Mental Health Services Act Innovation Plan

New Proposed Projects

June 2014

RECEIVED
AUG 14 2014
MHSOAC

Table of Contents

New Proposed Innovation Projects 3
Exhibit A: Innovation Work Plan County Certification 4
Exhibit B: Description of Community Program Planning and Local Review Processes 5
Introduction to Exhibit C's Innovation Work Plans 8
Exhibit C: Cognitive Remediation Therapy Program (CRT) 9
Exhibit C: Alliance for Building Communities 18
Exhibit C: Employment Stability Project 29
Exhibit D: Description for Cognitive Remediation Therapy 41
Exhibit D: Description for Alliance for Building Communities 42
Exhibit D: Description for Employment Stability 43
Exhibit E: MHSA Innovation Funding Request, FY 14/15 44
Exhibit E: MHSA Innovation Funding Request, FY 15/16 45
Exhibit E: MHSA Innovation Funding Request, FY 16/17 46
Exhibit F: Innovation Projected Revenues and Expenditures 47

Attachment A - Sign-In Sheets from Public Hearing 55

Attachment B - Summary of Outreach and Participation in the Planning Process and Public Hearing 67
Roster of Participants 68
Planning Process and Public Hearing Outreach by various demographics 71

Attachment C -Summary of Written and Oral Feedback from May 22, 2014 Public Hearing 72
Summary of Written Feedback 73
Summary of Oral Feedback 76

Attachment D – Summary of Recommendations for Program Improvement 77
Phase One Workgroup Recommendations 78

New Proposed Innovation Projects

Exhibit A: Innovation Work Plan County Certification

County Name: Tri-City Mental Health Center

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

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

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

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

Jesse H Duff	8-8-14	Executive Director
Signature (Local Mental Health Director)	Date	Title

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

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

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

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

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

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

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

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

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

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

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

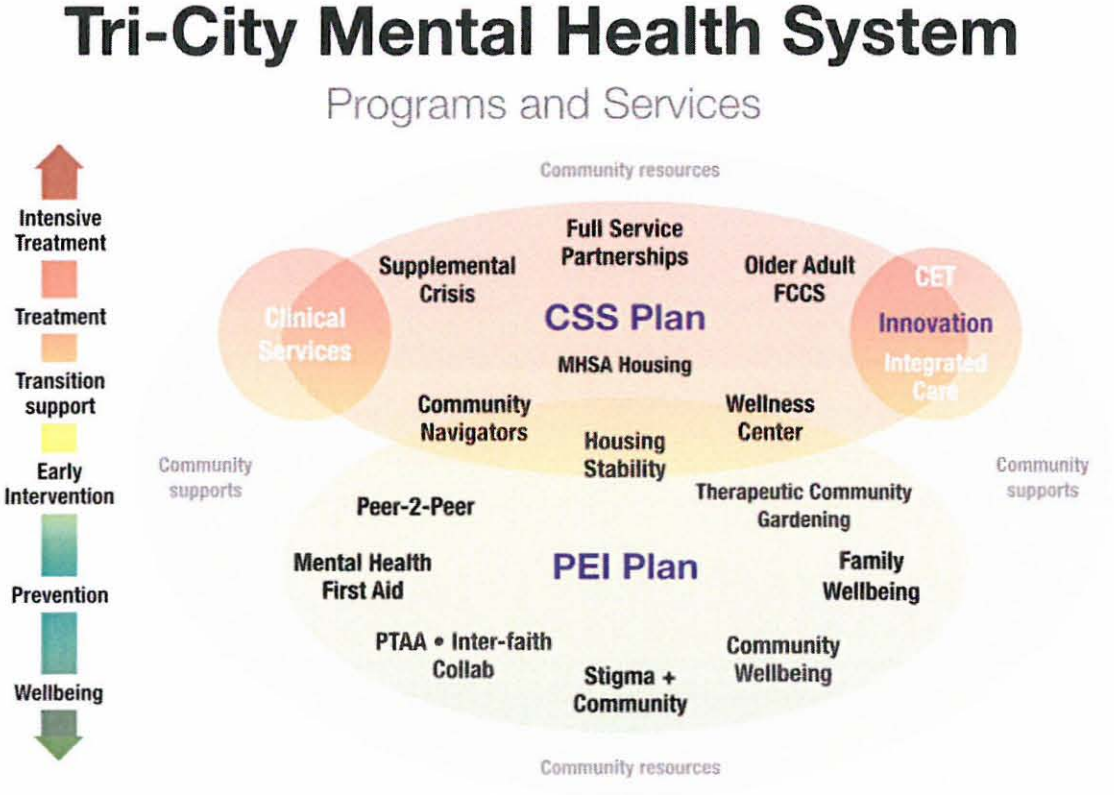
This addition to our Innovation Plan is included as part of TCMHC's Annual Update and Three-Year Program and Expenditure Plan, which was posted on April 21, 2014, and the required 30-day review process ended on May 20, 2014. Staff circulated a draft by making electronic copies available on TCMHC's website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

