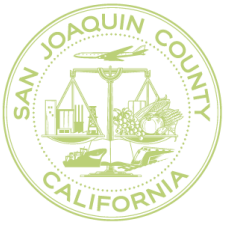


SAN JOAQUIN
COUNTY
Greatness grows here.

San Joaquin County
Behavioral Health Services

Mental Health Services Act (MHSA)

Annual Update to the 2020-23
Three-Year Program and Expenditure Plan
FY 2021-22

June 24, 2021

Board of Supervisors Approval: July 27, 2021

SAN JOAQUIN COUNTY

MHSA FISCAL ACCOUNTABILITY CERTIFICATION

County/City: SAN JOAQUIN COUNTY

☐ **Three-Year Program and Expenditure Plan**

X Annual Update

☐ Annual Revenue and Expenditure Report

Local Mental Health Director		**County Assistant Auditor-Controller**	
Name:	Tony Vartan	Name:	Jeffery Woltkamp
Telephone Number:	209-468-8750	Telephone Number:	209-468-3925
E-mail:	tvartan@sjcbhs.org	E-mail:	jwoltkamp@sjgov.org
Local Mental Health Mailing Address:			
1212 N. California St. Stockton CA 95202			

I hereby certify that the Three-Year Program and Expenditure Plan is true and correct and that the County has complied with all fiscal accountability requirements as required by law or as directed by the State Department of Health Care Services and the Mental Health Services Oversight and Accountability Commission, and that all expenditures are consistent with the requirements of the Mental Health Services Act (MHSA), including Welfare and Institutions Code (WIC) sections 5813.5, 5830, 5840, 5847, 5891, and 5892; and Title 9 of the California Code of Regulations sections 3400 and 3410. I further certify that all expenditures are consistent with an approved plan or update and that MHSA funds will only be used for programs specified in the Mental Health Services Act. Other than funds placed in a reserve in accordance with an approved plan, any funds allocated to a county which are not spent for their authorized purpose within the time period specified in WIC section 5892(h), shall revert to the state to be deposited into the fund and available for counties in future years.

I declare under penalty of perjury under the laws of this state that the foregoing and the attached update/revenue and expenditure report is true and correct to the best of my knowledge.

Tony Vartan, Mental Health Director _____ Signature

6/30/2021
Date

I hereby certify that for the fiscal year ended June 30, 2020 the County has maintained an interest-bearing local Mental Health Services (MHS) Fund (WIC 5892(f)); and that the County's financial statements are audited annually by an independent auditor and the most recent audit report is dated for the fiscal year ended June 30, 2020. I further certify that for the fiscal year ended June 30, 2020, the State MHSA distributions were recorded as revenues in the local MHS Fund; that County MHSA expenditures and transfers out were appropriated by the Board of Supervisors and recorded in compliance with such appropriations; and that the County has complied with WIC section 5891(a), in that local MHS funds may not be loaned to a county general fund or any other county fund.

I declare under penalty of perjury under the laws of this state that the foregoing, and if there is a revenue and expenditure report attached, is true and correct to the best of my knowledge.

Jeffery Woltkamp, County Asst Auditor Controller _____ Signature

7/8/2021
Date

SAN JOAQUIN COUNTY
MHSA COMPLIANCE CERTIFICATION

County/City: SAN JOAQUIN COUNTY

☐ **Three-Year Program and Expenditure Plan**

X Annual Update

Local Mental Health Director		**Program Lead**	
Name:	Tony Vartan	Name:	Cara Dunn
Telephone Number:	209-468-8750	Telephone Number:	209-468-2082
E-mail:	tvartan@sjcbhs.org	E-mail:	cdunn@sjcbhs.org
Local Mental Health Mailing Address:			
1212 N. California St. Stockton CA 95202			

I hereby certify that I am the official responsible for the administration of county/city mental health services in and for said county/city and that the County/City has complied with all pertinent regulations and guidelines, laws and statutes of the Mental Health Services Act in preparing and submitting this Three-Year Program and Expenditure Plan, including stakeholder participation and non-supplantation requirements.

This Annual Update to the Three-Year Program and Expenditure Plan has been developed with the participation of stakeholders, in accordance with Welfare and Institutions Code Section 5848 and Title 9 of the California Code of Regulations section 3300, Community Planning Process. The draft Annual Update to the Three-Year Program and Expenditure Plan was circulated to representatives of stakeholder interests and any interested party for 30 days for review and comment and a public hearing was held by the local mental health board. All input has been considered with adjustments made, as appropriate. The Annual Update to the Three-Year Program and Expenditure Plan, attached hereto, was adopted by the County Board of Supervisors on 7/27/21.

Mental Health Services Act funds are and will be used in compliance with Welfare and Institutions Code section 5891 and Title 9 of the California Code of Regulations section 3410, Non-Supplant.

All documents in the attached Annual Update to the Three Year Program and Expenditure Plan are true and correct.

Tony Vartan, Mental Health Director _____ Signature

6/30/2021 Date

Preface Statement

This 2021-22 Annual Update to the 2020-23 Three-Year Mental Health Services Act (MHSA) Plan, developed by San Joaquin County Behavioral Health Services (BHS) in Spring 2021, presents a continuation of most MHSA projects included in 2020-21 with other program edits being kept to a minimum. The Plan continues to take a conservative approach to programming and limits changes from the prior year's Plan due to the continued uncertainty of the economy in the midst of the COVID-19 crisis.

BHS conducted a community planning effort that resulted in a lower level of community participation due to the COVID-19 Pandemic. Feedback provided identification of some gaps in services and many valuable ideas for new projects. Page 8 of the Plan provides more information about the process and outcomes. BHS thanks everyone that participated in the community planning process and thanks them for their commitment to improving and enhancing mental health services in our County.

Local MHSA revenues are based upon personal income tax receipts collected by the State. The current COVID-19 pandemic has impacted many aspects of this nation, particularly the economy. However, it is too early in the current situation to quantify how significantly MHSA funding will be impacted. In an effort to responsibly and cautiously move forward with budgetary planning, BHS recommends the outlined approach included in this Plan given the revenue uncertainty in the coming fiscal years. Once the pandemic's impact on MHSA revenue can be assessed, BHS may revise this Plan and its projects.

A high-level summary of changes to the 2021-22 Plan's expenditures are included below:

- Contractual increases as a result of full program implementation in prior year/negotiated increases in multi-year contracts
- Adjustments to projections of non-MHSA offsetting revenues to reflect receipts based on actual, historical activity
- Natural increases to personnel costs/cost of services, per annual budgeting process

Table of Contents

I. Introduction

In 2004, California voters approved the enactment of the Mental Health Services Act (MHSA) for expanding mental health services to unserved, underserved, and inappropriately served populations in California to reduce the long-term impacts of untreated serious mental illness on individuals and families. The Act was amended and updated by the California Legislature in 2012 and 2016.

MHSA consists of five components, each focusing on a different aspect of the mental health system of care. These are:

- Prevention and Early Intervention (PEI)
- Community Services and Supports (CSS)
- Workforce Education and Training (WET)
- Innovation (INN)
- Capital Facilities and Technological Needs (CFTN)

The MHSA requires the County to develop a MHSA Plan for each of the five components based on the funding allocation provided by the State and in accordance with established stakeholder engagement and planning requirements.

All MHSA component plans must address the needs of children and transitional age youth (TAY) with serious emotional disturbances or mental illnesses and adults and older adults with serious mental illnesses. It must also address cultural competency and the needs of those previously unserved or underserved.

All MHSA Plans and funded programs must operate in accordance with applicable guidelines and regulations, including the California Code of Regulations, Title 9, Chapter 14, Sections §3100 - §3865.

This Annual Update to the Three-Year Program and Expenditure Plan for the period of FY 2020-21, FY 2021-22, and FY 2022-2023 was developed and approved by the San Joaquin County Board of Supervisors on __7/27/2021__.

All San Joaquin County MHSA Plans are available for review at www.sjcbhs.org.

MHSA Program Priorities

MHSA programs align with the mission, vision, and planning priorities established by San Joaquin County BHS in collaboration with its consumers and stakeholders.

Mission Statement

> The mission of San Joaquin County BHS is to partner with the community to provide integrated, culturally and linguistically competent mental health and substance abuse services to meet the prevention, intervention, treatment and recovery needs of San Joaquin County residents.

Vision Statement

> The vision of San Joaquin County BHS is to collaborate as a resilient team exploring changes, sharing ideas, striving to empower consumers, families, volunteers and care providers toward building hope, addressing disparities, and fostering wellness and recovery through individual strength-based treatment.

Planning Priorities

II. Community Program Planning and Stakeholder Process

Community Program Planning Process

The BHS community planning process serves as an opportunity for consumers, family members, mental health and substance abuse service providers and other interested stakeholders to discuss the needs and challenges of consumers receiving mental health services and to reflect upon what is working for the diverse range of consumers served. The following activities were conducted to gather information regarding current services and to provide recommendations on the need for updates and revisions.

