

**INNOVATIVE PROJECT PLAN**  
**Connectedness 2 Community – Tulare County**

County: Tulare Date Submitted: 01/17/2019

Project Name: Connectedness 2 Community

**I. Overview**

<b>Primary Problem</b>
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Tulare County seeks to foster a partnership between mental health professionals/providers, community leaders/cultural brokers and staff on the importance of incorporating consumer cultural values/beliefs to build a feeling of community connectedness into traditional mental health treatment services for a diverse population. The community and faith-based leaders, as well as cultural brokers, will assist in expanding providers' awareness of an individual's cultural values and beliefs, and these same leaders will become better informed about mental health diagnoses, wellness and recovery. This will result in reducing the stigma and discrimination across the community. This program will include development and implementation of training modules from both sides of the partnership, as well as round table discussions and operating supports for targeted community organization leadership to sustain the work.

The community has expressed via Mental Health Services Act (MHSA) Community Planning Process (CPP) feedback that while they feel mental health providers are representative of the various ethnicities within Tulare County, they desire to work with providers who are sensitive to their specific culture/group while also understanding the cultural values and beliefs, including spirituality and connectedness related to the culture, that impact them. Upon further exploration of this theme during focus groups, consumers expressed they want to feel their cultural/group beliefs and practices, to include their interests, attitudes and outlook on life, are being respected and intentionally included in their treatment plans.

Feeling connected to one's community represents an extension of the fundamental human need to belong, is associated with positive individual and social outcomes (Baumeister & Leary, 1995), and is central to establishing collective identity (Ashmore, Deaux, & McLaughlin-Volpe, 2004; Gamson, 1997). When examining literature related to incorporation of cultural values, beliefs and practices with a resulting community connectedness within mental health treatment, Cornah, D. (2006) found that, for many, clinicians either do not consider an individual's cultural values and beliefs completely or they treat experiences as nothing more than manifestations of psychopathology. Research has shown more positive outcomes occur when mental health providers ask consumers about their cultural values and beliefs upon entry to the program and throughout their care and treatment. With the provider initiating the conversation, they can assist the consumer with identifying those aspects of life that provide them with meaning, hope, connectedness and purpose. For example, in the monolingual Spanish-speaking and Native American cultures, if providers were culturally informed and open to combining cultural beliefs and modern mental health practices, there would be an increase in consumers receiving effective services. (Maldonado, 2015)

Tulare County has a rich history of culture and diversity. This INN proposal was influenced by a "3 legged stool model", whereby cultural, spiritual and sexual identity/connectedness are the "legs" that support the strategy.

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These strategies emerged during the MHSA Community Planning process, with data of that planning process in the *Community Planning* section.

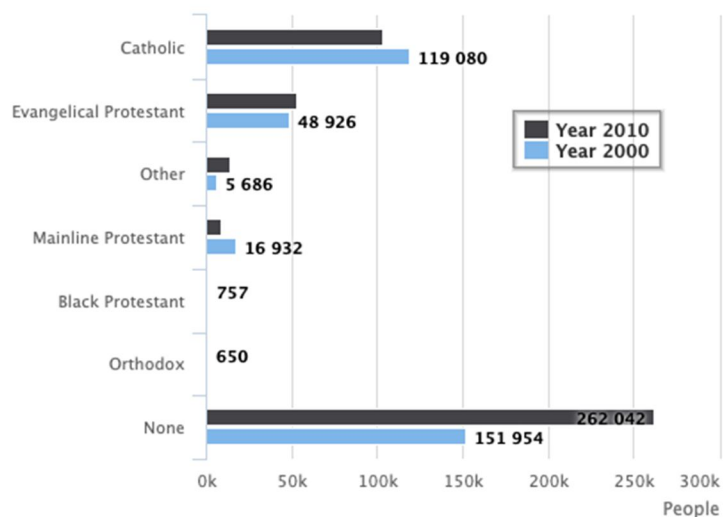
Tulare County is home to a population of approximately 452,000, and ranks the 18<sup>th</sup> largest county in California in population, **12<sup>th</sup> in diversity**, and first in poverty and residents younger than 5 years and 18 years of age. Even as the population of California has declined over the past 10 years, Tulare County has seen a growth of 2.5%. (<https://lafco.co.tulare.ca.us/lafco/>) The ethnic composition of the population is 64.7% Hispanic, 27.6% White, 2.2% Black, 3% Asian residents and 2.8% American Indian, with Spanish the most common foreign language spoken in the home (52.03%). (Census 2010) The **Tule River Indian Tribe of the Tule River Reservation** is a federally recognized tribe of Native Americans, located in Tulare County, was made up of Yokuts, about 200 Yowlumne, Wukchumni, and Western Mono and Tübatulabal. Tribal enrollment today is approximately 1,857 with 1,033 living on the Reservation.

Tulare County Mental Health serves approximately 11,000 people through outpatient services, with those served matching closely the ethnic composition of the county overall. Sexual orientation and gender identity (SOGI) data is new to the data collection as of fiscal year 2016/2017, and has not been collected widely throughout the Mental Health Plan.

The Tulare County religious landscape, like that of the United States, is transforming rapidly. At one time, religious diversity meant the “Big Four”: Catholic, Baptist, Methodist and Episcopalian. Today, it encompasses a multiplicity of religious traditions such as Sikhism, Buddhism, Islam and Baha’i, as well as an increasing variety of non-institutional belief systems such as humanism, skepticism, atheism and subjective spirituality. Racial and ethnic shifts have also changed the face of Christianity. (Cox, 2016) The number of congregations in Tulare County grew from 242 in 1980 to over 400 in 2010, yet at the same time the percentage of the population who indicated adherence remained consistent at 40%. Figure 1 below indicates the shifts in religion affinity from the period of 2000 to 2010, again **indicating movement away from the “Big Four” toward more cultural/ethnic/group identifying congregations (Black Protestant, Buddhism, Pentecostal, and non-denominational)**. Because religion and spirituality elicit deep feelings in people and because they speak to peoples’ deepest values, practicing mental health professionals must be careful to approach these processes with knowledge, sensitivity and care. Unfortunately, the large majority of practicing clinicians receive no training in religion and spirituality during their education. Competent care rests on basic knowledge about religious and spiritual diversity, understanding of how religion and spirituality are interwoven into adaptive and maladaptive human behavior, and skills in assessing and addressing religious and spiritual issues that arise in treatment. It is also very helpful to consult with leaders who represent different religious and spiritual traditions and different professional traditions. This can provide important perspective and wisdom in dealing with the thorny value and ethical issues that can arise when addressing religion and spirituality in mental health practice.

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Figure 1- Tulare County Religion Affinity 2000 Compared to 2010



(Source: Grammich, et al, 2012)

During the MHSA Planning process, participants expressed that when people feel safe and included, the whole community thrives. Data was examined and narratives shared about LGBT community in particular. It was stated that LGBT people are often tossed away and thrown out because of who they are, and that 1 in 4 youth who come out to their families will become homeless that day. In religious, conservative areas like Tulare County, LGBT people are searching for connection to community and acceptance, the same acceptance that straight and cisgender people often receive from their faith based communities. Many LGBT people have negative experience within their faith community and seek other ways to connect to spirituality. LGBT people are impacted by religion and spirituality on an *individual* level through its effects on mental health and physical well-being. Exposure to anti-LGBT theological messages are correlated with increased internalized homophobia, which in turn is linked to low self-esteem, substance abuse, suicidal ideation, and self-harming behaviors (Barnes and Meyer, 2012). However, LGBT people who are regularly involved in affirming spiritual spaces have higher measures of psychological health compared to those who are not part of affirming communities (Lease et. al., 2005). LGBT people are impacted by religion and spirituality on a *systemic* level through the ways faith-based rhetoric influences laws, politics, and media representation, contributing to structural stigma and distress (Brown et. al., 2011; Hatzenbuehler et. al., 2014). **The Source**, a local community based organization whose mission is to provide spaces for the LGBT+ population to Learn, Grow, Belong, Transform, Question + Support, has an open door for people who are seeking something outside of themselves and a place to belong. The Source supports 2,000 drop-ins per year and engage over 20,000 individuals in outreach events. They believe in a whole person approach to peer support and offer a chance for isolated individuals to connect to themselves, to others, and to vital resources. The Source validates and affirms all LGBT+ people as individual expressions of creativity, and in many ways serves as the spiritual center of Tulare County LGBT+ community.

