amount is \$421,101; and the third project year projected amount is \$226,176.

The budget incorporates personnel costs and operating costs. Each staff member position funded in this budget is essential to the provision and coordination of services for this project. The Peer Specialists will serve as support for the religious leaders to coordinate and schedule all matters related to the trainings. In addition, the Peer Specialists will also act as case manager/advocates to provide referrals/linkages to County/community based mental health services and resources as applicable and needed. The operation costs include training materials, training student books, and general office printing and supplies for the project. The budget incorporates a percentage of a County work plan management team to help develop project design, develop and monitor project infrastructure, guide data collection and evaluation, and offer supervision and support to the project. The budget for the final year of the project reflects a decrease in operating expenses, as trainings we begin to wind down and as staff efforts are turned to focus on project evaluation. One time non-recurring costs include the purchase of computer technology for the project staff- the use of laptops and projectors will help make the staff mobile and able to facilitate the behavioral health trainings in the field at various locations in the religious community. Work plan management costs, as described below, are spread across the Innovation Projects for the percentage of time dedicated to each project.

After the project's end, if the County chooses to continue these services, the project work plan will explore and consider transition to CSS funding and/or other funding sources.

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7. Provide an estimated annual program budget, utilizing the following line items.

Below please find the estimated annual budget as requested, Project Year 1 (FY 14-15). This year was chosen to illustrate estimated costs to run the project at its peak capacity. Budget amounts have been rounded up to the nearest whole dollar.

NEW ANNUAL PROGRAM BUDGET

A. EXPENDITURES

	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/CBO's	Total
1.	Personnel			78,728	78,728
2.	Operating Expenditures			170,000	170,000
3.	Non-recurring Expenditures			6,896	6,896
4.	Contracts (Training Consultant Contracts)				
5.	Work Plan Management	173,408			173,408
6.	Other Expenditures				
	Total Proposed Expenditures	\$173,408		\$255,624	\$429,032
B. REVENUES					
1.	New Revenues	0		0	0
	a. Medi-Cal (FFP only)	0		0	0
	b. State General Funds	0		0	0
	c. Other Revenues	0		0	0
	Total Revenues	0		0	0
C. TOTAL FUNDING REQUESTED		\$173,408		\$255,624	\$429,032

D. Budget Narrative

1. Provide a detailed budget narrative explaining the proposed annual program expenditures for each line item.

This project is being considered to be contracted out to a community based organization. The following budget narrative is an estimate based on initially anticipated expenses. The final budget will depend on the selected contract provider's proposal.

Personnel: Suggested staffing will include 2 (FTE) Peer Specialists who will serve as training support and case manager/advocates for project participants. Staffing patterns will be suggested by County but project personnel will depend on contract provider's proposal.

Operating Expenditures: Operating expenses include services and supplies, which include phone/email, desks, computers, printing, training materials, office supplies, etc. One time training certification fees for the religious leaders is an operating expense that occurs in Project Years 1 and 2. Training handbooks for the trainees enrolled in the leader's trainings will be included as operating expenditures. Operating expenses decrease in the last year of the project as services wind down and project evaluation ramps up.

Non-recurring Expenditures: Start-up costs will include laptops and portable projectors as training tools.

Work Plan Management: Included in work plan management will be a team to provide project and administrative oversight and support. Work plan management, includes ongoing project development, project management, planning, contract monitoring, data collection, supervision support, project evaluation and outcome reporting.

Program Evaluation: The contractor selected to implement this project will be expected to have the capability to create/use a database to collect and analyze all program data. It will not be known until the contractor is selected, if there is a need to include software purchase for the purpose of program evaluation but will be an expected and approved cost if needed.