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

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

Introduction to Exhibit C's Innovation Work Plans

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



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

Exhibit C: Cognitive Remediation Therapy Program (CRT)

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

Primary Purpose of Proposed Innovation Project

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

Briefly explain the reason for selecting the above purpose.

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

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

Project Description

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

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

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

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

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

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

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

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

Contribution to Learning

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

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

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

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

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

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

Timeline

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

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

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

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

March 2015 – June 2015: Preparation for launch

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

July 2015 – April 2017: Full implementation

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

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

May-June 2017

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

Project Measurement

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

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

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

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

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

How much did we do?

- How many participants enrolled in the program?

How well did we do it?

- How many enrolled participants completed the program?

Is anybody better off?

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

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

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

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

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

Leveraging Resources (if applicable)

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

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

Exhibit C: Alliance for Building Communities -- WITHDRAWN

Date:	**April 21, 2014**
County:	**Tri-City Mental Health Center**
Work Plan #:	**4**
Work Plan Name:	**Alliance for Building Communities**

Primary Purpose of Proposed Innovation Project

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

Briefly explain the reason for selecting the above purpose.

Program data, staff experiences, and community members' experiences suggest that there is a need and readiness to engage historically underserved people in the three cities by partnering with informal community leaders in new ways. TCMHC's large immigrant population includes many people who are not eligible for services under the Affordable Care Act. While there are no data available specific to our three cities, it is estimated that 11% of Los Angeles adults are undocumented, and that nearly one in five Los Angeles children have an undocumented parent.[1] In addition, staff members of our mental health programs consistently see considerable unmet need for mental health services among cultural, ethnic and faith-based groups (e.g., Latino, Hispanic, Vietnamese, Asian-Pacific Island, Islamic). For members of these groups, they may be at risk of serious mental illness or experiencing the onset of serious mental illness, but acknowledging mental illness carries significant stigma and seeking mental health services is either unacceptable or not possible.

Meanwhile, through our programs, we are finding volunteers, residents, and consumers in underserved communities with natural, untapped leadership skills and a desire to share information about supporting each other's mental health. TCMHC sees an opportunity for these "hidden" leaders in underserved communities to be engaged to increase access for underserved groups to services, particularly for those at risk of or experiencing the onset of serious mental illness. For example, TCMHC's Therapeutic Community Gardening (TCG) program helps people transition from intensive to less intensive services and to more independence. When they are ready to leave the program, some participants look for ways to stay connected to the support while they move onto more independent lives. Staff members see potential for these participants to be trained as leaders and serve as mentors to other program participants and to be trusted, well-informed advocates.

[1] Pastor, Manuel and Enrico Marcelli. Center for the Study of Immigrant Integration, "What's at Stake for the State: Undocumented Californians, Immigration Reform, and Our Future Together." May 2013.

Our hypothesis is that these newly-trained, culturally-diverse leaders with lived experience of mental illness in underserved communities will expand outreach in the three cities area, and as a result, TCMHC will experience increased access to underserved groups as evidenced through:

- A decreased burden on intensive mental health services as more underserved residents seek care before crisis services are needed;
- A shift in who approaches and initiates conversations with hard to reach, underserved Tri-City residents from mental health staff to newly trained and empowered natural community leaders; and
- Reduced stigma of accessing mental health services and improved understanding of mental health.

Project Description

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

Inspired by the Promotoras model for community health, this project seeks to provide leadership development and community organizing training to those with lived mental health experience and natural community leaders in currently underserved communities. Participants would be identified by program staff and community partners and would be known and naturally influential in their communities. The new elements of this program from the Promotoras model are: 1) training those with lived mental health experience, and 2) using the model for the purpose of extending the capacity of the mental health system beyond professional staff into underserved communities.

We expect those trained to be able to:

- Advocate for their own mental health needs and for others in the communities in which they live;
- Move from a stance of recipient of service to a stance of one who can render a service of value; and,
- Partner with TCMHC staff in new ways to expand and deepen relationships with people at risk of serious mental illness and groups who historically do not access services or do so only at the onset of serious mental illness or other crisis.