Barriers to mental health treatment exist at the individual level, the community level, and the systemic level. For example, among the most prevalent behavioral health conditions for Latinos are depression, substance abuse disorders, and anxiety disorders. Few Latinos get the treatment they need, and youth in particular face a

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number of stressors that may increase their risks, including poor housing, trauma and social exclusion. But even when services are available, as many as 75% of the California Latinos who access treatment for the first time, fail to continue with a second session. This signifies a lack of appropriate engagement. (Aguilar-Gaxiola, 2012) Research suggests that many LGBT and allied providers are not only uncomfortable, but also professionally unprepared to integrate religious and spiritual concerns into their work with clients. Very few clinical programs build religious and spiritual competency. Furthermore, many queer and transgender people have experienced some kind of bias against religious involvement from their mental health provider (Buser et. al., 2011; Moe and Sparkman, 2015; Shelton and Delgado-Romero, 2011).

While the health care system is constantly changing and expanding to better address the growing issues with mental health, we can definitely improve how mental health issues are perceived and how they are treated among different cultures and ethnic groups. It is clear that different cultures view mental health differently, see different causes for the issues and look to different areas for help. It is important to address the cultural separation between the consumer and the providers. During Tulare County focus group discussions, consumers expressed that while providers spoke the same language, they “did not understand the culture and the spirituality of the cultural group”. Many discussion participants expressed feeling misunderstood and, as a result, do not continue to seek appropriate treatment. Cultural sensitivity on the part of the therapist may be beneficial to treatment because it may lead to a broader evaluation of the person seeking treatment and allow the therapist to explore a wider variety of treatment solutions. (Spirituality As a Coping Mechanism, www.goodtherapy.org Feb. 2017) Stress reduction, through an appreciation of the devotional aspect, is an effective approach since the spiritual “can enhance inner strength and enable individuals to find meaning in stressful situations, provide people with an optimistic perspective and positive purpose in life, and subsequently reduce anxiety.” (Langman, Louise; Chung, Man Cheung, 2012)

**Describe what led to the idea development of the idea and prioritization**

Tulare County conducted the Community Planning Process for the Tulare County Mental Health Services Act (MHSA) Integrated Plan Update on the previous Three-Year Plan (2017-2020) community planning process which is detailed within that plan. The planning process consisted of an inclusive process for consumers, family members, staff, agencies, specialty groups, and general community stakeholders. Feedback opportunities were offered through stakeholder meetings, focus groups, and surveys, as well as through a public hearing. Additional and ongoing stakeholder feedback is provided during the year at various committees, which includes consumers, family members, providers, staff, etc.

MHSA stakeholders reflected and refined strategies based on the data from the community assessment. Not every finding from the surveys and focus groups were addressed; rather they were developed as a reflection of main themes that are felt to be most pertinent when considering existing programs and practices within Tulare County Mental Health. What emerged was continuing efforts toward cultural competence related to traditionally un/underserved cultures/ethnicities such as Native American, South East Asian, African American, and Monolingual Spanish that demonstrates awareness and sensitivity of cultural practices and beliefs to include subcultural differences, and how these practices and beliefs may impact mental health services. Additionally weighed by the stakeholders was begin to further efforts of cultural competence related to staff reflecting the experience(s) of the individual consumer, and educational support groups tailored to families and

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social-cultures such as LGBTQ, and the traditionally un/underserved cultures/ethnicities such as Native American, South East Asian, African American, and Monolingual Spanish.

The community has expressed via MHPA Community Planning Process (CPP) feedback that, while they feel mental health providers are representative of the various ethnicities within Tulare County, **they desire to work with providers who are sensitive to their specific culture or group of identify while also understanding the cultural/group traditions and manners that impact them.** Upon further exploration of this theme during focus groups, consumers expressed they want to feel their cultural/group beliefs and practices, to include their interest, attitudes and outlook on life, are being respected and intentionally included in their treatment plans. The incorporation of consumer cultural values and beliefs has become a priority project as we seek to meet the needs of our diverse community. We are listening to the community voice. **They want assistance but they want the assistance from someone to whom they can relate, as well as someone who will assist in incorporating cultural beliefs and practices into their mental health treatment.** A wider voice of consumers have also identified the ways in which traditional cultural practices can contribute to mental health and wellbeing, mental illness and recovery (Mental Health Foundation, 2006). **The prevalent community need, ranked at #4 in our community survey, was access to mental health providers who have discernment and cultural awareness.** Competent care through the foundation of basic knowledge about values and beliefs, understanding of how they are interwoven into human behavior, and the skills to assess and address cultural values and beliefs will require a new approach from the traditional training that mental health practitioners receive during graduate and post-graduate education. Competent care also evolves from one's own self-awareness and connectedness. (Pargament, 2013). Homelessness, substance abuse, and suicide were the top three community needs identified through the CPP, and Tulare County Mental Health has several efforts working to address these needs. The Suicide Prevention Task Force and Alcohol and Other Drug Unit continue to improve and expand existing programs. To address homelessness, the Mental Health Branch works in partnership with the Homeless Task Force which was created in late 2017, in addition to pursuing such grant funding opportunities as No Place Like Home and the Homeless Mentally Ill Outreach and Treatment Program.

Research has shown that consumers would like to talk about matters of cultural values and belief during treatment, therefore indicating that integrated approaches to treatment are as effective as other treatment approaches. (Pargament, 2013). This proposed program approach is for mental health practitioners unfamiliar with work in this area, "to dip their toes in the water" by simply asking their clients a question or two about their cultural practices, values and beliefs to help frame the process (Pargament, 2013).

**What Has Been Done Elsewhere to Address Your Primary Problem?**

Culture is a broad and vexed term that can be defined in a range of ways, depending on the field of study and the perspective of the person using the term. As Tribe (2005) argues, it is a multi-layered concept influenced by a range of issues such as gender, class, religion, language, and nationality, just to name a few. Giddens (1993) from a sociological perspective, presents culture as the set of values that the members of a given group hold and includes the norms they follow and the material goods that they create. For the purposes of this project, we are using the term in the context of ethnic identity, or the multidimensional set of ascriptive group identities to which religion, spirituality, language, and race (as a social construct) belong and all of which contribute to a person's view of themselves.

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We have researched numerous published approaches and practices around inner self- connectedness; however, none of them addressed cultural beliefs to connectedness. This may be related to how we define the relational formation of cultural values and beliefs to connectedness, and brought forward the need to include “spirituality” as a cultural dynamic as this was expressed specifically from task force participants. In 2007, J. Scott Tonigan defined Spirituality as “Gaining knowledge through connectedness to others”. Christina Puchalski, MD, contends that “Spirituality is the aspect of humanity that refers to the way individuals see and express meaning and purpose and the way that they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.”

Fernando (2014) suggests that “[m]ental health development, like development in any other field, must start by tapping into what people in any location currently want and value.” One of the ways that Tulare County wants to explore more systematically is the possibility of integrating *positive resources in the community* into the provision of mental health services, such as our proposed community leaders/community brokers model. Marsella (2011) argues that community-based ethno-cultural services are a positive resource in the community that can provide an essential function in working with mental health issues in diverse cultural groups. Further, he argues that the development of a strong social support and community-based network must be intrinsic to the process. In the context of working with refugees in the UK, Tribe (2005) also endorses this view, suggesting that community-based mental health services “may prove more accessible, acceptable and relevant services which are more in line with other types of community care.” Besides these forms of services, there is also significant evidence to show that many people within culturally diverse communities are likely to utilize avenues other than professional therapists for dealing with mental distress, such as elders in the community, religious leaders, priests, and traditional healers (NIMH, 2001). These positive resources, including especially *traditional healing practices and systems* can be integrated in the provision of mental health services through collaborations, partnerships, and community-based health systems. The broader and deeper our partnerships, the more positive the impact.

Another way forward is to go beyond *cultural competence* frameworks and practice toward developing *cultural partnerships to develop connectedness*. Cultural competence “refers to the awareness, knowledge, and skills and the processes needed by individuals, profession, organizations and systems to function effectively and appropriately in culturally diverse situations in general and in particular encounters from different cultures” (Bean, 2006). Quite a few authors point to cultural competence as the most commonly used framework of practice in working with issues of mental health in culturally diverse settings (Campinha-Bacote, Christman, Wright). While the cultural competence framework has proved useful in terms of working across cultures, it suffers from a few significant flaws. Firstly, cultural competence frameworks approach culture from a purportedly value-neutral position, thereby ignoring the differences in power and the nature of historical and present-day oppression experienced by cultural groups (Pon 2009). Secondly the “competence” approach focuses on the providers and their institutions and their capabilities to provide culturally appropriate services and disregards the participation of the clients and their communities (USDHHS 2001). In circumstances where some cultural groups can be marginalized, as in the context of the issues of historical deprivations, racism, stereotyping, stigmatization, and power disparities, it becomes extremely important to work toward more equitable ways of engaging with communities (Pon, Bin-Sallik, Sakamoto). And finally, cultural competence draws on static notions of cultures that are not based on the reality of the constantly changing and transforming nature of cultures (Pon, Chen 2015).