Quantitative Analysis (Program period July 2019 – June 2020):

1. Program Service Assessment
    - Utilization Analysis
    - Penetration and Retention Reports
    - External Quality Review
2. Workforce Needs Assessment/Cultural Competency Plan
3. Evaluation of Prevention and Early Intervention Programs

Community Discussions:

4. Behavioral Health Board
    - December 2020 Introduction to MHSA Community Planning
    - MHSA Presentations and Updates on Community Convenings in January, February, April, May 2021 MHSA Community Planning Meetings and Public Hearing
5. Public Forums (Via Video Conferencing (Zoom)
    - January 13, 2021 - BHS Consortium of Mental Health Providers
    - January 20, 2021 - BHS Behavioral Health Board
    - January 21, 2021 – General Community Planning Session
    - January 26, 2021 – General Community Planning Session
    - January 28, 2021 - Co-hosted by El Concilio -Spanish (in person in Stockton, CA)

Targeted Discussions:

6. Consumer Focus Groups (Via Video Conferencing (Zoom)
    - January 13, 2021 - Co-hosted by the Wellness Center
    - January 14, 2021 - Co-hosted by the Martin Gipson Socialization Center

Consumer and Stakeholder Surveys:

7. 2020-21 MHSA Consumer and Stakeholder Surveys

Assessment of Mental Health Needs

Population Served

BHS provides mental health services and substance use disorder treatment to nearly 18,550 consumers annually. In general, program access is reflective of the diverse population of San Joaquin County, with a roughly even division of male and female clients. An analysis of services provided in 2019-20 demonstrates the program participation compared to the county population.

Mental Health Services Provided in 2019-20

Services Provided by Age	Number of Clients*	Percent of Clients
Children	2,690	17%
Transitional Age Youth	3,108	19%
Adults	8,674	53%
Older Adults	1,780	11%
Total	**16,252**	**100%**

*Source: BHS Client Services Data

Program participation is reflective of the anticipated demand for services, with the majority of services being delivered to adults ages 25-59 years of age.

Services Provided by Race/Ethnicity	County Population by Race/Ethnicity**	Percent of County Population	Clients Served*	Percent of Clients
White	257,795	34%	5,542	34%
Latino	312,075	41%	4,609	28%
African American	56,239	7%	2,792	17%
Asian	108,799	14%	1,510	9%
Other	25,716	3%	1,226	8%
Native American	3,548	.5%	497	3%
Pacific Islander	3,763	.5%	76	0.5%
Total	**776,068**	**100%**	**16,252**	**100%**

*Source: BHS Client Services Data
**Source: https://www.dof.ca.gov/Forecasting/Demographics/Projections

The diversity of clients served is similar to the distribution in prior years. African Americans are disproportionately over-represented amongst consumers compared to their proportion of the general population (17% of participants, though comprising 7% of the population of the County). Native Americans are also over-represented within the service continuum (3% of clients are Native American) and data indicates that nearly one-third of Native Americans in the County received services from BHS at least one time during the past year. Latinos are enrolled in mental health treatment services at rates

lower than expected, compared to their proportion of the general population (28% of clients versus 41% of the population). Asian clients are also underrepresented by 5%.

Services Provided by City	County Population by City**	Percent of County Population	Clients Served*	Percent of Clients
Stockton	318,522	41%	10,843	67%
Lodi	67,930	9%	1,409	8%
Tracy	95,931	12%	992	6%
Manteca	84,800	11%	1,113	7%
Lathrop	26,833	4%	311	2%
Ripon	15,930	2%	117	1%
Escalon	7,478	1%	101	1%
Balance of County	156,208	20%	1,366	8%
Total	**773,632**	**100%**	**16,252**	**100%**

*Source: BHS Client Services Data
**Source: http://www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1/

The majority of clients are residents of the City of Stockton. Stockton is the County seat of government and the largest city in the region, accounting for 41% of the County population. The majority of services and supports for individuals receiving public benefits, including mental health, are located in Stockton.

Discussion Group Input and Stakeholder Feedback

Due to the limitations on in-person gatherings brought on by the pandemic, the majority of the community forums and discussion groups for this year's planning were conducted via the Zoom video call platform.

Community Program Planning for 2020-21:

Behavioral Health Board Agenda Items

At the December 2020 Behavioral Health Board meeting, the MHSA Coordinator announced that the MHSA Plan's community program planning process would begin in January 2021. He shared the methodology and timeline for the annual planning process, which will inform the Plan's 2021-22 update. Promotional flyers with details for both consumer and community discussion groups were distributed to the Board electronically.

Community and Consumer Discussion Groups

There were five community and consumer discussion groups convened in January and February 2021, two of which specifically targeted adult consumers. A community discussion group was included in a Behavioral Health Board meeting, so stakeholders could present their input directly to members of the Board.

All community discussion groups began with an overview of the MHSA, a summary of its five components, and the intent and purpose of the different components including:

- Funding priorities
- Populations of need
- Regulations guiding the use of MHSA funding

Stakeholder participation was tracked through the Zoom chat and completed, anonymous demographic Survey Monkey links. Stakeholder participants were demographically diverse and included representatives of unserved and underserved populations, according to the surveys. The community discussion and focus groups had participation by 120 individuals, 51% of whom self-identified as a consumer of public mental health services or as a family member of a consumer. The majority of participants identified as adults ages 26-59, 20% were older adults over 59 years of age, and 7% were youth ages 18-25.

Community discussion groups were also attended by individuals representing the following groups:

- Consumers Advocates
- Substance use disorder treatment providers
- Community-based organizations
- Children and family services
- Law Enforcement
- Veterans services
- Senior services
- Housing providers
- Health care providers
- County mental health department staff

A diverse range of individuals from racial and ethnic backgrounds attended the community discussion and focus groups. Similar to the County's demographic breakdown and those BHS provides services to, no one racial or ethnic group comprised a majority of participants. As with BHS service delivery patterns, African American participants were slightly overrepresented, compared to the County population, and Latinx participants were underrepresented.

Survey Input and Stakeholder Feedback

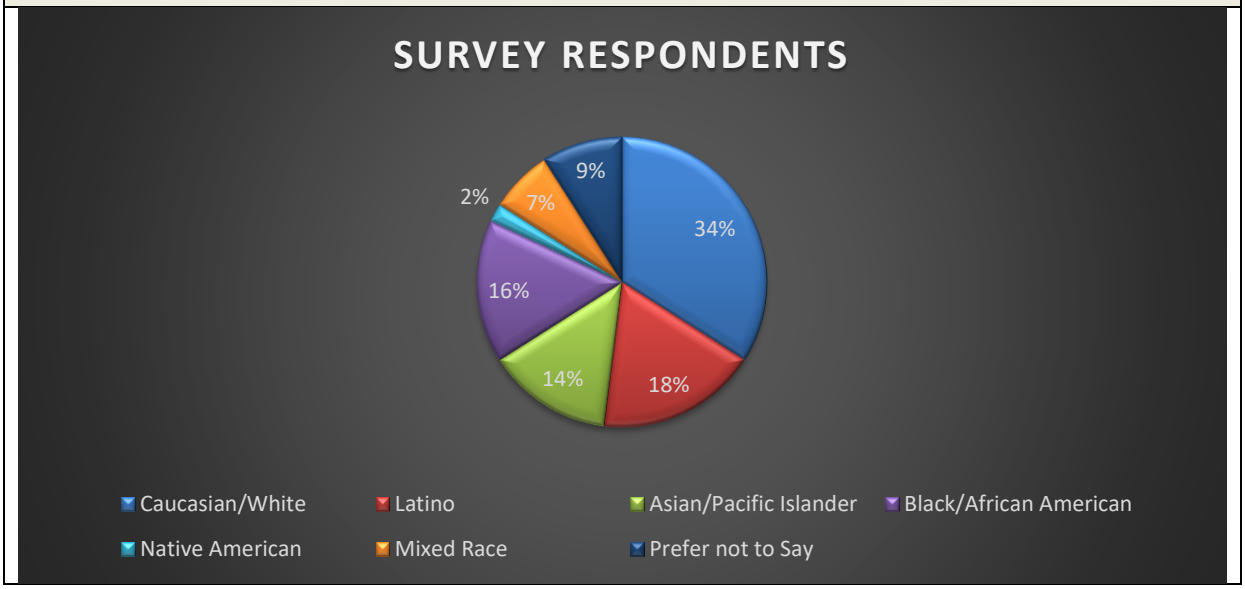
In March of 2021, BHS distributed electronic surveys to consumers, family members, and stakeholders to learn more about the perspectives, needs, and lives of clients served through mental health programs. Surveys were completed online with multiple-choice answers and responses were tallied through Survey Monkey reports. There were 117 surveys completed. Survey instruments can be reviewed in the Appendix.

BHS consumers and their family members reported mid to high levels of satisfaction with the services provided to address mental health and/or substance use disorders, with 73% of respondents reporting that they would recommend BHS services to others. According to respondents, the greatest service challenge is the length of time it takes to get an appointment. Respondents reported that cultural competency needs more work particularly in making the lobbies and reception areas feel more welcoming and friendly. Respondents agreed strongly with statements regarding staff courtesy and professionalism, respect of cultural heritage, and their capacity to explain things in an easily understood manner.