Current promotoras trainings will need to be adapted for people with lived experience. For example, we may need to spend more time discussing and working through self-stigma and practice strategies for addressing stigma in the general population. We anticipate that these trainings will also help us collectively evolve our understanding of what it means to be a leader in mental health.

We anticipate a total of 45-70 participants in the project and a cohort of 15-20 trainers who can conduct the workshops on a volunteer basis. Our adaptation of this leadership development model has the potential to advance the transformation of TCMHC's mental health system by enhancing the outreach and impact of our programs without additional staff, particularly for underserved cultural groups. For example, in TCMHC's Housing Stability project, recipients of services who are doing well and who have natural leadership skills are wanting to develop the skills needed to help new recipients succeed. There is potential to develop their skills to work with landlords and partner with TCMHS staff in expanding housing for people with mental illness. We see additional potential populations for whom this leadership model could be adapted such as seniors, youth, and veterans.

We have already identified a potential "base" curriculum that we can use and adapt. We also expect to develop another curriculum after the first cohort for training trainers.

This Innovation project supports and is consistent with MHSA values. By its nature, it supports greater community collaboration as we are providing leadership development opportunities as a way to expand our system of care beyond professional staff. It will help improve cultural competency as we learn more about how people of various communities understand mental illness and prefer to seek out care. It is consumer- and family-driven as the feedback provided by participants will help evolve the program, and because it acknowledges and relies upon the leadership of people with lived experience for its success. The project will assist with creating integrated service experiences because participants will be trained about how the different services (e.g., mental health, physical health and substance abuse) fit together and about available resources. Lastly, the participants in this project will model what is possible when we focus our systems of care on wellness, recovery, and resiliency and become an inspiration to others.

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)

Despite new MHSA programs, unmet need continues to escalate, particularly among unserved and underserved populations. Thousands of people in the Tri-City area could benefit from formal services and informal supports but are unlikely to receive them at current staffing and budget levels. This project is one way TCMHC is looking to formalize our model of supporting the communities' capacity to function as a system of care.

This project makes a change to the Promotoras model as an existing mental health system practice/approach and adapts it to a new target population and orients it towards a new purpose. While there are many adaptations of the Promotoras model in existence, none that we know of focus on training people with lived experience of mental illness as consumers or family members.

The main learning question we identified is: If we provide training and support to people who have lived experience with mental health and who already have a network of relationships or who have the capacity to build relationships and trust within under- and un-served communities, can they help us extend the reach of Tri-City mental health programs where relevant and strengthen the array of informal community supports to help people who currently don't or can't access professional services until they are at risk of or experiencing the onset of serious mental illness?

Additional learning questions for the RBA-based evaluation process include:

- Will people who receive services and other informal leaders of underserved and unserved communities, take advantage of leadership development opportunities and experience these opportunities as empowering and help community members attend to and support each other's wellbeing? Does this new model of leadership development decrease internal and external stigma among people who receive the training?
- Does this project reduce internal and external stigma among people who are engaged by the project participants?
- Will the project promote early intervention and help people access the support they need before it becomes a crisis?

As outcomes, we expect those trained to be able to:

- Advocate for their own mental health needs and for others in the communities in which they live;
- Move from a stance of recipient of service to a stance of one who can render a service of value; and,

- Partner with TCMHC staff in new ways to expand and deepen relationships with people at risk of serious mental illness and groups who historically do not access services or do so only at the onset of serious mental illness or other crisis.

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: 7/14-6/16

Phase 1: Development (July-December 2014)

- Adapt the Promotoras curriculum to Tri-City and the project intention. The adaptation would build on the leadership development experience and lessons learned in a number of TCMHC programs including Community Well Being, Mental Health First Aid, Integrated Care Project, and Therapeutic Community Gardening.
- Develop a recruitment process (e.g., invitation, application, interview, screening) using a targeted approach working with and through internal TCMHC programs (e.g., Integrated Care Project, Wellness Center, TCG, CWB, MFHA, Community Navigators, P2P), NAMI, faith communities, Courageous Mind, mental health, social service and other partners.
- Identify and recruit participants for leadership development training. (15-25 per class)
- Define data to be collected and collection methods to assess non-professional leadership development.
- Design the process for assessing and learning from collected data.
- Recruit and hire the evaluator.
- Conduct a community evaluation of access and engagement of community health services in order to establish a baseline
- Develop pre- and post-testing for the trainings.