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These issues pointed Tulare County toward the need for developing partnerships that are more equitable and that realign power relationships between service providers and individuals. The focus must be to move from traditional relationships built in power relationships to more interdependent and synergistic relationships (Chen, Bhugra). Tulare County envisions a range of diverse partnerships would be useful toward developing more effective mental health systems. They would include key cultural partnerships between mental health providers and diverse cultural communities via community leaders/community brokers to support cultural values and beliefs into traditional mental health treatment services for a diverse, multi-ethnic population. The community and faith-based leaders, as well as cultural brokers, will assist in expanding providers' awareness of an individual's cultural values and beliefs, and these same leaders will become better informed about mental health diagnoses, wellness and recovery. Partnerships could also be developed between mental health providers and traditional healers and/or community elders where synergies could be built on (Kirmayer, Campbel-Hall et al). Finally, the goal of the relationship between the therapist and the client would be viewed as a cultural partnership, very much in line with the recovery approach, where the client would be an active participant in the process.

The methodology for identifying existing practices of incorporating connectedness with modern day mental health practices began with looking at what existed in other counties or programs around this approach. Several programs were found operating nationwide with faith-based foundations and incorporating mental health practices. There have been studies conducted in the United States and the United Kingdom on the importance of having the therapist bring up the topic of one's sacred beliefs into the treatment conversation with consumers. Within California, Orange County and Santa Clara County have approved INN projects focusing on religion and spirituality; this program differs in that it will include cultural traditions and/or practices beyond religion or spirituality, beginning with inclusion of the LGBT+ community, which has its own culture and specific needs. Several articles outlined research conducted on faith and healing of illnesses including mental health disorder, but sample sizes were so small that they could not be duplicated due to the many variables affecting their subjects. There are no programs operating here in the United States or abroad that are focusing on cultural values and beliefs and connectedness. **We have determined that this "connection" is what Tulare County needs to better serve our mental health consumers by incorporating their cultural traditions and/or practices into the theory applied treatment plan that will lead to a more resilient consumer.**

### II. Proposed Project

Connectedness 2 Community (C2C) will explore an innovative approach to foster a partnership between the mental health providers and cultural brokers/leaders throughout Tulare County. It has long been a debate on the importance of incorporating cultural beliefs/connectedness into everyday treatment planning. For this partnership to be effective, the mental health providers must be open to relating to one's inner beliefs and values, and cultural brokers/leaders must be better informed about mental health and illness. This will include training modules from both sides of the partnership as well as round table discussions. We want our partners to educate one another on the perspective and wisdom in dealing with cultural values and beliefs in practice.

We hope the united approach of collaboration and knowledge will bridge a pathway for our mental health consumers to increase their participation, to build on their inner connectedness to their community and seek

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treatment once again. The support individuals derive from the members and leaders is widely considered one of the key mediators between cultural connectedness and mental health.

Cultural connectedness allows a person to reframe or reinterpret events that are seen as uncontrollable, in such a way as to make them less stressful or more meaningful. Some have argued that certain expressions or elements of culture, values and beliefs may positively affect various physiological mechanisms involved in health. Emotions are encouraged in many cultural traditions, including hope, contentment, love and forgiveness. This project will focus on the incorporation of cultural values and beliefs in consumer's treatment, compliance and usage of services.

**Approach**

We have selected to **introduce a new approach to the overall mental health system**, by building a path that will best allow our consumers to actively participate in how their cultural values, practices and beliefs are incorporated into their treatment plan. Studies have shown that consumers who have strong cultural values and beliefs are more likely to lean towards those beliefs when considering assistance from medical and mental health providers. In an Australian survey, a large majority of patients with psychiatric illness wanted their therapists to be aware of their spiritual beliefs and needs, and believed that their spiritual practices helped them cope better. (D'Souza RF 2002) Cultural values and beliefs can affect mental health in a positive way and creates an environment conducive for personal well-being.

C2C will dive into defining what cultural values and beliefs and connectedness means to the community of Tulare County. Cultural values and beliefs traditionally had a narrow definition centered on belief in supernatural spirits such as God. However, mental health service providers have been increasingly interested in addressing the physical and emotional needs of consumers in recent times, treating the "whole person", and as a result attempts have been made to redefine the term "connectedness" in a way that would be maximally inclusive, so as to apply to people from diverse backgrounds (Koenig, 2008). Many studies have broadened the term to incorporate a wide range of positive psychological concepts, such as purpose in life, hopefulness, social connectedness, peacefulness and well-being in general. This becomes problematic for research attempting to assess the relationship between cultural values and beliefs and mental health because by most **definitions good mental health implies that a person has some purpose in life, is hopeful, socially connected and has peace and well-being** (Lindeman & Aarnio, 2007). For the purposes of C2C, we have adopted the later definition to broaden our approach, to address the diverse needs of consumers of many backgrounds, ethnicities, and cultures.

**Innovative Component**

Key innovation aspects of the program are:

- Examination of the dual nature of connectedness and cultural values and beliefs within the culture/group, as vital resources for health and well-being.
- Training of professional/licensed providers to approach the processes of incorporating connectedness, cultural beliefs, practices and/or traditions, with knowledge, sensitivity and care.



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- Recruit subject matter experts and/or cultural leaders who represent different cultural traditions and different professions.
- Develop and/or select with cultural leaders/experts an assessment to utilize to assist providers with ways to initiate the conversation when addressing cultural values, group norms, and beliefs in practice.
- Establish goals and objectives that cut across a range of demographic (ethnic/racial and gender) variables while preserving their distinctive and substantive characteristics.
- Explore the impact of larger community connectedness on mental health and wellness.
- Logic Model attached in Exhibit 1.

**Learning Goals / Project Aims**

*The broad objective of the Innovative Component of the MHSA is to incentivize learning that contributes to the spread of effective practices in the mental health system. Describe your learning goals/specific aims and how you hope to contribute to the spread of effective practices.*

- **What is it that you want to learn or better understand over the course of the INN Project, and why have you prioritized these goals?**

*There is no maximum number of learning goals required, but we suggest at least two. Goals might revolve around understanding processes, testing hypotheses, or achieving specific outcomes.*

The goal is to meet the needs of the mental health community by exploring “**Connectedness as an Evidence Based Practice**”. This program will allow the Mental Health Branch to re-examine the approach to engaging clients when and where they seek assistance. Literature has shown the importance of connectedness in mental health and research suggests that inclusion of a person’s cultural/group beliefs may assist in therapy and the healing process.

Learning goals are three-fold:

- 1) To educate and train the community therapists on the sensitivity of addressing connectedness to community via the cultural/group lens through leveraging the engagement of cultural brokers/leaders in curriculum development and training delivery;
- 2) Increase access to services by providing training and support to cultural brokers/leaders on County behavioral health basics, which will help them respond appropriately to individuals seeking their help and assist with linkage and referrals to county behavioral health services; and
- 3) To create an established protocol incorporating different cultural values, practices and beliefs as part of mental health therapeutic strategies.

- **How do your learning goals relate to the key elements/approaches that are new, changed or adapted in your project?**

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Since a person's beliefs can affect their mental health, the goal is to bring the idea of connectedness into the concept of modern therapy. Through the process of training staff and providers, broadening treatment solutions, supporting all potential access points for mental health support, and creating new protocols, we can better meet the needs of those who seek services. For example, the approach of initiating an inner self assessment at the beginning of the intake process, will allow for the consumer to volunteer more information on what they believe and how those beliefs can add to their wellness and health. Another unique approach is to address the meaning of connectedness in many cultures and groups that are underserved in Tulare County through reciprocal training and curriculum development that reflects the cultural/group values, practices and beliefs. Another approach will be to create an outlet where consumers can practice connectedness through many forms of expression such as dance, yoga, meditation, and group counseling.

**Evaluation or Learning Plan**

*For each of your learning goals or specific aims, describe the approach you will take to determine whether the goal or objective was met. What observable consequences do you expect to follow from your project's implementation? How do they relate to the project's objectives? What else could cause these observables to change, and how will you distinguish between the impact of your project and these potential alternative explanations?*

*The greater the number of specific learning goals you seek to assess, generally, the larger the number of measurements (e.g., your "sample size") required to be able to distinguish between alternative explanations for the pattern of outcomes you obtain.*

*In formulating your data collection and analysis plan, we suggest that you consider the following categories, where applicable:*

- **Who are the target participants and/or data sources (e.g., who you plan to survey to or interview, from whom are you collecting data); How will they be recruited or acquired?**

The project will target:

- Consumers
- Clinical providers
- Cultural Brokers/Community Leaders

Across the target population, the approach for recruitment and survey will be tailored for the audience, including the cultures of those who have lived with mental health issues. We anticipate casting a wide net, capturing feedback along the way, and focusing on capturing not only the data that measures impact and change, but the stories which describe the journey.