In the interest of learning more about individuals who use mental health services, survey respondents were asked to anonymously self-report additional demographic information. The objective was to have a more nuanced understanding of the clients from the data collected in standardized BHS intake forms. The respondent data revealed a deeper understanding of client demographics, criminal justice experiences, and their living situations that was previously unknown.

Adult survey respondents were more likely to be Latinx, African American, Asian, or Native American than is reflective of the general population in San Joaquin County.

Self-Reported Race and Ethnicity of Stakeholder Respondents
MHSA 2020-21 Consumer and Stakeholder Surveys



Self-Reported Age/Gender of Stakeholder Respondents

Age Range	Percent
Under 18	10%
18-25	4.5%
26-59	55%
60 and over	23%
Prefer not to say	6%

Gender	Percent
Male	30%
Female	64%
Trans	1%
Prefer not to say	5%

The 117 respondents surveyed represent the broad diversity of stakeholders and consumers served by Behavioral Health Services. Most consumers have children, with 62% describing themselves as parents. Consistent with the general population, 7% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQQI). Few have a disability, with 15% describing themselves as having a physical or developmental disability. Few are military veterans, with only 2% reporting that they have served in the US Armed Forces. Six percent (6%) of consumers reported experiencing homelessness more than four times or being homeless for at least a year; and 17% of respondents reported having been arrested or detained by the police.

Community Mental Health Issues

Key Issues for Children and Youth (Birth to 15 Years of Age)

Strengthening services and supports for children, youth and their families remains a major concern in San Joaquin County Stakeholders continue to assert that more needs to be done to support and

strengthen families, particularly those where risk factors for mental illness are present. In several of the Community Discussion and Focus groups, stakeholders discussed the importance of earlier interventions for children and families.

- Greater focus on 0-5 Population with the expansion of parenting and family strengthening course
- The biggest gap in services is early intervention for children and families following the identification of a social-emotional risk factor. Schools are seeking more behavioral health consultation in the classroom to assist teachers in working with students (including pre-school age students) that display behaviors suggestive of an emerging emotional disorder.
- ACE's programming for Children and Youth; training and awareness for the community of utilizing the 10 question assessment on ACE's through all MH Programming.
- Stakeholders expressed a need for education and training for all family/caregivers to recognize signs and symptoms of mental health Concerns.

Recommendations to Strengthen Services for Children and Youth:

- Explore programming for 0-5 population within PEI programs for Children and Youth.
- Provide Youth Mental Health First Aid Training for the community and schools.
- Make PEI school-based behavioral health intervention programs available to all children, including those in pre-school or transitional kindergarten programs.
- Provide Family Services for API Community to educate parents on signs and symptoms of mental illness and stigma reduction.

Key Issues for Transitional Age Youth (16 to 25 Years of Age)

Stakeholders expressed the most concern for transition age youth (TAY) who have aged out of the foster care system, are college-age, or are from communities that are historically unserved or underserved by mental health services. Aside from a few specialty treatment programs, most interventions target either children and youth, or adults. Despite these gaps, stakeholders remain optimistic that current resources can be leveraged in a better way to serve transitional age youth.

- Focused efforts to insure that TAY programming includes enhancing life skills and suicide prevention
- Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, or allied youth were also identified as being at higher risk for untreated behavioral health concerns, including using alcohol of other substances as a coping mechanism for depression or anxiety related to social stigma and discrimination. LGBTQIA youth have few resources or supports in San Joaquin County, though an emerging allies movement is increasing awareness of the need for more deliberate and integrated approaches to supporting LGBTQIA youth in the county.

Recommendations to Strengthen Services for Transition Age Youth

- Stronger outreach and engagement to TAY population including hiring peer specialists/outreach worker positions specifically in-tuned with the TAY Community. Work with local colleges to develop a pathway for referrals for student mental health concerns. Convene a workshop for college mental health professionals on the prevention and early interventions services available in the community, and tips for accessing services for mild to moderate behavioral health concerns.

- BHS TAY services programs should demonstrate capacity to deliver culturally competent and trauma informed services, by enhancing TAY mentoring program that includes and utilizes a cultural component to meet the needs of the TAY population

Key Issues for Adults

Consumers and stakeholders discussed the challenges of being homeless while recovering from a mental illness, and the need to develop more housing for people with mental illnesses. Consumers and stakeholders expressed the lack of outreach and engagement into underserved communities within San Joaquin County.

- Individuals with mental illnesses, and co-occuring disorders that are homeless lack wrap around services and specialized housing case management.
- Consumer expressed the need for ancillary supportive services to enhance life skills, benefits, transitional services for adults out of incarceration and strengthening adults in family life skills.
- Latino communities are underrepresented in the adult mental health service system. Education is needed to reduce stigma towards mental illness that may prevent self and family help-seeking behavior. Education is also needed to address suicide risk and ideation, especially targeting adult men.
- BHS should work with community partners to better serve Southeast Asian clients as there is low language proficiency among BHS staff to serve some Southeast Asian clients in their native languages.

Recommendations to Strengthen Services for Adults

- BHS should continue to strengthen the housing continuum for people with serious mental illnesses.
- BHS should strengthen community engagement to underserved communities with Communities of Color and faith based organizations by funding community organizations to conduct targeted focus community planning.
- BHS should explore the use of Community Centers in the county to provide community driven/culturally appropriate outreach and engagement and education of Communities of Color.
- BHS should continue enhancing culturally aligned assessment/treatment and recovery needs of adults.

Key Issues for Older Adults

Older adults with mild to moderate mental health concerns remain at-risk for untreated depression and suicide ideation. More articulation is needed with senior and older adult service providers to offer interventions for older adults that have escalating behavioral health challenges. More public information and education about the risk of suicide in adults and older adults is needed; particularly focusing on adult men who are at the highest risk for suicide in San Joaquin County. Finally, stakeholders identified the biggest risk among older adults living independently as social isolation, especially in light of the COVID-19 Pandemic. Stakeholders encouraged more behavioral health services co-located at county community centers that provide senior activities, services, and supports throughout the County.

- There are few behavioral health prevention services for older adults in San Joaquin County.
- There are few evidence based substance use disorder treatment programs designed for older adults in San Joaquin County, of serious concern because alcohol abuse is strongly correlated with older adult depression.
- Older adult behavioral health prevention services should work in partnership with local community centers.
- Vulnerable older adults include those that are homeless, and living alone.

Recommendations to Strengthen Services for Older Adults:

- BHS Older Adult Services should provide meaningful alternatives for daily living that combat depression and isolation including more socialization activities and more activities that prevent memory deterioration or loss of cognitive functioning.
- Provide culturally appropriate services that understand the cultural and generational trauma experienced by older adults by providing cultural healing practices in services.
- Co-locate senior peer counseling programs at community centers once a week. Ensure that senior peer partners have training in recognizing signs and symptoms of alcohol abuse and have an array of tools and resources to refer older adults who are requesting assistance with behavioral health concerns, including co-occurring disorders. Utilize county community centers to link older adults with technology learning program to connect with telehealth and zoom applications.
- Work with Human Services Agency to identify isolated older adults with escalating mental health symptoms. Convene a workshop for Adult Protective Services staff on the prevention and early interventions services available in the community, and tips for accessing mental health interventions for mild to moderate behavioral health concerns.
  Broaden suicide prevention efforts to target the adult community. Include targeted prevention information for middle age and older adult men. Address handgun and firearm safety when living with loved ones experiencing depression.

Public Review of 2021-22 MHSA Annual Update to the Three Year Program and Expenditure Plan

Dates of the 30 day Review

The public was invited and encouraged to review and submit input to the draft MHSA Plan from May 17, 2021 until June 16, 2021.

Methods of Circulation

The draft MHSA Plan was posted for review on the San Joaquin County Behavioral Health Services website at https://www.sjcbhs.org/MHSA/mhsaplan.aspx. Comments were accepted via e-mail at mhsacomments@sjcbhs.org or by U.S. Postal Service at:

MHSA Coordinator
San Joaquin County Behavioral Health Services
1212 N. California Street
Stockton, CA 95202

E-mail notices were sent to the BHS MHSA e-mail list which has been continuously maintained since MHSA planning began in 2006. Contracted providers were asked to post notifications in their public program areas, indicating that the draft annual update to the 2020-23 MHSA Plan was available for review.

Public Hearing

A public hearing convened on June 16, 2021 at the Behavioral Health Board Meeting

The San Joaquin County Board of Supervisors accepted the 2021-22 MHSA Three Year Program and Expenditure Plan Update on 7/27/2021.

Public Comments:

Overall, there was strong support at the public hearing for the 2021-22 MHSA Annual Update. Questions on planning process were answered during the public hearing. No additional substantive comments were received during the public comment period.