Phase 2: Training: 1st Class (January - April 2015)

- Train recruited participants.
- Participants and staff develop shared understanding and align intention regarding what they will do once trained (this could be part of the curriculum). Define specific actions/processes to build trusting relationships and relevancy with individuals and communities who are underserved and unserved, and develop (participants and staff) systems of ongoing support for program participants.
- Collect, assess data and implement process for learning from collected data.

Phase 3: First Class in Action: (May 2015 - ongoing)

- Put in place systems of support. For example, establish regular meetings of participants as a group with lead TCMHC staff (modeled after Integrated Care Project Advisory panel); coordinate with appropriate TCMHC staff and community partners to build relevant support for those participants who will be linking to individuals and communities through specific programs (e.g., through Therapeutic Community Gardening, Integrated Care Project, Housing, Community Wellbeing, other PEI and CSS programs)

- 1st Class Participants begin interacting with individuals and in communities as defined during Phase 2. For example, through developed listening skills, newly trained leaders would identify needs within the community. Then these leaders would use their developed advocacy and community organizing skills to help meet those needs including linking people to needed resources within the community.
- Collect and assess data.
- Implement process for learning from collected data.

Phase 4: Assessment, Learning, and Refinement (July - September 2015)

- Create opportunities to reflect on assessments and learning from Phases 1-3.
- Based on lessons learned adjust the recruitment process, modify the training and strengthen the systems of support as needed for non-professional participants
- Continue supporting the first class of trained leaders.

Phase 5: Develop Curriculum and Train the Trainers (May - September 2015)

- Develop Train the Trainer curriculum. Adapt a Train the Trainer promotoras curriculum to TCMHC needs. Build on leadership development experience in TCMHC programs and in Phases 1-4 of this Innovation project.
- Identify and recruit a group to be trained as trainers (15-20 participants). Use a similar targeted approach as with the first class of participants. Potential trainers do not have to have participated in the first class to qualify to become trainers. Work with and through internal programs and community partners to identify people with lived experience, with developed or the capacity to develop relationships in under and unserved communities and who are willing to commit to this level of training and ongoing engagement.
- Train recruited people as trainers. During training, define with participants strategies for trainers such as potential trainings they might do and where, community events, small groups they might convene once they have the tools and skills to organize and conduct trainings in communities where they live, work and play and to be able to hear, in the voices of community members, what they may need. Participants and staff together assess need and develop appropriate system of support for trainers to do training. This support will be the same as the support for the first class of trained participants with amendments as needed for trainers.
- Work with trainers to develop pre- and post-tests for the trainings they provide
- Recruit and select the second class of non-professional participants (could be part of Train the Trainer curriculum).
- Define data to be collected and collection methods to assess train the trainer element.
- Design process for assessing and learning from collected data.

Phase 6: Training: 2nd Class (October - December 2015)

- Newly-trained trainers will conduct the second class of recruited participants.
- 2nd class: Repeat Phase 2 steps, incorporate lessons from Phase 4, and adapting to the specific circumstances and requirements of this 2nd class of participants.

- Trainers: Put in place any supports needed for new trainers beyond those already in place so they have what they need to continue as trainers
- Continue supporting the first class of trained leaders.

Phase 7: Second class in Action; 1st Class ongoing (January - June 2016)

- 2nd class begins interacting with individuals in communities: Repeat Phase 3 Steps (a), (b), (c) and (d) incorporating lessons from Phases 4 and 6 and adapting to the specific circumstances and requirements of the 2nd class.
- Based on lessons learned to date, refine and continue providing the systems of support for the 1st and 2nd classes and for trained trainers.

Phase 8: Final learning events, Final reflections, Final report (January - June 2016)

- Using the collected and assessed data, create opportunities with participants, staff, community partners and key stakeholders to reflect and harvest the lessons from the experience.
- Conduct a final community evaluation of access and engagement of community health services in order to compare to baselines established at the beginning of the project
- Based on the project lessons, discern how to proceed with specific measures (e.g., actions, policy or program changes, other training) in order to transform the system as indicated and sustain changes. For example, link ongoing training and support for trained leaders and trained trainers with compatible efforts in extant programs such as Community Wellbeing and Mental Health First Aid. Ensure opportunities for regular leadership check-ins among participants and ongoing updates in order to stay current. Consider the use of technology such as online training and social media as potential resources for sustaining ongoing support and engagement.
- Continue supports for trained leaders in the 1st and 2nd classes and for the trained trainers.
- Document and disseminate findings through annual stakeholders meetings and presentations at conferences

Project Measurement

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

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

How much did we do?

- Number of non-professional leaders trained

How well did we do it?