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- **What is the data to be collected? Describe specific measures, performance indicators, or type of qualitative data. This can include information or measures related to project implementation, process, outcomes, broader impact, and/or effective dissemination. Please provide examples.**

Cultural considerations include, but are not limited to: ethnicity, race, age, gender identity, primary language, English proficiency, sexual orientation, immigration status, acculturation factors, sacred beliefs and practices, physical abilities and limitations, family roles, community networks, limited literacy, employment, and/or socioeconomic factors. Additional data includes stability in housing, education and employment; criminal justice status; perception of care; social connectedness; services received; status at reassessment; and clinical discharge.

Tools and resources could include:

- DSM-V, Cultural Formulations and Glossary of Culture-Bound Syndromes
- Cultural considerations and guiding questions
- Community specific information sources, e.g., census data
- Culturally and Linguistically Appropriate Services Standards (CLAS standards 4 – 7)
- Cultural competence fact sheets
- SAHLSA (Short Assessment of Health Literacy for Spanish-speaking Adults)
- REALM (Rapid Estimate of Adult Literacy in Medicine, English version)
- Test of Functional Health Literacy in Adults (English & Spanish versions, as well as a short version for screening)
- Surgeon General's Report: Mental Health: Culture, Race and Ethnicity, (DHHS, 2001)

Measures and performance indicators would be based upon data such as adherence to treatment plan, demonstrated new competencies of trained therapists, reflection of new populations served, perception of care, and status at reassessment of targeted clients. Additionally, we anticipate collection of the narrative – the stories that emerge from the connectedness work through the diverse partnerships established through this initiative.

- **What is the method for collecting data (e.g. interviews with clinicians, focus groups with family members, ethnographic observation by two evaluators, surveys completed by clients, analysis of encounter or assessment data)?**
- **How is the method administered (e.g., during an encounter, for an intervention group and a comparison group, for the same individuals pre and post intervention)?**

Information can be obtained through the use of comprehensive intake assessment tools, culturally tailored engagement strategies, and ongoing documentation of culturally relevant information from consumers.

- Surveys will be given before and after each training session with Subject Matter Experts.

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- Therapists will be asked to return for future groups.
- Interviews will be held with therapists, at least 6-months after initial training is completed. Can be held earlier if necessary.
- Consumers and participants will be asked to complete surveys on the services they receive pre and post treatment

Most data will be collected at the time of encounter. Some instruments may be administered digitally (Survey Monkey, etc.)

**What is the *preliminary* plan for how the data will be entered and analyzed?**

All data will be entered into a database by a program analyst and reviewed by INN Coordinator.

**Contracting**

Independent contractor organizations will be selected to conduct subject matter expert (SME) training.

Identified for Year One to serve as cultural brokers/leaders are:

1. Tule River Rancheria – Native American focus
2. The Source – LGBT focus
3. New Life – African American focus

Year Two will include organizations representing Asian/Pacific Islanders and Monolingual Spanish speaking populations. These two organizations are still to be identified and vetted.

An external project evaluator will be hired for this program. The project evaluator will work closely with the INN coordinator to evaluate all data collection instruments and materials.

Each contractor will develop a scope of work that aligns with project activities and outcomes, and will be overseen by the INN Coordinator.

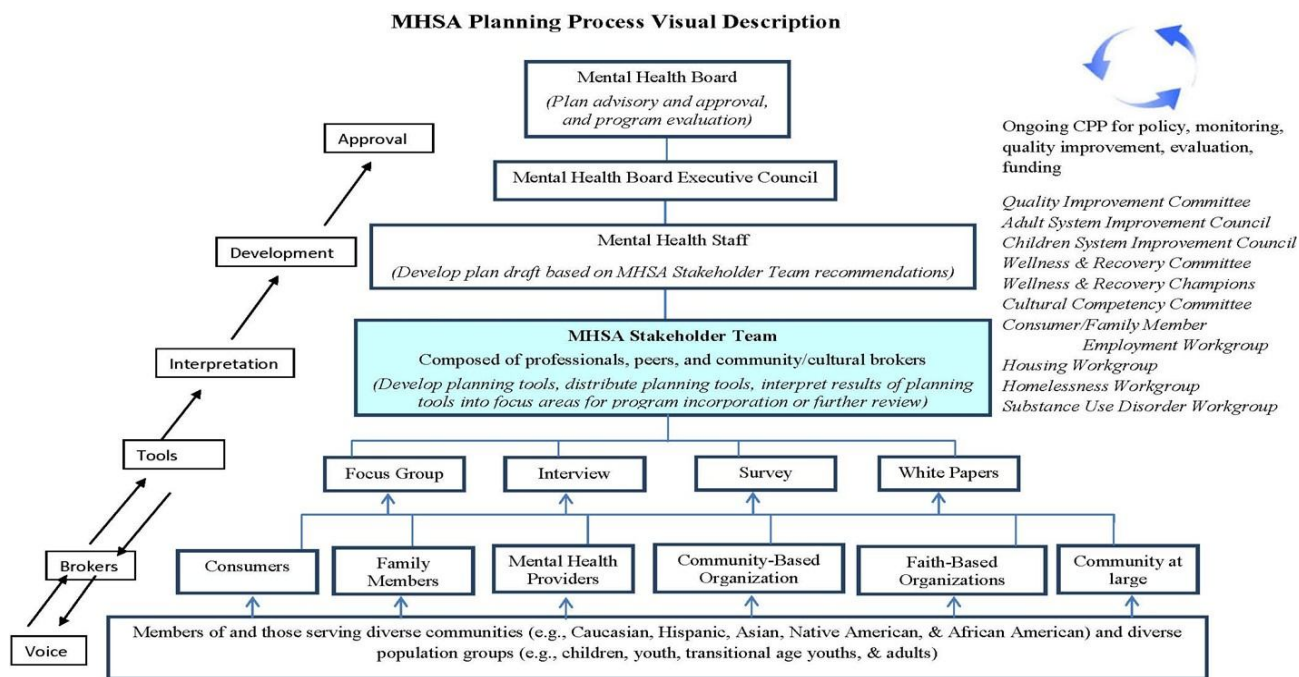
**Community Program Planning**

Tulare County conducted the Community Planning Process for the Tulare County Mental Health Services Act (MHSA) Integrated Plan Update on the previous Three-Year Plan (2017-2020) community planning process which is detailed within that plan. The planning process consisted of an inclusive process for consumers, family members, staff, agencies, specialty groups, and general community stakeholders. Feedback opportunities were offered through stakeholder meetings, focus groups, and surveys, as well as through a public hearing. Additional and ongoing stakeholder feedback is provided during the year at various committees, which includes consumers, family members, providers, staff, etc.

In alignment with Welfare & Institutions Code § 5858, the MHSA Stakeholder Team consists of representatives from agency partners, consumers of mental health services, family members of consumers of mental health

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services, mental health providers, faith-based organizations, community-based organizations, and community/cultural brokers. Those invited included, but were not limited to: Division of Alcohol and Other Drugs (AOD); TulareWORKs; Aging and Veterans Services; Psychiatric Emergency Team; Health Services and Public Health Services; Child Welfare Services; Lindsay Healthy Start; Cutler/Orosi Family Education Center; Family Resource Centers; Visalia Parenting Network; Central California Family Crisis Center (Porterville); Goshen Family Services; consumers of Mental Health Services from the Porterville Adult Clinic, Visalia Adult Integrated Clinic, Mobile Units, Transitional Age Youth Transitional Supportive Housing, and Adult Transitional and Permanent Supportive Housing; Mental Health Board members and Board of Supervisors members; Brooks Chapel (African Methodist Episcopal Church); Southern Baptist Church (Latino and Lahu Worship); Lighthouse Rescue Mission and Visalia Rescue Mission; Owens Valley Career Development Center (Porterville, Visalia, and Tule River Reservation); Visalia Police Department; Tule River Department of Public Safety; Tule River Tribal Council; First 5 Tulare County; Kings/Tulare Continuum of Care; Kaweah Health Care District Bridge Program; The Source LGBT+ Center; Trevor Project; and the Tulare County Office of Education.



The following main themes were derived from the 28 focus groups among 198 community members:

- Knowledge of resources is improving but does not yet reach the wider community.
  - **Spanish-speaking communities were less knowledgeable about available resources.**
  - Education within the schools, to reach parents, teachers and administrators, could assist with prevention and early intervention efforts, as well as stigma and discrimination reduction efforts.
- Stigma surrounding mental health is slowly changing.
  - **There is more understanding and acceptance that mental health is part of physical health and emotional well-being.**

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- There seemed to be a shift from thinking that someone could be “cured”, to acceptance, with education about the diagnosis, and ways to manage the symptoms.
- **Cultural awareness and lack of connectedness across gender and race/ethnicity still presents as a barrier to accessing services.**
  - **While providers are representative of the various ethnicities within Tulare County, consumers and family members desire to work with providers who truly understand their experience and are reflective of where they are in life (age, values, beliefs, language, gender).**
- Support is necessary
  - **Family support differs between cultures.**
  - Additional supports, such as groups, assist consumers with sobriety, parenting skills, and life skills, are valuable, however, participants expressed a desire for a change in tone and focus, offering some lightness and fun to the groups.