Before the Board of Supervisors

County of San Joaquin, State of California

B-21-461

Approval of the 2021-2022 Annual Update to the 2020-2023 Mental Health Services Act Three Year Program and Expenditure Plan, for an Amount of $71,733,505

THIS BOARD OF SUPERVISORS DOES HEREBY approve the 2021-2022 Annual Update to the 2020-2023 Mental Health Services Act Three Year Program and Expenditure Plan, for the period of July 1, 2021 to June 30, 2022, for an amount of $71,733,505.

I HEREBY CERTIFY that the above order was passed and adopted on July 27, 2021 by the following vote of the Board of Supervisors, to wit:

MOTION: Villapudua/Miller/5

AYES: **Villapudua, Miller, Winn, Rickman, Patti**

NOES: **None**

ABSENT: **None**

ABSTAIN: **None**

ATTEST: RACHÉL DeBORD
Clerk of the Board of Supervisors
County of San Joaquin
State of California

Rachél DeBord

III. MHSA Component Funding for FY 2021-22

MHSA Component Worksheets describe the total planned expenditures for Fiscal Years 2021-22

1. Summary Worksheet
2. Community Services and Support Worksheet
3. Prevention and Early Intervention Worksheet
4. Innovation Worksheet
5. Workforce Education and Training Worksheet
6. Capital Facilities and Technological Needs Worksheet

FY 2021/22 Mental Health Services Act Annual Update
Funding Summary

County: San Joaquin County

Date: 4/1/2021

	MHSA Funding					
	A	B	C	D	E	F
	Community Services and Supports	Prevention and Early Intervention	Innovation	Workforce Education and Training	Capital Facilities and Technological Needs	Prudent Reserve
A. Estimated FY 2021/22 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	42,602,482	11,723,051	8,573,423	753,940	12,928,496	
2. Estimated New FY 2021/22 Funding	33,338,268	8,334,567	2,193,307			
3. Transfer in FY 2021/22	(6,143,355)			500,000	5,643,355	0
4. Access Local Prudent Reserve in FY 2021/22						
5. Estimated Available Funding for FY 2021/22	69,797,395	20,057,618	10,766,730	1,253,940	18,571,851	
B. Estimated FY 2021/22 MHSA Expenditures	46,220,359	14,058,940	3,830,631	661,846	6,961,729	
G. Estimated FY 2021/22 Unspent Fund Balance	23,577,036	5,998,678	6,936,099	592,094	11,610,122	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2020	6,939,866
2. Contributions to the Local Prudent Reserve in FY 2020/21	0
3. Distributions from the Local Prudent Reserve in FY 2020/21	0
4. Estimated Local Prudent Reserve Balance on June 30, 2021	6,939,866

a/ Pursuant to Welfare and Institutions Code Section 5892(b), Counties may use a portion of their CSS funds for WET, CFTN, and the Local Prudent Reserve. The total amount of CSS funding used for this purpose shall not exceed 20% of the total average amount of funds allocated to that County for the previous five years.

FY 2021/22 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: San Joaquin Date: 4/1/2021

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CSS Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
FSP Programs						
1. Children and Youth FSP	11,954,848	8,662,124	3,291,974			750
2. Transitional Age Youth FSP	1,019,494	709,568	308,426			1,500
3. Adult FSP	8,948,165	4,589,116	4,337,399			21,650
4. Older Adult FSP	1,511,718	1,118,093	383,375			10,250
5. Community Corrections FSP	1,653,929	1,394,358	258,231			1,340
6. InSPIRE FSP	775,956	669,368	105,588			1,000
7. Intensive Adult FSP	2,014,108	1,424,860	589,248			
8. Intensive Justice Response FSP	2,017,257	1,742,929	274,328			
9. Housing Empowerment Services FSP	1,029,610	1,029,610				
10. High-Risk Transition Team	727,200	727,200				
11. Adult Residential Treatment Services	1,010,000	1,010,000				
Non-FSP Programs						
12. Mental Health Outreach and Engagement	643,073	643,073				
13. Mobile Crisis Support Team	1,104,761	1,102,261				2,500
14. Peer Navigation	303,000	303,000				
15. Wellness Center	540,293	540,293				
16. Project Based Housing	1,646,300	1,646,300				
17. Employment Recovery Services	370,777	370,777				
18. Community Behavioral intervention Services	912,172	694,134	216,438			1,600
19. Housing Coordination Services	3,227,101	3,098,344	128,757			
20. Crisis Services Expansion	7,781,680	3,985,211	3,755,919			40,550
21. System Development Expansion	4,755,440	4,618,695	136,745			
CSS Administration	6,141,044	6,141,044				
Total CSS Program Estimated Expenditures	60,087,927	46,220,359	13,786,428	0	0	81,140
FSP Programs as Percent of Total	57.4%					

FY 2021/22 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: San Joaquin Date: 4/1/2021

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated PEI Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
Prevention Programs for Children, Youth & Families						
1. Skill Building for Parents and Guardians	2,560,669	2,560,669				
2. Mentoring for Transitional Age Youth	886,373	886,373				
Early Intervention Programs for Children and Youth						
3. Early Mental Health Services	1,199,533	1,199,533				
4. School Based Interventions	2,604,017	2,604,017				
5. Early Interventions to Treat Psychosis	1,239,650	672,770	566,780			100
Early intervention Programs for Adults and Older Adults						
6. Trauma Services for Adults	1,380,000	1,380,000				
7. Recovery Services for Nonviolent Offenders	461,258	461,258				
Access and Linkage to Treatment Program						
8. Whole Person Care Project	967,042	967,042				
Outreach for Increasing Recognition of the Early Signs of Mental Illness						
9. Increasing Recognition of Mental Illnesses	301,866	301,866				
Stigma and Discrimination Reduction Program						
10. Information and Education Campaign	1,756,521	1,756,521				
Suicide Prevention Program						
11. Suicide Prevention with Schools and School Community	610,194	610,194				
12. Suicide Prevention Awareness Campaign	633,696	633,696				
PEI Administration	0					
PEI Assigned Funds						
Funds assigned to CalMHSA	25,000	25,000				
Total PEI Program Estimated Expenditures	14,625,820	14,058,940	566,780	0	0	100

FY 2021/22 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: San Joaquin Date: 4/1/2021

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Assessment and Respite Center	2,165,513	2,165,513				
2. Progressive Housing	1,665,118	1,665,118				
	0					
	0					
	0					
	0					
INN Administration	0					
Total INN Program Estimated Expenditures	3,830,631	3,830,631	0	0	0	0

FY 2021/22 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: San Joaquin Date: 4/1/2021

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated WET Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
WET Programs						
1. Training and Technical Assistance	364,455	364,455				
2. Internship and Financial Assistance	297,391	297,391				
	0					
	0					
	0					
WET Administration	0					
Total WET Program Estimated Expenditures	661,846	661,846	0	0	0	0

FY 2021/22 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: San Joaquin Date: 4/1/2021

	Fiscal Year 2021/22					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated CFTN Funding	Estimated Medi-Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
CFTN Programs - Capital Facilities Projects						
1. Residential Treatment Facilities for COD	8,197,845	2,767,659				5,430,186
2. Facility Renovations	0					
3. Facility Repair and Upgrades	3,689,070	3,689,070				
	0					
CFTN Programs - Technological Needs Projects						
4. Technology Equipment and Software	505,000	505,000				
	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	12,391,915	6,961,729	0	0	0	0

IV. Community Services and Supports

Essential Purpose of Community Services and Supports Component Funds

The Mental Health Services Act (MHSA) allocates funding for Community Services and Supports (CSS) programs that provide treatment and interventions with individuals with serious mental health illnesses who meet the criteria for specialty mental health care services.

"Community Services and Supports" means the component of the Three-Year Program and Expenditure Plans that refers to service delivery systems for mental health services and supports for children and youth, transition age youth, adults, and older adults. These services and supports are similar to those found in Welfare and Institutions Code Sections 5800 et. seq. (Adult and Older Adult Systems of Care) and 5850 et. seq. (Children's System of Care). *CA Code of Regulations §3200.080*

In San Joaquin County CSS funding will support:

1) Full Service Partnership Programs – to provide all of the mental health services and supports necessary to an individual who is unserved, underserved, and experiencing homelessness, justice involvement, or other indicator of severe unmet need (see eligibility criteria below.)

2) Outreach and Engagement Programs – to provide outreach and engagement to people who may need specialty mental health services, but are not currently receiving the care they need or are only receiving episodic or crisis mental health services.

3) General System Development Programs- to improve the overall amount, availability, and quality of mental health services and supports for individuals who receive specialty mental health care services.

The Mental Health Services Act is intended to expand and enhance mental health services to reduce the long-term adverse impacts on individuals and families resulting from untreated serious mental illness. The Community Services and Supports component of the Act, improves *outreach and engagement* to ensure that more individuals are successfully engaged in specialty mental health care services to reduce the incidence of untreated serious mental illness; *full service partnership programs* improve the quality and intensity of specialty mental health services for the most seriously ill and gravely disabled individuals that are experiencing negative outcomes associated with incarceration, homelessness, and prolonged suffering; and *system development projects* expand and enhance the entire specialty mental health system of care to better address the needs of all individuals diagnosed with serious mental illnesses or serious emotional disorders.