- Demographics of those trained
- Trainee completion and attrition rates
- Trainee satisfaction
- Trainees experiencing a sense of empowerment
- Changed perceptions of mental health, mental illness (reduced stigma)

Is anybody better off?

- People accessing services sooner—e.g., prevention and early intervention services
- Diverse people, representing hard to reach, traditionally underserved cultural, ethnic, and faith groups, increase their access to mental health services and their experience of personal wellbeing.
- Number of underrepresented groups coming for services

In addition, TCMHC will hire an evaluator (to be shared among all three Innovation projects) for the purposes of conducting a more rigorous evaluation of project, including the impact of the adaptations to the Promotoras model for people with lived experience.

Perspectives of project trainees, community partners, front line and administrative staff and organizational leadership will be involved in the assessment. Other stakeholders will be identified as the assessment process unfolds and can be engaged in regular stakeholder gatherings and other relevant community venues. People who have taken the training will invite those they have engaged to participate.

Leveraging Resources (if applicable)

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

Extending the capacity of the community to support mental health and recovery is essential to TCMHC's system of care. If this training methodology proves successful, we will find cost-effective ways to incorporate it into our work and continue to support participants and trainers. In addition, many of the CSS, PEI and WET programs we have already developed fit in well with supporting these new community leaders, so we expect that the lessons from this Innovation project can be easily absorbed.

Exhibit C: Employment Stability Project

Date:	**April 21, 2014**
County:	**Tri-City Mental Health Center**
Work Plan #:	**5**
Work Plan Name:	**Employment Stability Program**

Primary Purpose of Proposed Innovation Project

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

Briefly explain the reason for selecting the above purpose.

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

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

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

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

- To create a healthier work environment;

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

Project Description

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

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

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

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

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

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

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

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

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

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

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

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

- Building a cohort among employers;

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

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

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

Contribution to Learning

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

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

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

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

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

Timeline

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

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

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

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

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

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

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

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

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

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

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

Project Measurement

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

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

How much did we do?

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

How well did we do it?

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

Is anybody better off?

- Number of clients placed in new position(s)

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

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

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

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

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

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

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

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

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

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

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

Leveraging Resources (if applicable)

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

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

Exhibit D: Description for Cognitive Remediation Therapy

(For Posting on DMH Website)

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

Population to Be Served (if applicable):

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

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

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

Exhibit D: Description for Alliance for Building Communities -- WITHDRAWN

(For Posting on DMH Website)

County Name: Tri-City Mental Health Center
Work Plan Name: Alliance for Building Communities
Annual Number of Clients to Be Served (if Applicable): 45-70 total

Population to Be Served (if applicable):

Through our CSS and PEI programs, TCMHC staff are finding volunteers, residents, and consumers in underserved communities with natural, untapped leadership skills and a desire to share information about supporting each other's mental health. TCMHC sees an opportunity for these "hidden" leaders in underserved communities to be engaged to address the mental health needs and help TCMHC access underserved communities in ways that our outreach efforts cannot.

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

Inspired by the Promotoras model for community health, this project seeks to provide leadership development and community organizing training to those with lived mental health experience and natural community leaders in currently underserved communities. Participants would be identified by program staff and community partners and would be known and naturally influential in their communities. The new elements of this program from the Promotoras model are: 1) training those with lived mental health experience, and 2) using the model for the purpose of extending the capacity of the mental health system beyond professional staff into underserved communities.

We expect those trained to be able to:

- Advocate for their own mental health needs and for others in the communities in which they live;
- Move from a stance of recipient of service to a stance of one who can render a service of value; and,
- Partner with TCMHC staff in new ways to expand and deepen relationships with people and groups who historically do not access services or do so only when in extreme crisis.

Exhibit D: Description for Employment Stability

(For Posting on DMH Website)

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

Population to Be Served (if applicable):

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

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

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

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

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

Innovation Work Plans			FY 14/15 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	#01	Modifications to Cognitive Enhancement Therapy	$177,581	$0	$58,602	$118,979	$0
2	#02	Integrated Care (previously Integrated Services)	$288,264	$72,066	$72,066	$72,066	$72,066
3	#03	Cognitive Remediation Therapy Project	$137,626	$0	$45,417	$92,209	$0
4	#04	Alliance for Building Communities – WITHDRAWN	$0	$0	$0	$0	$0
5	#05	Employment Stability	$203,092	$0	$50,773	$152,319	$0
6							
7							
8							
9							
10	Subtotal: Work Plans		$806,563	$72,066	$226,857	$435,573	$72,066
11	Plus County Administration		$121,000				
12	Plus Optional 10% Operating Reserve						
13	Total MHSA Funds Required for Innovation		$927,566				