The following were derived from the 884 surveys (756 in English and 128 in Spanish):

- 52% of respondents or their family member have received mental health services in Tulare County.
- Although 40% of respondents stated there were no barriers in accessing services, appointment availability, lack of transportation, and difficulty finding a mental health professional s/he feels comfortable with were the top 3 noted barriers in accessing mental health services.
- Family Resource Centers, doctor’s offices, and their homes were the top 3 places where people will likely access/use mental health programs and services.
- The top 3 places where respondents have looked for or received mental health information were the internet, word of mouth, and mental health provider.
- Homelessness and substance abuse were perceived as the top community needs related to mental illness, chosen by more than 50% of respondents for all surveys. Poverty, suicide, and unemployment were chosen by approximately 30% of respondents for all surveys.
- The Spanish survey respondents felt that the lack of resources and/or resource awareness was the greatest community need (38%), followed by substance abuse (32%) and poverty (31%).
- **Overall, lack of resources or resource awareness was chosen by all respondents approximately 28%, along with isolation and untreated medical conditions.**

MHSA stakeholders reflected and refined strategies based on the data from the community assessment. Not every finding from the surveys and focus groups were addressed; rather they were developed as a reflection of main themes that are felt to be most pertinent when considering existing programs and practices within Tulare County Mental Health. What emerged was continuing efforts toward cultural competence related to traditionally un/underserved cultures/ethnicities such as Native American, South East Asian, African American, and Monolingual Spanish that demonstrates awareness and sensitivity of cultural practices and beliefs to include subcultural differences, and how these practices and beliefs may impact mental health services. Additionally weighed by the stakeholders was begin to further efforts of cultural competence related to staff reflecting the experience(s) of the individual consumer, and educational support groups tailored to families and

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social-cultures such as **LGBT**, and the traditionally un/underserved cultures/ethnicities such as **Native American, Asian/Pacific Islander, African American, and Monolingual Spanish.**

**Primary Purpose**

- a) **Increase access to mental health services to underserved groups**
- b) Increase the quality of mental health services, including measurable outcomes
- c) Promote interagency collaboration related to mental health services, supports, or outcomes
- d) Increase access to mental health services

**MHSA Innovative Project Category**

Which MHSA Innovation definition best applies to your new INN Project (select one):

- a) Introduces a new mental health practice or approach.
- b) Makes a change to an existing mental health practice that has not yet been demonstrated to be effective, including, but not limited to, adaptation for a new setting, population or community.
- c) **Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.**

**1) Population (if applicable)**

- a) **If your project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance, please estimate number of individuals expected to be served annually. How are you estimating this number?**

The primary target are the professional staff who provide treatment, with a secondary target being the “customer”, the consumers who receive treatment and the members of their family and/or community support system. **It is estimated that this program will reach approximately 200 consumers and professional clinicians per year.**

- b) **Describe the population to be served, including relevant demographic information such as age, gender identity, race, ethnicity, sexual orientation, and/or language used to communicate. In some circumstances, demographic information for individuals served is a reporting requirement for the Annual Innovative Project Report and Final Innovative Project Report.**

When addressing the need for fusing cultural values, beliefs and connectedness with mental health practice, we find that it does not affect any specific demographic in our community; however, it affects all of them at a different level. Cultural values and beliefs crosses all races, ethnicities, age groups and sexual orientation.

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Although cultural values and beliefs can play a part in connectedness, every person has their own unique experience.

**c) Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.**

The focal population or “primary customer” will be the mental health professionals who desire to provide therapy through a more intentional inner/connected manner, and the secondary customer as the consumer who seeks and receives these services and their family/community support system.

**2) MHSA General Standards**

- a) Community Collaboration - The project selection process has involved community collaboration from the beginning. The project was birthed from the community’s input, tailored by their voices, and continues to be deepened with each engagement of stakeholders.
- b) Cultural Competency - Tulare County has an established Mental Health Cultural Competency Committee which meets monthly and is made up of peer specialists, community organizations, clinicians and county staff.
- c) Client-Driven - The primary approach for the project is to obtain the consumer’s input from the very start on what their beliefs are and how they connect to their well-being. The assessment tools will assist with meeting this goal.
- d) Family-Driven - Sometimes individuals need the support of family in their journey to well-being. The project honors families by embracing the strengthening of the clients system by including family involvement in the overall treatment plan.
- e) Wellness, Recovery, and Resilience-Focused - The project design focuses on non-traditional practices that connect the body and mind to the soul (whole person).
- f) Integrated Service Experience for Clients and Families - By design a person’s cultural values and beliefs are integrated into traditional mental health practices. This may allow to the person seeking treatment and the therapist to explore a wide variety of treatment solutions.

**3) Continuity of Care for Individuals with Serious Mental Illness**

This project will provide services to individuals with serious mental illness as previously mentioned related to the target population.

When Innovation funds for this project are no longer available, and if the evaluation outcomes are sufficiently strong to warrant it, we plan to continue to support it with Community Services and Supports (CSS) funds.

If no funds for this project are available, some elements of it will continue within the Wellness & Recovery activities, and continued discussions within the Mental Health Cultural Competency Committee.



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**INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.**

The project evaluation methodology and design will be discussed as it is being developed with our Mental Health Cultural Competency Committee (MHCCC), which meets on a monthly basis. Once the project is approved, this will be a standing agenda item to be discussed monthly.

**Explain how you plan to ensure meaningful stakeholder participation in the evaluation.**

The MHCCC is made up of peers, community members, clinical professionals and county staff. We are confident that we will have meaningful stakeholder participation with much discussion and recommendations being made from this group of diverse stakeholders.

**Deciding Whether and How to Continue the Project Without INN Funds**

At the conclusion of this INN project, should the evaluation indicate that the project or elements of it are successful; the project will be incorporated into CSS.

All project results will be presented in a public forum setting during our mental health board's general meeting. After the initial presentation, copies of results will be available upon request.

**Communication and Dissemination Plan**

**How will program participants or other stakeholders be involved in communication efforts?**

Program participants, family members, and stakeholders will be encouraged to participate in the public meeting. Shared experiences on the project's impact in the lives of our community will be welcomed.

**KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.**

- Connectedness
- Cultural values and beliefs
- Self –Care
- Wholeness
- Harmony

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**Timeline**

**a) Specify the total timeframe (duration) of the INN Project:** 5 Years , 0 Months

**b) Specify the expected start date and end date of your INN Project:**

*Note: Please allow processing time for approval following official submission of the INN Project Description.*

Start Date: July 2019\*

End Date: June 2024\*

\*These dates are tentative and subject to revision based on approval from MHSOAC.

**c) Include a timeline that specifies key activities and milestones and a brief explanation of how the project's timeframe will allow sufficient time for**

- i. Development and refinement of the new or changed approach;**
- ii. Evaluation of the INN Project;**
- iii. Decision-making, including meaningful involvement of stakeholders, about whether and how to continue the Project;**
- iv. Communication of results and lessons learned.**

**(1) Program Development Design/Contracting (Years 1 and 2)**

- Identify Cultural Brokers, Subject Matter Expert Leaders
- Develop program structure
- Create curriculum /modules for discussions
- Establish stakeholder steering committee
- Develop pre and post surveys
- Foster community partnerships and collaborations
- Identify possible training locations
- Create benchmark calendar
- Incorporate webinar access to trainings
- Create and disseminate event flyers

**(2) Program Implementation (Year 3)**

- Establish online registration portal for trainings
- Market and recruit clinical professionals to attend trainings
- Implement training modules
- Organize bi-annual best practices conference
- Schedule bi-monthly steering committee meetings

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- Conduct feedback interviews of all subject matter experts (SME) following their training sessions
- Provide written and verbal update to MHB on program progress

**(3) Program Implementation Continued (Year 4)**

- Input survey data for analysis
- Collect survey data from:
  - Clients
  - Cultural Brokers
  - Clinical Professionals
  - Family Members and Community
- Organize family and caregivers feedback sessions (bi-annual)
- Provide written and verbal update to MHB on program progress

**(4) Results & Recommendations (Year 5)**

- Hold quarterly cultural roundtable
- Foster collaboration with community to continue program by locating sustainable funding
- Submit evaluator report and final program report to executive management
- Revise & finalize program report
- Present final report to Mental Health Board (MHB)
- Submit final report to OAC

**(5) Final Decision-Making Phase**

- Decide whether to continue the project with another funding source or sources, such as Community Services and Supports funds, based on the evaluation outcomes. Include stakeholder input, including that of program participants and family members, in the process.