Full Service Partnership Program Regulations

BHS provides a range of community-based specialty mental health services to support consumers and family members. Individuals with a mental health diagnosis may be served at various levels within the continuum of care depending upon their treatment needs. Full Service Partnership Programs are offered to consumers who require the highest level of treatment interventions to achieve their recovery goals and who meet the Full Service Partnership eligibility criteria.

"Full Service Partnership Service Category" means the service category of the Community Services and Supports component of the Three-Year Program and Expenditure Plans, under which the County, in collaboration with the client, and when appropriate the client's family, plans for and provides the full spectrum of community services so that children and youth, transition age youth, adults and older adults can achieve the identified goals. *CA Code of Regulations §3200.140*

"Full Spectrum of Community Services" means the mental health and non-mental health services and supports necessary to address the needs of the client, and when appropriate the client's family, in order to advance the client's goals and achieve outcomes that support the client's recovery, wellness and resilience. *CA Code of Regulations §3200.150*

FSP Eligibility Criteria

All individuals referred to, and receiving, FSP Program Services must meet the eligibility criteria for enrollment in a FSP as described by state statute, regulation, and local priority needs. Individuals enrolled in a FSP program will be reassessed every six months to ensure eligibility criteria remain current. Individuals that no longer meet the eligibility criteria and have stabilized in their treatment plan will be transitioned to more appropriate mental health services.

Criteria 1: Eligibility for Public Mental Health Services (WIC § 5600.3)

All individuals enrolled in a Full Service Partnership program must meet the criteria for specialty mental health services as defined by the California Welfare and Institutions Code.

Children and Youth (0-17)	Adults (18 and older)

Have a primary diagnosis of a mental disorder which results in behavior inappropriate to the child's age, and
• As a result, has substantial impairment, *and*
  ○ Is at risk of removal from the home, *or*
  ○ The mental disorder has been present for more than 6 months and is likely to continue for more than a year if untreated.
 	
OR
 	
The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.
	Have a primary diagnosis of a serious mental disorder which is severe in degree, persistent in duration, and which may cause behavioral functioning that interferes with daily living.
	• Mental disorder, diagnosed and as identified in Diagnostic and Statistical Manual of Mental Disorders.
	• As a result of the mental disorder, the person has substantial functional impairments
	• As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services, or entitlements.
	
	OR
	Adults who are at risk of requiring acute psychiatric inpatient care, residential treatment, or an outpatient crisis intervention.

Criteria 2: Designated as Underserved or Unserved (CCR §3200.300 and 3200.310)

Individuals enrolled in a Full Service Partnership program must meet the MHSA definition of an individual who is underserved or unserved by mental health services, as described in the California Code of Regulations.

Underserved	Unserved
"Underserved" means clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services, but are not provided the necessary or appropriate opportunities to support their recovery, wellness and/or resilience. When appropriate, it includes clients whose family members are not receiving sufficient services to support the client's recovery, wellness and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out of home placement or other serious consequences; members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services; and those in rural areas, Native American rancherias and/ or reservations who are not receiving sufficient services.	**"Unserved"** means those individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the County may be considered unserved.

Criteria 3: MHSA Criteria for Full Service Partnership Category (CCR § 3620.05)

Individuals enrolled in a Full Service Partnership programs must meet the MHSA eligibility criteria for enrollment.

- All children and youth identified at risk and seriously emotionally disturbed (SED) as a result of a mental health diagnosis, are eligible for enrollment in a Full Service Partnership Program.
- All others, (including, Transitional Age Youth, Adults, and Older Adults) must meet the following additional criteria:

Transitional Age Youth (Ages 16-25)	Adults (Ages 26-59)	Older Adults (Ages 60 and Older)
TAYS are unserved or underserved and one of the following: • Homeless or at risk of being homeless. • Aging out of the child and youth mental health system. • Aging out of the child welfare systems • Aging out of the juvenile justice system. • Involved in the criminal justice system. • At risk of involuntary hospitalization or institutionalization. Have experienced a first episode of serious mental illness.	(1) Adults are unserved and one of the following: • Homeless or at risk of becoming homeless. • Involved in the criminal justice system. • Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment. OR (2) Adults are underserved and at risk of one of the following: • Homelessness. • Involvement in the criminal justice system. • Institutionalization.	Older Adults are unserved experiencing, or underserved and at risk of, one of the following: • Homelessness. • Institutionalization. • Nursing home or out-of-home care. • Frequent users of hospital and/or emergency room services as the primary resource for mental health treatment. • Involvement in the criminal justice system.

Criteria 4: San Joaquin County Priority Service Needs

San Joaquin County has developed further clarification on the criteria for enrollment in a Full Service Partnership program, based on the priority service needs expressed during the MHSA Community Program Planning Process.

- For children and youth ages 3-17, Full Service Partnership Program enrollment will prioritize recipients of Child Welfare Services (e.g. foster care services); Juvenile Justice Services (e.g. juvenile detention or probation); or any Crisis Mental Health Services.
- Transitional Age Youth, Adults, and Older Adults eligible for enrollment in a Full Service Partnership Program will have a high acuity of impairment *and* have one or more of the following specific conditions:

Baseline Priority: Acuity of Impairment	**Local Priority 1: Homeless**	**Local Priority 2: Other At-Risk Conditions**
Clinical Indication of Impairment • As indicated by a score within the highest range of needs on a level of care assessment tool*. *BHS has reviewed and piloted a level of care assessment tool. Use of the *Child and Adult Needs and Strengths Assessment (*CANSA) tool is currently being implemented throughout BHS's clinical program areas.	**Homeless; or,** • Living on the street, in a vehicle, shelter, a motel, or a place not typical of human habitation. **Imminent Risk of Homelessness; or** • Having received an eviction notice, living in temporary housing that has time limits, discharged from health facility or jail without a place to live. * In consultation with stakeholders BHS is making the provision of FSP Services a priority for all individuals with serious mental illnesses who are homeless or at imminent risk of homelessness. This prioritization also aligns with the priorities outlined by members of the Board of Supervisors interviewed for this Plan.	**Involved with the Criminal Justice System**; • Recent arrest and booking • Recent release from jail • Risk of arrest for nuisance of disturbing behaviors • Risk of incarceration • SJC collaborative court system or probation supervision, including Community Corrections Partnership **Frequent Users of Emergency or Crisis Services; or** • Two or more mental health related Hospital Emergency Department episodes in past 6 months • Two or more Crisis or Crisis Stabilization Unit episodes within the past 6 months **At risk of Institutionalization.** • Exiting an IMD • Two or more psychiatric hospitalizations within the past 6 months • Any psychiatric hospitalization of 14 or more days in duration. • LPS Conservatorship

Full Service Partnership Program Implementation in San Joaquin County

FSP Component Services

The foundation of San Joaquin County's FSP Program is the provision of a full spectrum of community supports and services (e.g. housing, employment, education, mobile crisis response, peer support, and substance abuse treatment services) to sustain and stabilize individual consumers within their recovery process. FSP Programs have a high staff to consumer ratio, and a team approach that is predicated upon the partnership between the consumer, the mental health clinical team, and family or peer partners in recovery.

BHS will operate five FSP Programs and four intensive FSP programs for very high-risk individuals who are extremely reluctant to engage in mental health services, at imminent risk of institutionalization, and/or have a history of repeated contact with law enforcement for serious offenses.

<u>Standard FSP Programs</u>

- Children and Youth FSP
- Transitional Age Youth FSP
- Adult FSP
- Older Adult FSP
- Community Corrections FSP

<u>Enhanced FSP Programs</u>

- InSPIRE:
  for individuals with serious mental illnesses who are extremely reluctant to engage in services
- Intensive Adult:
  for individuals with serious mental illnesses who are at imminent risk of institutionalization
- Intensive Justice Response:
  for individuals with serious mental illnesses who commit serious offenses and are justice-involved
- *High Risk Transition Team*
  for individuals with serious mental illness transitioning from institutionalization to other services

BHS also operates several programs that are designed for the exclusive use of FSP clients including: *FSP Housing Empowerment Services* (available for eligible FSP Clients ages 18 and over) and long-term *Adult Residential Treatment Services* for FSP clients and FSP eligible clients that require enhanced engagement or specialty services to avoid institutionalization and stabilize in treatment services.

Accessibility and Cultural Competence

Equal Access:

FSP program services are available to all individuals that meet the clinical eligibility criteria for specialty mental health care and full service partnership programming without regard to the person's race, color, national origin, socio-economic status, disability, age, gender identification, sexual orientation, or religion. All program partners are required to take reasonable steps to ensure that organizational behaviors, practices, attitudes, and policies respect and respond to the cultural diversity of the communities and clients served.