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

County: Tri-City Mental Health Center

Date: April 21, 2014

Innovation Work Plans			FY 15/16 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	#03	Cognitive Remediation Therapy Project	$392,690	$0	$129,588	$263,102	$0
2	#04	Alliance for Building Communities - WITHDRAWN	$0	$0	$0	$0	$0
3	#05	Employment Stability	$284,971	$0	$71,243	$213,728	$0
4							
5							
6							
7							
8	Subtotal: Work Plans		$677,661	$0	$200,831	$476,830	$0
9	Plus County Administration		$105,000				
10	Plus Optional 10% Operating Reserve						
11	Total MHSA Funds Required for Innovation		$782,661				

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

County: Tri-City Mental Health Center

Date: April 21, 2014

Innovation Work Plans			FY 16/17 Required MHSA Funding	Estimated Funds by Age Group (if applicable)			
	No.	Name		Children, Youth, Families	Transition Age Youth	Adult	Older Adult
1	#03	Cognitive Remediation Therapy Project	$445,794	$0	$147,112	$298,682	$0
2	#05	Employment Stability	$289,771	$0	$72,443	$217,328	$0
3							
4							
5							
6							
7	Subtotal: Work Plans		$735,565	$0	$219,555	$516,010	$0
8	Plus County Administration		$110,000				
9	Plus Optional 10% Operating Reserve						
10	Total MHSA Funds Required for Innovation		$845,565				

Exhibit F: Innovation Projected Revenues and Expenditures

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

Work Plan #: INN-03

Work Plan Name: Cognitive Remediation Therapy Project

X New Work Plan

Months of Operation: 09/14 to 6/17

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

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

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

BUDGET NARRATIVE

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

General

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

A. Expenditures

1. Personnel Expenditures—$531,621

   Personnel expenditures include:

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

      Positions include:

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

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

2. Operating Expenditures—$114,921

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

3. Non-recurring expenditures—$4,000

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

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

   Tri-City will engage an evaluation analyst consultant for the last two years of the CRT program as it will take one year to develop and design the curriculum and hire staff.

Treatment will begin in the second year at which time the evaluation process will begin. The consultant will dedicate .35 FTE to this program for each of these two years at an estimated cost of $70 per hour, or $101,920 in total.

5. Work Plan Management—$223,649

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

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

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

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

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

B. Revenues—$172,965

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

C. Funding Requirements—$803,145

Exhibit F: Innovation Projected Revenues and Expenditures -- WITHDRAWN

County: Tri-City Mental Health Center Fiscal Year: 2014-15 through 2015-16

Work Plan #: INN-04

Work Plan Name: Alliance for Building Communities

X New Work Plan

Months of Operation: 07/14 to 6/16

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

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

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

BUDGET NARRATIVE -- WITHDRAWN

County Name: Tri-City Mental Health Center
INN Work Plan Name: Alliance for Building Communities
INN Project #: 04

Date: April 21, 2014

Exhibit F: Innovation Projected Revenues and Expenditures

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

Work Plan #: INN-05

Work Plan Name: Employment Stability

X New Work Plan

Months of Operation: 09/14 to 6/17

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

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

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

BUDGET NARRATIVE

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

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

A. Expenditures

1. Personnel Expenditures—$339,068

   Personnel expenditures include:

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

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

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

2. Operating Expenditures—$66,291

   Operating expenditures for the three years include:

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

3. Non-recurring expenditures—$2,000

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

4. Consultant Contracts—$135,893

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

5. Work Plan Management—$234,581

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

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

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

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

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

B. Revenues—none

C. Funding Requirements—$777,833

Attachment A - Sign-In Sheets from Public Hearing

TRI·CITY Mental Health Services

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

Name	Affiliation / Agency	Phone Number	Email Address
Nancy E. Muñoz	Tri-City	909-622-8906	
Zonia Cruz	Tri-City	909542-9538	
Lisa Tran	TCMH	909 623 6131	LTRAN@TricityMHS.org
Luis Garcia	RUMH	909-784-3226	lgarcia@friendshipcorp
Carol Riddell	Pomona Resident	(909) 837-0183	
Asela Calhoun	Phillips Graduate Institute	(626)-922-0016	amccouce@gmail.com
James R Spaeth	TRI CITY	909 868 7320	336 PHILLIPS AVE APT B
DAVID. GONZALEZ	LOELL-CENTER	909-394-1979	NONE
GUADALUPE GONZALEZ	" "	" "	ELLOPINO@VERIZON.NET
MARY GONZALEZ	" "	" "	
Claudia Arenas	Tri-City	909-762-7192	Daphne1534@Yahoo.com
Elvira Cuevas	TRI-CITY	208 4044047	1186 N Hamilton Blvd