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**4) INN Project Budget and Source of Expenditures**

The next three sections identify how the MHSAs funds are being utilized:

- a) **BUDGET NARRATIVE (Specifics about how money is being spent for the development of this project)**
- b) **BUDGET BY FISCAL YEAR AND SPECIFIC BUDGET CATEGORY (Identification of expenses of the project by funding category and fiscal year)**

**BUDGET CONTEXT (If MHSAs funds are being leveraged with other funding sources)**

**A. Budget Narrative**

Provide a brief budget narrative to explain how the total budget is appropriate for the described INN project. The goal of the narrative should be to provide the interested reader with both an overview of the total project and enough detail to understand the proposed project structure. Ideally, the narrative would include an explanation of amounts budgeted to ensure/support stakeholder involvement (For example, “\$5000 for annual involvement stipends for stakeholder representatives, for 3 years: Total \$15,000”) and identify the key personnel and contracted roles and responsibilities that will be involved in the project (For example, “Project coordinator, full-time; Statistical consultant, part-time; 2 Research assistants, part-time...”). Please include a discussion of administration expenses (direct and indirect) and evaluation expenses associated with this project. Please consider amounts associated with developing, refining, piloting and evaluating the proposed project and the dissemination of the Innovative project results.

Budget Narrative – Connectedness 2 Community

**Total 2019-2020 Year 1 Budget: \$ 244,357**

**Personnel (Includes Salary, Benefits)**

- 1. Administrative Specialist, .50 FTE: \$ 56,191

*Administrative Specialist responsibilities include:*

- a. Acting INN Coordinator
- b. Oversee program development
- c. Organize stakeholder meetings
- d. Consults with evaluator on program design and data collection methods
- e. Schedules training sessions
- f. Prepares training materials
- g. Arrange schedules for subject matter experts to conduct training
- h. Collect program survey data
- i. Analyze program data
- j. Prepare bi-annual program updates
- k. Prepare annual program reports

- 2. Benefits : \$ 20,376

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- a. Employee benefits to include but not limited to: Medical, Vision, Dental, Retirement, Life insurance.

**Operating Costs –\$ 25,376**

1. Direct Cost- \$20,376
  - a. Subject matter material provided to the beneficiary. Resources provided to the beneficiary to include but not limited to: Handouts, booklets, pamphlets, and cards.
2. Indirect Cost- \$5,000
  - a. Contracted speaker fees for meetings, trainings and other events. Conference room reservation cost.

**Technology - \$ 5,500**

- a. Jabber license fees, \$500 renewal every three (3) years.
- b. Laptop, Projector, and Screen - \$5,000

Jabber is a communication tool which will be utilized to conduct the trainings, allowing providers to participate online, increasing the potential for participation.

**Contractors –\$132,214**

1. Program Consultant – \$50,000
  - a. Five (5%) increase each year of program.
2. Evaluator - \$22,214
  - a. Ten (10%) percent of program cost each year (i.e. total prior to including evaluator cost).
3. Subject Matter Experts (SME)- \$60,000
  - a. Five (5) SME will be contracted at \$12,000/each for the first year, with a five (5%) percent increase each program year.

**Other Expenditures: \$4,700**

1. Printing, \$1,500
  - a. Cost of printing materials for community outreach to include but not limited to: fliers, handouts and information cards.
2. Meeting and Training Venue Fees, \$ 500
  - a. Rental cost of additional equipment, table, chairs, and audio services.
3. Cell Phones, \$200
  - a. Annual cost for county cell phone use by administrative staff.
4. Travel and Mileage, \$500
  - a. Reimbursement for personal car mileage and cost for overnight stay, and per diem pay.
5. Training and Meeting Supplies, \$1,000
  - a. Registration cost for additional training, and/or conferences. Cost of training/meeting specific material to include but not limited to: poster boards, Easel pads, white boards.
6. Office Supplies, \$ 1,000

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- a. Cost of general office supplies to include but no limited to: paper, pens, notebooks, tissue, folders, hand sanitizer.

***Total Five Year (FY 2019 – FY 2024) Costs by category:***

**Personnel** (Includes 5% annual percent increase for personnel costs): \$423,084

FY 19/20: \$ 76,567  
FY 20/21: \$ 80,396  
FY 21/22: \$ 84,416  
FY 22/23: \$ 88,637  
FY 23/24: \$ 93,068

**Operating Costs:** \$140,219

FY 19/20: \$ 25,376  
FY 20/21: \$ 26,645  
FY 21/22: \$ 27,978  
FY 22/23: \$ 29,376  
FY 23/24: \$ 30,845

**Technology Costs:** \$ 6,000

FY 19/20: \$ 500  
FY 20/21: \$ 5,000  
FY 21/22: \$ 0.00  
FY 22/23: \$ 500  
FY 23/24: \$ 0.00

**Contractors Cost:** \$ 727,881

FY 19/20: \$ 132,214  
FY 20/21: \$ 138,224  
FY 21/22: \$ 145,112  
FY 22/23: \$ 152,394  
FY 23/24: \$ 159,937

**Other Expenditures:** \$ 23,500

FY 19/20: \$ 4,700  
FY 20/21: \$ 4,700  
FY 21/22: \$ 4,700  
FY 22/23: \$ 4,700  
FY 23/24: \$ 4,700

***Total Five Year Program Budget: \$1,320,684***

\* Tulare County Mental Health Branch anticipates utilizing Assembly Bill (AB) 114 funding reversion the first two years of the program (2019-20 at \$244,357 and 2020-21 at \$249,965) for a total of \$494,322. These AB 114 funds will utilize some funds available from FY 2010-11 for Tulare County.

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<b>A. New Innovative Project Budget By FISCAL YEAR (FY)*</b>							
<b>EXPENDITURES</b>							
<b>PERSONNEL COSTS</b>		<b>2019-20</b>	<b>2020-21</b>	<b>2021-22</b>	<b>2022-23</b>	<b>2023-24</b>	<b>Total</b>
1.	Personnel Salary	\$56,191	\$59,001	\$61,951	\$65,049	\$68,301	\$310,493
2.	Personnel Benefits	20,376	21,395	22,465	23,588	24,767	112,591
3.	Total Personnel Costs	<b><u>\$76,567</u></b>	<b><u>\$80,396</u></b>	<b><u>\$84,416</u></b>	<b><u>\$88,637</u></b>	<b><u>\$93,068</u></b>	<b><u>\$423,084</u></b>
<b>OPERATING COSTS</b>		<b>2019-20</b>	<b>2020-21</b>	<b>2021-22</b>	<b>2022-23</b>	<b>2023-24</b>	<b>Total</b>
4.	Direct Costs	\$20,376	\$21,395	\$22,465	\$23,588	\$24,767	\$112,591
5.	Indirect Costs	5,000	5,250	5,513	5,788	6,078	27,628
6.	Total Operating Costs	<b><u>\$25,376</u></b>	<b><u>\$26,645</u></b>	<b><u>\$27,978</u></b>	<b><u>\$29,376</u></b>	<b><u>\$30,845</u></b>	<b><u>\$140,219</u></b>

<b>TECHNOLOGY COSTS</b>		<b>2019-20</b>	<b>2020-21</b>	<b>2021-22</b>	<b>2022-23</b>	<b>2023-24</b>	<b>Total</b>
7.	Jabber License Fees	\$500			\$500		\$1,000
8.	Laptop, Projector, Screen	5,000					5,000
9.	Total Technology costs	<b><u>\$5,500</u></b>			<b><u>\$500</u></b>		<b><u>\$6,000</u></b>
<b>CONTRACTORS COST</b>		<b>2019-20</b>	<b>2020-21</b>	<b>2021-22</b>	<b>2022-23</b>	<b>2023-24</b>	<b>Total</b>
10.	Program Consultant	\$50,000	\$52,500	\$55,125	\$57,881	\$60,775	\$276,282
11.	Evaluator	22,214	22,724	23,837	25,055	26,231	120,061
12.	Subject Matter Experts	60,000	63,000	66,150	69,458	72,930	331,538
13.	Total Consultant Costs	<b><u>\$132,214</u></b>	<b><u>\$138,224</u></b>	<b><u>\$145,112</u></b>	<b><u>\$152,394</u></b>	<b><u>\$159,937</u></b>	<b><u>\$727,881</u></b>