Linguistic Competence:

FSP program services are delivered in a manner which factors in the language needs, health literacy, culture, and diversity of the population that is served. Information and materials are available in multiple languages and trained mental health translators are assigned as needed to ensure comprehension and understanding by the clinical team of the client's recovery goals and agreement or adherence to the treatment plan. All program partners are required to provide meaningful access to their programs by persons with limited English proficiency.

FSP programs also offer a range of culturally competent services and engagement to community-based resources designed for:

- African American consumers
- Asian / Pacific Islander consumers, including services in:
    - *Cambodian / Khmer*
    - *Hmong, Laotian, Mien*
    - *Vietnamese*
- Latino/Hispanic consumers, including services in
    - *Spanish*
- Lesbian, gay, bisexual and transgender consumers
- Middle Eastern consumers
- Native American consumers

BHS is continually striving to improve cultural competence and access to diverse communities. All partners are expected to provide meaningful linguistic access to program services and to address cultural and linguistic competency within their organization.

Full Service Partnership Program Services

FSP Engagement:

- *Enthusiastic Engagement:* Individuals with serious mental illnesses that do not respond to engagement services as usual may be referred to the InSPIRE FSP team. Enthusiastic engagement refers to a program strategy that supports daily attempts at contact and finding creative pathways to treatment services for hesitant or reluctant clients. This is an Enhanced FSP program with a limited case load. Following successful engagement clients are transitioned to an appropriate FSP program for ongoing treatment and supports.

- *Transition to Treatment:* Individuals that are treated within the BHS crisis continuum (Crisis Services, Crisis Stabilization Unit, or Psychiatric Health Facility) are discharged with a transition to treatment plan that includes a scheduled follow-up appointment and linkage to routine services. Peer navigators are also a part of the transition to treatment process following a crisis episode and may be a component of the discharge plan.

FSP Assessment and Referral Process:

- *Assessment:* Prior to receiving treatment services for a serious mental illness, all individuals must undergo a complete psychosocial assessment to evaluate their mental health and social wellbeing. The assessment examines clinical needs, perception of self, and ability to function in the community. The assessment process may also include an assessment of substance use disorders. The assessment is typically completed by a Mental Health Clinician through a scheduled appointment or as a component of a crisis evaluation – though in some (limited) instances it may be completed by a psychiatrist or psychologist.

- *Referral to Care:* Based on the assessment, the Clinician will develop a preliminary treatment plan and make a referral to the appropriate level of care. Depending on the findings of the assessment this may be a referral to a primary care physician or health plan to address a mild-moderate mental health concern; a referral to an outpatient clinic to enter into routine treatment services; or a referral to either standard or enhanced FSP services, per the MHSA eligibility criteria reviewed above *and* the purpose and capacity of the FSP program to address individual treatment needs.

FSP Enrollment into a Treatment Team

- *FSP Treatment and Support Team:* Individuals enrolled in an FSP program will have a treatment team that includes a clinician, nursing or medical staff, case manager, and frequently a peer or parent partner with lived experience in recovery is part of the team. FSP treatment teams provide targeted clinical interventions and case management and work with community based partners to offer a full range of wraparound services and supports.

- *Orientation to FSP Services:* FSP program staff will evaluate the needs and orient the eligible consumer to the program philosophy and process; providing enough information so that the consumer can make an informed choice regarding enrollment. This process is used to explore the natural supports individuals have to build into recovery efforts, including family and community supports and to further understand treatment needs. Clinicians will conduct comprehensive clinical assessment to make recommendations for treatment and service interventions which are outlined in the Client Treatment Plan.

- *Partnership Assessment Form:* The Partnership Assessment Form (PAF) is completed once, when a partnership is established within a FSP program. The PAF is a comprehensive intake that establishes history and baseline data in the following areas: residential, education, employment, sources of financial support, legal issues, emergency interventions, health status, substance abuse, and other special age and dependency related concerns.

- *Enhanced FSP Treatment Team:* All services described above, and additionally; Individuals enrolled in one of the Enhanced FSP Programs will be engaged by a larger treatment team that may additionally include an alcohol and drug counselor; and a housing, rehabilitation, or vocational specialist as part of the team. There is a low ratio of clients to treatment team staff; ideally 10:1, but not less than 15:1. The treatment team also has 24-hour responsibility responding to a psychiatric crisis and will respond at the time of any hospital admission.

FSP Treatment and Recovery Plan

- *(TAY, Adult, and Older Adult) Client Treatment Plan*: Plans describe the treatment modalities and services recommended to support recovery. Planning may occur in one or more sessions and will be completed within 60 days of enrollment. Plans include a *Strength Assessment* that highlights the interests, activities and natural supports available to the consumer and the core areas of life, or domains, (e.g. housing or personal relationships) they wish to focus on through treatment. Clients will be evaluated by a psychiatrist to review and discuss medications as a component of the treatment plans. Client Treatment Plans will be updated every six months.

- *(Children and Youth)* Client Treatment Plan: For youth in treatment in a FSP, a client treatment plan describes the treatment modalities and services recommended to support recovery. Planning may occur in one or more sessions and is driven by the Child Family Team and CANSA results. The CANSA includes a strengths section that highlights interests, activities, natural supports and internal characteristics that the CFT can use to support the client on their path to wellness. The CANSA also identifies areas of need that can be the focus of treatment. Client Treatment Plans are updated at least annually.

- *Wellness Recovery Action Plan (WRAP):* Adult Consumers will work with peer partners to develop their own WRAP plans with strategies to decrease and prevent intrusive or troubling thoughts and to increase positive activities and quality of life. WRAP plans are consumer-directed and empowerment focused.

Clinical and Service Interventions:

- *Psychiatric Assessment and Medication Management: FSP* Consumers will meet with a prescribing practitioner to determine appropriate medications and will be followed by a nurse or psychiatric technician to ensure that the prescribed medications are having the desired effects. Follow-up visits with the psychiatrist or prescribing practitioner will be scheduled as needed to refine or adjust prescriptions. Additionally, case management services may include daily or weekly reminders to take medications as prescribed.

- *Clinical Team Case Management:* FSP Consumers are enrolled into a clinical team that provides intensive home or community-based case management. The frequency of contact is directed by consumer needs and level of care. With most FSP programs clients are seen 1-3 times a week. Within enhanced FSP programs clients have 3-6 contacts per week. Case Management services include:
    - Treatment planning and monitoring of treatment progress
    - Individualized services and supports
    - Group services and supports
    - Referrals and linkages to health care services, public benefit programs, housing, legal assistance, etc.

- *Individual interventions:* FSP consumers receive individualized interventions from a clinician. BHS clinicians are trained in several modalities. Consumers work with clinicians that have training in the modality that best meets their treatment needs. Individual therapeutic approaches to support consumers may include:
    - Cognitive Behavioral Therapies, including for psychosis
    - Trauma Focused Cognitive Behavioral Therapy
    - Parent Child Interactive Therapy

- *Cognitive Behavioral and Skill-Building Groups:* FSP consumers will additionally participate in group skill building and treatment activities. Group activities are intended to further refine, reflect, and practice the behaviors and thinking-patterns identified within the WRAP and treatment plans. Consumers with co-occurring disorders will also be screened for substance use disorder treatment services, including residential or outpatient treatment services. A range of evidence-based treatment and support groups may be offered, including, but not limited to:

    - Aggression Replacement Training

- Anger Management for Individuals with Co-occurring Disorders
- Chronic Disease Self-Management Skills
- Dialectical Behavior Therapy
- Seeking Safety (a trauma-informed, cognitive behavioral treatment)
- Matrix (a cognitive behavioral substance use disorders)
- Cognitive Behavioral Interventions for substance use disorders
- Various peer and consumer-driven support groups

- *Additional Clinical Supports:*
  - Community Behavioral Intervention Services are available to adult and older adult FSP clients who are having a hard time managing behaviors and impulses and have experienced a severe loss of functioning. The services are based on the principles of *Applied Behavioral Analysis* and intended to address specific behaviors to support long-lasting functional change.
  - Intensive Home Based Services and Intensive Care Coordination are available for children, youth, and their families for any children or youth who meet Specialty Mental Health Services, and who would benefit from those services.
  - Substance Use Disorder Treatment Services are available through the Substance Abuse Services Division and include a range of outpatient, intensive outpatient, and residential treatment programs. BHS also contracts with qualified community partners to provide medication assisted treatment for individuals with co-occurring disorders.

- *Additional Community Supports:* A broad range of community, housing, and employment support services are also available to consumers enrolled in an FSP program. Programs funded through MHSA are described in Systems Development Projects, and include:
  - Wellness Centers
  - Peer Navigation
  - Mobile Crisis Support Team
  - Housing Empowerment Programming
  - Employment Recovery Services

- *Enhanced FSP Services:* Individuals enrolled within one of the enhanced FSP programs will receive all housing, rehabilitation, substance use treatment and additional clinical support services through their FSP treatment team.