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

Name	Affiliation / Agency	Phone Number	Email Address
ARTHUR MARTINEZ	TRI CITY	9099641098	
Gibran Carter	Tri City	9097843171	gcarter@tricitymhs.org
Don WHITNEY	TRI CITY	9097843192	DWHITNEY@TRICITYMHS.ORG
Dave Stein	Tricity	909 784-3132	dstein@tricitymhs.org
Robert Marcher	TRY CITY	(909) 2360884	2295 N. SAN ANTONIO AVE POMONA CALIF 91767
Jessica Bentello	Wellness Center	626 703-3222	jessicabentello@gmail.com
Kim Tso	consultant	626-710-0707	kimtso@mac.com
Elizabeth Sadlon	consultant	818 6627043	sadlon@mindspring.com
HERIBERTO BERNAL MARTINEZ	PARTICIPANT	(909) 629-6002	N/A
FELIX ESPINOZA	TRI CITY	(909) 367-5361	FELIXESPINOZA82@YAHOO.COM
Jim Holmes	TRI CITY	909-209-	NO PHONE
Rudy Regalado	TRI CITY		NO

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

Name	Affiliation / Agency	Phone Number	Email Address
Remel Gibson	Tri City member	909-525-5340	
Betsy MacLaren	Tri City mental Health	951-217-7913	
PERLA BORJA	" " "	909-985-0166	
Dayetta Williams	" " " "	909 624 4229	
Betsey Coffman	" " " " LWV observer	909 626-1540	
Megan Salazar-Robertson	Tricity	(626)4865326	
Diana K. Robertson	tricity	626486 5326	
Charlene Robertson		6264865326	
Edina Martinez	Governing Board	ON FILE	ON FILE
Barbara Aswad	Tri City	909 4256 7855	b.aswad@ymail.com
ADNAN ASWAD	" "	" "	" "
Diana Acosta	Tri-City	(909)623-6131	

TRI·CITY Mental Health Services

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

Name	Affiliation / Agency	Phone Number	Email Address
Chris Scalzo	Tri-City MHS	909.996.1244	cscalzo@tricitymhs.org
Army Bloom	Tri City Com		armybloom@mac.com
Sylvia Whitlock	Tri City Comm		
Michael Robertson	Unity	(626) 486-5526	michaelnasyolo.surgery@gmail.com
Don Perez	TRI-CITY COMM	909 625-9159	DPERIA@MSN.COM
Don Pruyn	TRI-CITY MH	909 641-8797	DOANJOYCE@VERIZON.NET
Kevin Armstrong	Trinity MHS	909/772-8127	
Carlton [illegible]		450-3739	Boxxxu717@hotmail.com
Charlotte Brown	tricity comm	(909) 680-5045	Silkbutterfly222@gmail.com
* SONNY ALINO	Tri city/WELLNESS	(909) 623-6131	
Luis Resendez	TCMHS	(909) 766-302	lresendez@tricity
Yvonne Resendez	Community member		

TRI·CITY Mental Health Services

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

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

TRI·CITY Mental Health Services

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

Name	Affiliation / Agency	Phone Number	Email Address
Chris Anzalone	Tri-City MHS	9) 784-3237	canzalone@tricitymhs.org
Socorro Bernal	tri City mental		
MARIA Bernal	tri city mental		
[illegible]	TCMHS		
JANIS MSeller	TRI-city	909-784-3024	jseller@tricitymhs.org
Darold Pieper	TCAHH	760-814-1401	dpieper@pieperlaw.com
ROY V. MANGLICMOT	~~382 W.A~~ TRI-CITY	909-865-03-88	382 W. ARTESIA POMONA
Heidi Bonadie	Tri-City	(909) 625-2383	ed@nami.pv.org
Karen m Rosenthal	COA. Claremont	909 626-2045	karen.kmr@verizon.net
Elizabeth Owens	Tri-City	(909) 784-3022	eowens@tricitymhs.org
Debbie Johnso	Tri-city	909-784-3202	dgohnson@tricitymhs.org
Gordon Rogers			