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<b>OTHER EXPENDITURES</b>	<b>2019-20</b>	<b>2020-21</b>	<b>2021-22</b>	<b>2022-23</b>	<b>2023-24</b>	<b>Total</b>
14. Printing Costs	\$1,500	\$1,500	\$1,500	\$1,500	\$1,500	\$7,500
15. Cell Phones	200	200	200	200	200	1,000
16. Location & Meeting Rentals	500	500	500	500	500	2,500
17. Travel & Mileage	500	500	500	500	500	2,500
18. Meeting Supplies	1,000	1,000	1,000	1,000	1,000	5,000
19. Office Supplies	1,000	1,000	1,000	1,000	1,000	5,000
20. Total Other expenditures	<b><u>\$4,700</u></b>	<b><u>\$4,700</u></b>	<b><u>\$4,700</u></b>	<b><u>\$4,700</u></b>	<b><u>\$4,700</u></b>	<b><u>\$23,500</u></b>

<b>BUDGET TOTALS</b>	<b>2019-20</b>	<b>2020-21</b>	<b>2021-22</b>	<b>2022-23</b>	<b>2023-24</b>	<b>Total</b>
<b>Personnel (line 1)</b>	\$56,191	\$59,001	\$61,951	\$65,049	\$68,301	\$310,493
<b>Direct Costs (add lines 5 and 11 from above)</b>	70,376	73,895	77,590	81,469	85,542	388,872
<b>Indirect Costs (add lines 2, 5 and 11 from above)</b>	107,590	112,369	117,965	123,889	130,006	591,819
<b>Technology costs (line 9)</b>	5500			500		6,000
<b>Other Expenditures (line 20)</b>	4,700	4,700	4,700	4,700	4,700	23,500
<b>TOTAL INNOVATION BUDGET</b>	<b><u>\$244,357</u></b>	<b><u>\$249,965</u></b>	<b><u>\$ 262,206</u></b>	<b><u>\$275,607</u></b>	<b><u>\$288,550</u></b>	<b><u>\$1,320,684</u></b>



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<b>A. Expenditures By Funding Source and FISCAL YEAR (FY)</b>							
<b>Administration:</b>							
<b>A.</b>	<b>Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY &amp; the following funding sources:</b>	<b>2019-20</b>	<b>2020-21</b>	<b>2021-22</b>	<b>2022-23</b>	<b>2023-24</b>	<b>Total</b>
1.	Innovative MHSA Funds	\$112,143	\$111,741	\$117,094	\$123,213	\$128,613	\$592,803
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
<b>6.</b>	<b>Total Proposed Administration</b>	<b>\$112,143*</b>	<b>\$111,741*</b>	<b>\$117,094</b>	<b>\$123,213</b>	<b>\$128,613</b>	<b>\$592,803</b>
<b>Evaluation:</b>							
<b>B.</b>	<b>Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY &amp; the following funding sources:</b>	<b>2019-20</b>	<b>2020-21</b>	<b>2021-22</b>	<b>2022-23</b>	<b>2023-24</b>	<b>Total</b>
1.	Innovative MHSA Funds	\$132,214	\$138,224	\$145,112	\$152,394	\$159,937	\$727,881
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
<b>6.</b>	<b>Total Proposed Evaluation</b>	<b>\$132,214*</b>	<b>\$138,224*</b>	<b>\$145,112</b>	<b>\$152,394</b>	<b>\$159,937</b>	<b>\$727,881</b>
<b>TOTAL:</b>							
<b>C.</b>	<b>Estimated TOTAL mental health expenditures (this sum to total funding requested) for the</b>	<b>2019-20</b>	<b>2020-21</b>	<b>2021-22</b>	<b>2022-23</b>	<b>2023-24</b>	<b>Total</b>

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	<b>entire duration of this INN Project by FY &amp; the following funding sources:</b>						
1.	Innovative MHSA Funds	\$ 244,357	\$249,965	\$262,206	\$275,607	\$288,550	\$1,320,684
2.	Federal Financial Participation						
3.	1991 Realignment						
4.	Behavioral Health Subaccount						
5.	Other funding*						
<b>6.</b>	<b>Total Proposed Expenditures</b>	<b>\$ 244,357 *</b>	<b>\$249,965*</b>	<b>\$262,206</b>	<b>\$275,607</b>	<b>\$288,550</b>	<b>\$1,320,684</b>
<p>*If "Other funding" is included, please explain.</p> <p>*Tulare County Mental Health Branch anticipates utilizing Assembly Bill (AB) 114 funding reversion the first two years of the program (2019-20 at \$244,357 and 2020-21 at \$249,965) for a total of \$494,322. These AB 114 funds will utilize some funds available from FY 2010-11 for Tulare County.</p>							

## References

- Aguilar-Gaxiola, S., Loera, G., Méndez, I., Sala, M., Latino Mental Health Concilio, and Nakamoto, J. (2012). Community-Defined Solutions for Latino Mental Health Care Disparities: California Reducing Disparities Project, Latino Strategic Planning Workgroup Population Report. Sacramento, Ca: UC Davis.
- Ashmore RD, Deaux K, McLaughlin-Volpe T. An organizing framework for collective identity: Articulation and significance of multidimensionality. *Psychological Bulletin*. 2004;130:80–114.
- Barnes, David M., and Ilan H. Meyer. "Religious Affiliation, Internalized Homophobia, and Mental Health in Lesbians, Gay Men, and Bisexuals." *American Journal of Orthopsychiatry* 82, no. 4 (2012): 505–15.
- Baumeister RF, Leary MR. The need to belong: Desire for interpersonal attachments as a fundamental human motivation. *Psychological Bulletin*. 1995;117:497–529. [[PubMed](#)]
- Bean R. (2006) The Effectiveness of Cross-Cultural Training in the Australian Context. Canberra: *Department of Immigration and Multicultural Affairs*
- Bin-Sallik M. (2003) Cultural safety: lets name it! *Aust J Indig Educ*.
- Buczynski, R. (n.d.) Does Spirituality Belong in Therapy? Spirituality As A Coping Mechanism from 2017 [www.goodtherapy.org](http://www.goodtherapy.org).
- Bhugra D. (2004) Migration, distress and cultural identity. *Br Med Bull*.
- Campbell-Hall V, Petersen I, Bhana A, Mjadu S, Hosegood V, Flisher AJ. (2010) Collaboration between traditional practitioners and primary health care staff in South Africa: developing a workable partnership for community mental health services. *Trans Psychiatry*.
- Buser, Juleen K, Kristopher M Goodrich, Melissa Luke, and J Buser. "A Narratology of Lesbian, Gay, Bisexual, and Transgender Clients' Experiences Addressing Religious and Spiritual Issues in Counseling." *Journal of LGBT Issues in Counseling* 5, no. 3–4 (2011): 282–303.
- Campinha-Bacote J (2002) The Process of Cultural Competence in the Delivery of Healthcare Services: a model of care. *Transcult Nurs*.
- Chen GM. (2015) Theorizing global community as cultural home in the new century. *Int J Int Relat*.
- Chrisman NJ. (2007) Extending cultural competence through systems change: academic, hospital, and community partnerships. *J Transcult Nurs*.
- Cox, Daniel, Juhem Navarro-Rivera, [Robert P. Jones, PhD](#), (2016) "Race, Religion, and Political Affiliation of Americans' Core Social Networks". *PRRI.org*
- Cornah, D., (2006). The impact of spirituality on mental health: A review of the literature. *Mental Health Foundation*
- D'Souza R.F. Do Patients Expect Psychiatrists to be Interested In Spiritual Values? *Australian Psychiatry*.
- Fernando, S. (2014) Globalization of psychiatry - a barrier to mental health development. *Int Rev Psychiatry*.
- Gamson J. Messages of exclusion: Gender, movements, and symbolic boundaries. *Gender & Society*. 1997;11:178–199.
- Giddens A. (1993) *Sociology*. Cambridge: *Polity Press*.

Grammich, Clifford, Kirk Hadaway, Richard Houseal, Dale E. Jones, Alexei Krindatch, Richie Stanley, and Richard H. Taylor. 2012. 2010 U.S. Religion Census: Religious Congregations & Membership Study. Association of Statisticians of American Religious Bodies, Jones, Dale E., et al. 2002. Congregations and Membership in the United States 2000. Nashville, TN: Glenmary Research Center Website © 2019 Advameg, Inc.

Hatzenbuehler, Mark L., Anna Bellatorre, Yeonjin Lee, Brian Finch, Peter Muennig, and Kevin Fiscella. "Structural Stigma and All-Cause Mortality in Sexual Minority Populations." *Social Science & Medicine* (1982) 103 (February 2014): 33–41.

King, M., Marston, L., McManus, S., Brugha, T., Meltzer, H., & Bebbington, P. (2013). Religion, Spirituality and Mental Health: Results from a national study of English households. *The British Journal of Psychiatry*.

Kirmayer LJ, Gomez-Carrillo A, Veissiere S. (2017) Culture and depression in global mental health: An ecosocial approach to the phenomenology of psychiatric disorders. *Soc Sci Med*.

Koenig, H.G. (2008). Concerns About Measuring "Spirituality" in Research. *The Journal of Nervous and Mental Disease*.