- *FSP Housing Services:* Individuals with serious mental illnesses need a stable place to live in order to manage their recovery, participate effectively in treatment, and address their own health and wellness. FSP program participants may be eligible for one of several housing programs, with services ranging from assistance finding housing to placements in more long

term assisted living facilities. Housing related services and supports are based upon individual assessment of needs and strengths, and the treatment plan, and vary significantly.

- "*Whatever It Takes*" funding is set aside to help consumers achieve their recovery goals. These funds assist in paying for resources when typical services are unavailable. (MHSA CCR Title 9 Section 3260 (a) (1) (B)). FSP Programs are guided by the BHS "Client Expense Policy".

Monitoring Treatment Progress

- *Monitoring and Adapting Services and Supports:* A level of care assessment will be re-administered every six months and will be used to inform and update the intervention recommendations described in a *Client Treatment Plan*.
    - The *Child and Adult Needs and Strengths Assessment* (CANSA) is used to measure and track client progress. The CANSA is made of domains that focus on various areas in an individual's life, and each domain is made up of a group of specific items. There are domains that address how the individual functions in everyday life, on specific emotional or behavioral concerns, on risk behaviors, on strengths and on skills needed to grow and develop, and on general family concerns. The provider gives a number rating to each of these items. These ratings help the provider, client and family understand where intensive or immediate action is most needed, and also where an individual has assets that could be a major part of the treatment or service plan.

- *Quarterly Assessment Form:* The Quarterly Assessment Form is completed every three months following the enrollment. This is an abbreviated version of the PAF intake form and documents for client status of key performance measures in the areas of education, sources of financial support, health status, substance use, and legal issues (incarceration, dependency, and legal guardianship), etc.

- *Key Event Tracking Form:* A key event tracking (KET) form is completed every time there is a change in status in one of the following key areas: housing status/change; hospitalization; incarceration, education; employment; legal status (dependency, guardianship, etc.); or if there has been an emergency crisis response.

Transition to Community or Specialty Mental Health Services

- *Transition Planning:* Transition planning is intended to help consumers "step-down" from the highly intensive services of the full service partnership program into specialty and/or community based mental health services. Indicators that a consumer is ready to step-down include, increase stability in housing; increase functionality as indicated by attainment of treatment goals; completion of therapeutic interventions and readiness as determined by the FSP clinical team; and clients ability to move successfully to a lower level of care.

- *Engagement into Community or Specialty Mental Health Services*: All FSP consumers will have a *FSP Discharge Process* that includes a specific plan for follow up, linkage to a lower level of care, community resources to support progress obtained and stability in living environment. Adult consumers will be encouraged to develop (or update) their own wellness recovery action plan.

- *Post FSP Services*: FSP consumers stepping down from an FSP program will be linked with a Peer Specialist. Peer Specialist workers will ensure that individuals who have stabilized in treatment services will remain stable by providing regular follow-up services to ensure satisfaction and engagement with new treatment services and continued stability in the community for a period of up to six months following discharge from an FSP.

    - CYS Post FSP Services: CYS FSP Consumers step down from an FSP program via a warm handoff when appropriate. The FSP team introduces the consumer to their new treatment team. Often times this introduction takes place during a Child Family Team Meeting. The FSP does not close out services until the consumer is fully engaged in the step down program.

Community Services and Supports Funded Programs

Full Service Partnerships

1. Children and Youth FSP
2. Transitional Age Youth (TAY) FSP
3. Adult FSP
4. Older Adult FSP
5. Community Corrections FSP
6. InSPIRE FSP
7. Intensive Adult FSP
8. Intensive Justice Response FSP
9. FSP Housing Empowerment Services
10. High Risk Transition Team FSP
11. FSP Adult Residential Treatment Services

Outreach & Engagement

12. Mental Health Outreach & Engagement
13. Mobile Crisis Support Team
14. Peer Navigation

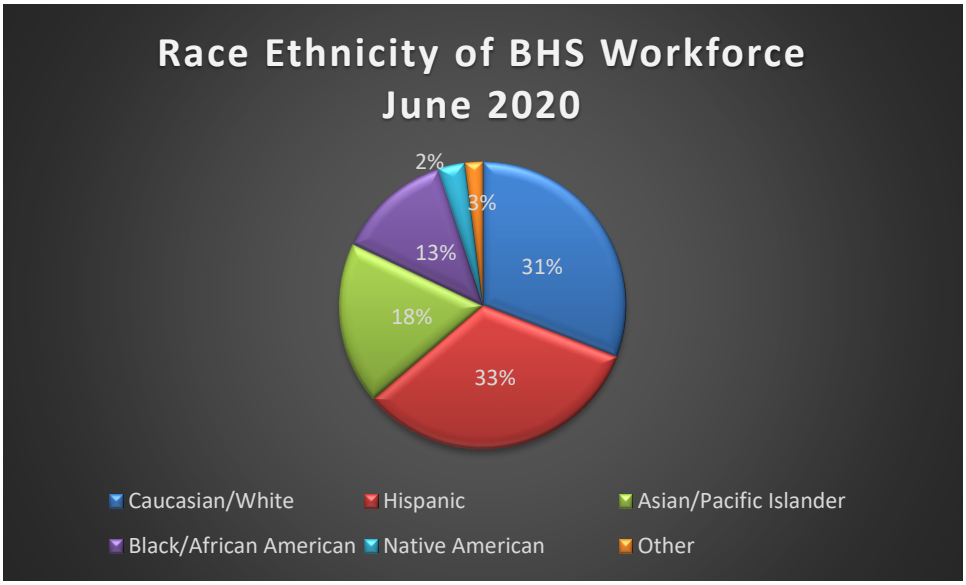
General System Development

15. Wellness Center
16. Project Based Housing
17. Employment Recovery Services
18. Community Behavioral Intervention Services
19. Housing Coordination Services
20. Crisis Services Expansion
21. System Development Expansion

Capacity to Implement CSS Programs

Over 1,000 mental health services staff and partner staff work throughout the county to deliver mental health services to approximately 16,000 individuals with serious mental illness (a 16:1 ratio of clients to partners and staff). BHS employs the largest proportion of the workforce (N=782) or 77% of the workforce. Other network providers and community-based organizations account for the remaining portion of the workforce.

The mental health workforce is comprised of licensed and unlicensed personnel (31% and 39%, respectively), as well as managerial and support staff. Staffing shortages are challenging for many positions, with licensed positions being the hardest to fill; recruitment is ongoing and continuous for licensed mental health clinicians, psychiatric technicians, and psychiatrists.



BHS works hard to recruit and retain a diverse workforce. Compared to the general population the BHS workforce is relatively diverse, and somewhat reflective of the residents of San Joaquin County. Data shows that Hispanic/Latino individuals are under-represented in the workforce, comprising 33% of the workforce, compared to 42% of the county population and 46% of Medi-Cal Beneficiaries, however in the recent year, Hispanic/Latino individuals have become slightly higher in representation than their Caucasian/White counterparts.

Further details about language capacity and cultural competency at BHS are in the Cultural Competency Plan, located in the Appendix. The Cultural Competency Plan provides more insight on the strengths and limitations of the workforce to serve a diverse population and describes the ongoing activities and strategies to strengthen the workforce and meet community needs.

CSS FSP Program Work Plans

Funding is allocated towards nine FSP programs that are implemented by twenty different clinical teams comprised of psychiatrists, clinicians, case managers, peer partners, nurses, psychiatric technicians and others. Annually, over 1,800 individuals receive services within San Joaquin's FSP programs. FSP program participants may also participate in one or more specialty programs to receive additional services and supports beyond those usually provided by an FSP team.

	Unique Count of Clients Served in FY 19-20
Full Service Partnership Programs	
1. Children and Youth FSP (4 Teams)	533
2. Transitional Age Youth (TAY) FSP (1 Team)	74
3. Adult FSP (7 Teams)	720
4. Older Adult FSP (1 Team)	83
5. Community Corrections FSP (1 Team)	253
6. InSPIRE FSP (1 Team)	33
7. Intensive Adult FSP (2 Teams)	68
8. Intensive Justice Response FSP (2 Teams)	66
9. High Risk Transition Team FSP (1 Team; direct services initiated Spring 2021)	0
TOTAL CLIENTS ENROLLED IN FSP PROGRAMS	**1,830**

CSS Project 1: Children and Youth FSP

Project Description

The Children and Youth Services FSP programs provide intensive and comprehensive mental health services to children and youth who have not yet received services necessary to address impairments; reduce risk of suicide, violence, or self-harm; or to stabilize children and youth within their own environments (see FSP Enrollment Criteria 1, page 34). Full Service Partnership program interventions are targeted for children and youth who are: (1) juvenile justice involved, or (2) engaged with the Child Welfare System, or (3) diagnosed with a serious mental illness or severe emotional disturbance that necessitates service interventions beyond the scope of traditional specialty mental health care.

Target Populations

1. **Dependency Population:** FSP programs serve children and youth that are in the dependency system. All children and youth that meet California's Pathways to Wellbeing and Intensive Care Coordination requirements are eligible for FSP services.
2. **Children and Youth:** FSP programs serve children and youth that have a severe emotional disorder and /or a diagnosed serious mental illness that require a full spectrum of services and supports to meet recovery goals.