TRI·CITY Mental Health Services

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

Name	Affiliation / Agency	Phone Number	Email Address
Paul Caprario	Pomona Police	909 620-2122	
Silvia Zavala	Tri-City	909 461-0710	
Ofelia Valencia	Tri-City	(626) 404-2068	
Jorge Valencia	Tri-City	(626) 404-2068	
Danielle Zavala	Tri-City	(909) 461-0710	
Altagracia Varsas	Tri-City	(909) 865 8613	
Gail Range	Nami	909 263 1109	
Cynthia Angulo	Nami	909	
Stephen Mouton, Psy.D.	SGP Regional Center	909 868-7527	smouton@sgprc.org
Lora Illig	NAMI	909 625-2383	lmi@nami.org
Dawn Van Allen	The Garden	909 738 2435	dawnvanallen@gmail.com
Jude Ann Catayong	Tri City	909 623 6131	jcatayong@tricity.org

TRI·CITY Mental Health Services

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

Name	Affiliation / Agency	Phone Number	Email Address
Steven Brenner	T.C.G.		
Cindy Arequilo	NAMI PV	630-6676	CINIA31@MSN.COM
Marie Francois	FAP	909-884-2722x223	ellnod5@aol.com
Alfredo B. Larios	DMH	213 739-5955	alarios@dmh.lacounty.gov

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

Name	Affiliation / Agency	Phone Number	Email Address
Carrie Kennedy	TRI-CITY MHC	909-762-0214	ckennedy@tricitymhs.org
Cheyenne Stephens	tri-city	—	—
Anne Henderson	PYFM P		
Ellen Taylor			
Urhni Dubois	Sowing Seeds	—	-
Tina Brown	PEI	784 3023	tbrown@tricitymhs.org
Mike	—		

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

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

TRI·CITY Mental Health Services

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

Name	Affiliation / Agency	Phone Number	Email Address
Julie [illegible]	Tri City Commisson	9096703532	saliwt4@gmail.com
Monica Valencia	Tricity Delegate	(909) 784-9136	mvalencia@tricitymhs.org
Ally Ramzo	Community Member.	(909) 636 6022	allyramzo25@yahoo.com
Carolyn Cockrell	Board/Delegate	909 596-6001	carolyn.cockrell@gmail.com

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

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

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

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

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

Planning Process and Public Hearing Outreach by various demographics

Gender:

- Male: 579
- Female: 1,171

Ethnicity:

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

Age:

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

Total: 2,500

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

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

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

Participants in the public hearing feedback forms

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

What we like about the proposed Annual Update

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

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

Questions or concerns we have about the Annual Update

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

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

Other comments we want to share

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

Summary of Oral Feedback
From May 22, 2014 Public Hearing

What we like about the proposed Annual Update

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

Questions or concerns we have about the Annual Update

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

Attachment D – Summary of Recommendations for Program Improvement

Tri-City MHSA Integrated Plan
Phase One Workgroup Recommendations

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

Individual Program Recommendations

Community Services and Supports (CSS) Programs • Innovation Projects

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

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

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

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

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

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

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

Prevention and Early Intervention (PEI) Programs

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

9. Peer-to-Peer Counseling

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

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

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

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

Cross-Program and/or System Improvement Recommendations

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

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

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

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

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

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

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

Xerox WorkCentre 7845
SMTP Transfer Report

Job Status: FAILED The job exceeds the maximum size or fragment limits set by the System Administrator

Job Information

Device Name:	0PRT290
Submission Date:	08/08/14
Submission Time:	10:12 AM
Images Scanned:	78
Size:	0
Attachment Name:	
Format:	Image-Only PDF
Encrypted E-mail:	No

SMTP Server

Address:	10.100.5.20:25

Message Settings:

Subject:	Scan from Tricity 0PRT290
From:	0prt290@tricitymhs.org
Reply To:	0prt290@tricitymhs.org
To:	

1. imoreno@tricitymhs.org

©2012 Xerox Corporation. All Rights Reserved.
Xerox® and XEROX and Design® are trademarks of Xerox Corporation in the United States and/or other countries.

Xerox WorkCentre 7845
SMTP Transfer Report

Job Status: FAILED The job exceeds the maximum size or fragment limits set by the System Administrator

Job Information

Device Name:	0PRT290
Submission Date:	08/08/14
Submission Time:	10:14 AM
Images Scanned:	81
Size:	0
Attachment Name:	
Format:	Image-Only PDF
Encrypted E-mail:	No

SMTP Server

Address:	10.100.5.20:25

Message Settings:

Subject:	Scan from Tricity 0PRT290
From:	0prt290@tricitymhs.org
Reply To:	0prt290@tricitymhs.org
To:	

1. imoreno@tricitymhs.org

©2012 Xerox Corporation. All Rights Reserved.
Xerox® and XEROX and Design® are trademarks of Xerox Corporation in the United States and/or other countries.