Langman, L.; Chung, M.C. (2012) The Relationship Between Forgiveness, Spirituality, Traumatic Guilt and Posttraumatic Stress Disorder (PTSD) Among People with Addiction. *Psychiatric Quarterly*.

Lease, Suzanne H., Sharon G. Horne, and Nicole Noffsinger-Frazier. "Affirming Faith Experiences and Psychological Health for Caucasian Lesbian, Gay, and Bisexual Individuals." *Journal of Counseling Psychology* 52, no. 3 (2005): 378– 88.

Lindman, M, & Aarnio, K. (2007). Superstitious, magical, and paranormal beliefs: An integrative model. *Journal of Research in Personality*, 41(4), 731-744.

Maldonado, D.; Maldonado, L.; DeShazier, R. (2015) Tulare County Mental Health Services Act: *Community Assessment Focus Group Report*.

Marsella AJ. (2011) Twelve critical issues for mental health professionals working with ethno-culturally diverse populations. *Psychol Int*.

McGreal, S.A. (2013) Troubled Souls: Spirituality as a Mental Health Hazard. *Psychology Today*.

Moe, Jeffry L., and Narketta M. Sparkman. "Assessing Service Providers at LGBTQ-Affirming Community Agencies on Their Perceptions of Training Needs and Barriers to Service." *Journal of Gay & Lesbian Social Services* 27, no. 3 (July 3, 2015): 350–70.

NIMH, Office of the Surgeon General (US), *Center for Mental Health Services* (US) 2001 Aug.

Pargament, K.I. (2013) What Role Do Religion and Spirituality Play In Mental Health? *American Psychological Association*.

Pon G. (2009) Cultural competency as new racism: an ontology of forgetting. *J Prog Hum Serv*.

Puchalski, Christina M., Robert Vitillo, Sharon K. Hull and Nancy Reller. "Improving the Spiritual Dimension of Whole Person Care: Reaching National and International Consensus." *Journal of Palliative Medicine*

Royal College of Psychiatrists' Spirituality and Psychiatry Special Interest Group Executive Committee. (2014). *Royal College of Psychiatrists*.

Sakamoto I. (2007) An anti-oppressive approach to cultural competence. *Can Soc Work*  
[www.jstor.org/stable/41669865](http://www.jstor.org/stable/41669865)

Shelton, Kimber, and Edward A. Delgado-Romero. "Sexual Orientation Microaggressions: The Experience of Lesbian, Gay, Bisexual, and Queer Clients in Psychotherapy." *Journal of Counseling Psychology* 58, no. 2 (April 2011): 210–21.

Tonigan, J. Scott. (2007). Spirituality and Alcoholics Anonymous. *Southern Medical Journal*

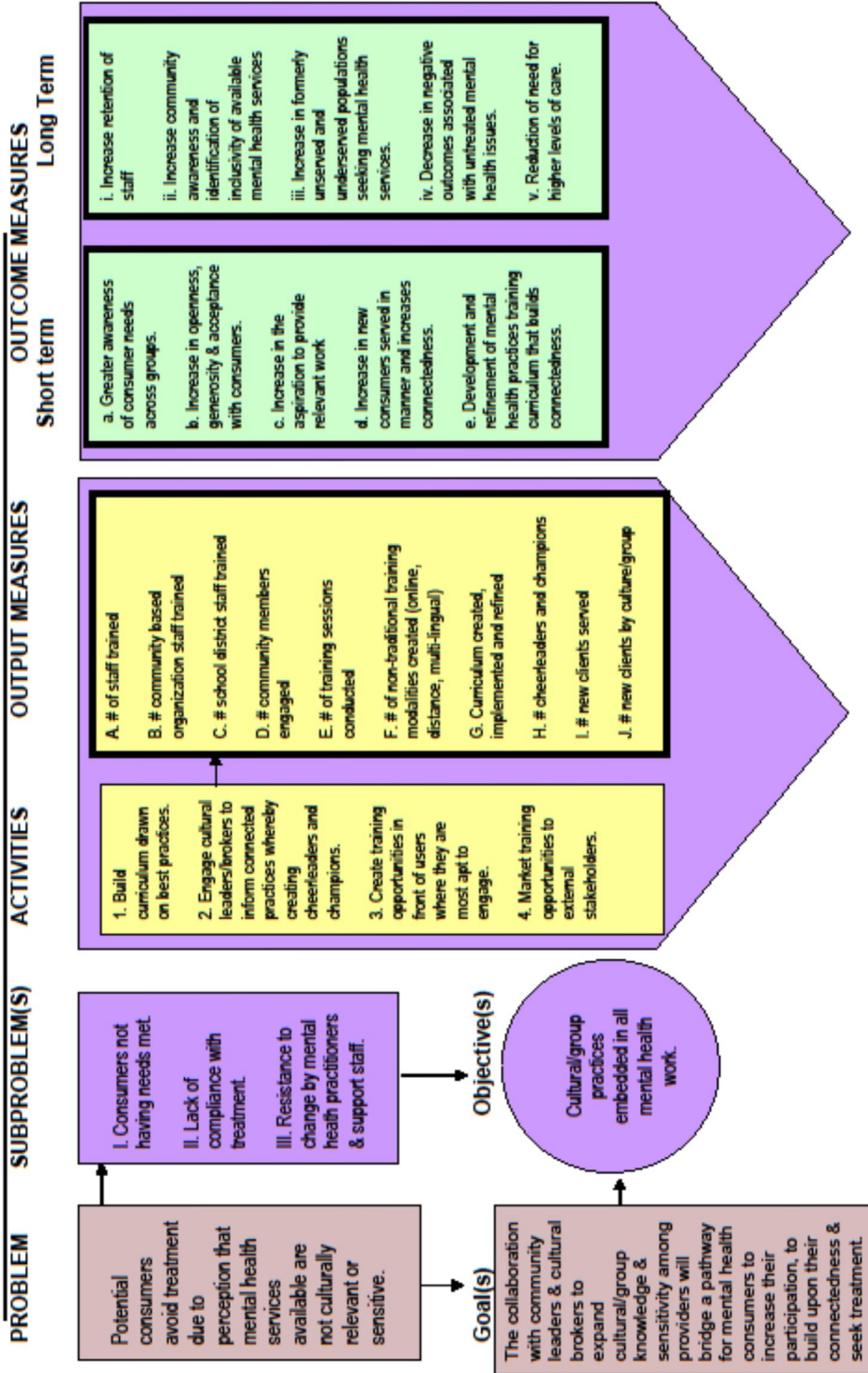
Tribe R. (2005) The mental health needs of refugees and asylum seekers. *Mental Health Review*.

USDHHS Mental Health (2001): Culture, Race, and Ethnicity: A supplement to mental health: *A Report of the Surgeon General*

Wight J. (2012) The varied expressions of 'cultural competence': findings from an exploratory study with health and human services practitioners. *Aust Mos*.

**EXHIBIT 1**

**INN TULARE COUNTY - LOGIC MODEL**  
**Connectedness to Community (C2C)**



Updated 1/17/19

## **EXHIBIT 2**

### **A spiritual assessment**

This should be considered as part of every mental health assessment. [Depression](#) or substance misuse, for example, can sometimes reflect a spiritual void in a person's life. Mental health professionals also need to be able to distinguish between a spiritual crisis and a mental illness, particularly when these overlap.

A helpful way to begin is to be asked "Would you say you are spiritual or religious in any way? Please tell me how." Another useful question is, "What gives you hope?" or "What keeps you going in difficult times?" The answer to this will usually reveal a person's main spiritual concerns and practices.

Sometimes, a professional may want to use a questionnaire. They will want to find out:

- what helpful knowledge or strengths do you have that can be encouraged?
- what support can your faith community offer?

A gentle, unhurried approach is important – at its best, exploring spiritual issues can be therapeutic in itself.

- **Setting the scene**

What is your life all about? Is there something that gives you a sense of meaning or purpose?

- **The past**

Emotional stress is often caused by a loss, or the threat of loss. Have you had any major losses or bereavements or suffered abuse? How has this affected you?

- **The present**

Do you feel that you belong and that you are valued? Do you feel safe and respected? Are you and other people able to communicate clearly and freely?

Do you feel that there is a spiritual aspect to your current situation? Would it help to involve a chaplain, or someone from your faith community? What needs to be understood about your religious background?

- **The future**

What do the next few weeks hold for you? What about the next few months or years? Are you worried about death and dying, or about the possibility of an afterlife? Would you want to discuss this more? What are your main fears about the future? Do you feel the need for forgiveness about anything? What, if anything, gives you hope?

- **The next step**

What kind of support would work for you? How could you best be helped to get it? Is there someone caring for you with whom you can explore your concerns?

## Connectedness 2 Community (C2C) Innovation Timeline