Project Components

There are four FSP teams working with children and youth.

FSPs for Children and Youth in the Dependency System

1. Dependency FSP Team

The vast majority of children and youth served by this FSP are simultaneously involved with the juvenile justice system or the child welfare system, or both. The purpose of the Dependency FSP team is to provide an intensive level of engagement and stabilization services while working in a cross-system, cross-agency team environment that more effectively and efficiently addresses concurrent and complex child, youth, and family needs. Trained clinical staff provide trauma-informed, evidence-based services and supports to include individual therapy and group therapy, Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS) anchored in the principles and values of the Core Practice Model.

The Child and Family Team (CFT) meeting along with the CANSA will be used to address emerging issues, provide integrated and coordinated interventions, and refine and inform the plan and services as needed.

2. MHSA Pathways FSP Team

This FSP serves children and youth with the highest and most acute treatment needs that meet criteria for sub-class services. Youth receive community-based Intensive Care Coordination (ICC) in compliance with State mandates, and Intensive Home Based Services (IHBS) per State Medi-Cal regulations. ICC includes the practice of teaming with the child/youth, family, child welfare social worker, probation officer, mental health worker, and other supports through the use of CANSA informed Child and Family Team (CFT) meetings. Contracted staff are CANSA certified and skilled in the use of methods of team facilitation in order to ensure effective engagement and inclusion of the child/youth and family.

3. Therapeutic Foster Care (TFC) Team

The TFC team provides a short-term, intensive, highly coordinated, trauma-informed, and individualized intervention via the TFC Resource Parent. TFC is intended for children and youth who require intensive and frequent mental health support in a family environment. Children in this program also receive ICC and other medically necessary SMHS, as set forth in the client plan. TFC service provision is guided by a Child and Family Team (CFT). The TFC Resource Parent works under the supervision of the TFC agency and under the direction of a Licensed Mental Health Professional (LPHA) or a Waivered or Registered Mental Health Professional (WRMP) employed by the TFC agency. To ensure continuity of care the TFC agency can continue to serve the youth when they are stepped down from a TFC placement and even if the youth transitions out of foster care.

4. Short Term Residential Therapeutic Programs (STRTP)

STRTP's offer the highest level of care for at-risk youth in the foster and juvenile justice system. STRTP's are an out of home placement. Services include 24-hour supervision and an intensive, trauma informed, treatment program. The focus of treatment is to help youth and families build skills to manage challenging behaviors, restore permanent family connections and strengthen community ties through a continuum of interventions. SMHS are guided by a Child and Family Team (CFT).

FSPs for non-dependent Children and Youth

5. BHS Child and Youth (CYS) FSP Team

This team provides intensive clinical treatment services for children and youth that are at risk for and/or presenting with delinquency, violence, substance use, conduct disorder, oppositional defiant disorder, disruptive behavior disorder, mood disturbances, anxiety symptoms, or trauma. Intensive Care Coordination (ICC) will include the practice of teaming with the child/youth, family, mental health worker, and other formal and natural supports through the use of CANSA informed Child and Family Teams (CFT). All services will be driven by the CFT and may include, therapy, Intensive Home Based Services (IHBS) and Intensive Care Coordination (ICC). Therapy, in conjunction with intensive care

coordination (ICC) and intensive home based services (IHBS), will be provided by a mental health clinician and paraprofessionals. Length of stay is 6-12 months. Services will be based on Wraparound principles and will utilize a Child and Family Team Meeting to monitor progress and engage with and support the family.

Project Operational Budget: $8,662,124.30

Clients Served within the Children and Youth FSP Program

Client Demographics

Children and Youth FSP Program 2019-2020 N=533		
	Number	**Percent**
Total by Age Group Served		
▪ Children and Youth	375	70%
▪ Transitional Age Youth	158	30%
Gender Identity		
▪ Female	273	51%
▪ Male	260	49%
Race/Ethnicity		
▪ African American	117	22%
▪ Asian / Pacific Islander	13	2%
▪ Hispanic/Latino	155	29%
▪ Native American	1	0%
▪ White/Caucasian	128	24%
▪ Other / Not-Identified	119	22%
Linguistic Group		
▪ English	507	95%
▪ Spanish	16	3%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	10	2%

Cost per Client

Number Served	**Total Expenditures**
533	$3,702,737
Average Annual Cost	**Average Monthly Cost**
$5,304	$442

Client Projections

Clients Served/Projected			
2019-20	**2020-21**	**2021-22**	**2022-23**
533	627	730	900

CSS Project 2: Transitional Age Youth (TAY) FSP

Project Description

The TAY FSP provides intensive and comprehensive mental health services to unserved and underserved transitional age youth 18-25 with a diagnosed mental illness who are having difficulty stabilizing in and managing their own treatment and recovery.

Services are designed to meet the needs of adolescents and young adults, with an emphasis on recovery and wellness through an array of community services to assist TAY consumers in developing the skills and protective factors to support self-sufficiency. TAY FSP services include age-specific groups and support services and features a clinical team experienced in helping adolescents and young adults learn how to manage their recovery and transition to adulthood.

Target Population 1: Exiting or Former Foster Care Youth

- *(SED/SMI) Adolescents 18-21,* who are exiting foster care system or were at one time in the foster care system. In addition to the full spectrum of mental health and support services provided within an FSP, services are designed to teach chronic illness management skills and to find and engage caring adults and/or peers to support treatment and recovery process.

Target Population 2: Transitional Age Youth

Young adults 18-25, with serious mental illness and/or co-occurring substance use disorders. Services include a high-focus on doing "whatever-it takes" to stabilize and engage individuals into treatment services, including addressing the young adult's readiness for recovery services, extended engagement, housing supports, substance use disorder treatment services, and benefit counseling prior to the formal "enrollment" into mental health treatment services.

Project Components

There is one FSP team working with Transitional Age Youth.

Project Operational Budget: $709,568.40

Clients Served within the Transitional Age Youth (TAY) FSP Program

Client Demographics

Transitional Age Youth FSP Program 2019-2020 N=74		
	Number	**Percent**
Total by Age Group Served		
▪ Adult	22	30%
▪ Transitional Age Youth	52	70%
Gender Identity		
▪ Female	25	34%
▪ Male	49	66%
Race/Ethnicity		
▪ African American	21	28%
▪ Asian / Pacific Islander	3	4%
▪ Hispanic/Latino	19	26%
▪ Other	6	7%
▪ White/Caucasian	26	35%
Linguistic Group		
▪ English	70	94%
▪ Spanish	3	4%
▪ Other, Asian	1	2%
▪ Arabic or Farsi	0	0%
▪ Other non-English	0	0%

Cost per Client

Number Served	**Total Expenditures**
74	$656,164
Average Annual Cost	**Average Monthly Cost**
$8,867	$739

Client Projections

Clients Served/Projected			
2019-20	**2020-21**	**2021-22**	**2022-23**
74	80	80	80

CSS Project 3: Adult FSP

Project Description

Adult FSP services are available throughout the county for any adult with serious mental illness who meets the criteria for FSP enrollment, with priority enrollment given to individuals who are currently homeless, involved with the criminal justice system, frequent users of crisis or emergency services, or are at-risk of placement in an institution.

Target Population

- *Adults 26-59,* with serious and persistent mental illnesses that have not otherwise stabilized in their recovery through specialty mental health services, and who are unserved or underserved, and experiencing at least one of the following (*see eligibility criteria p. 34-36*):
    - Involvement with the criminal justice system
    - Homeless or at imminent risk of homelessness
    - Frequent emergency room or crisis contacts to treat mental illness
    - At risk of institutionalization

Project Components

There are a variety of FSP teams working with Adults who have serious mental illnesses.

1. **Intensive FSP**
   BHS has three intensive FSP teams to serve adults with serious mental illnesses who require additional intensive wrap-around services and supports in order to engage and stabilize clients into standard FSP programs. The Intensive FSP teams are described as CSS Projects #6,#7, and #8 in order to better define and account for the specialized services provided by these teams.

2. **Standard FSP**
   Black Awareness and Community Outreach Program (BACOP) FSP Team
   Community Adult Treatment Services (CATS) FSP Teams
    - *Intensive Care Engagement*
    - *Adult Recovery Treatment Services*

   La Familia FSP Team
   Lodi FSP Team
   South East Asian Recovery Services (SEARS) FSP Team
   Tracy FSP Team

Adult FSP programs provide a full spectrum of treatment services and supports to address the social, emotional, and basic living needs of *adults with serious mental illness* to ensure ongoing participation in treatment services and stabilization in the recovery process. Adult FSP services work with individuals ages 18 and over. Enrollment into teams is based on client needs and preferences.

Project Operational Budget: $4,589,116.43

Clients Served within the Adult FSP Program

Client Demographics

Adult FSP Program 2019-2020 N=723		
	Number	**Percent**
Total by Age Group Served		
▪ Transitional Age Youth	42	6%
▪ Adults	604	84%
▪ Older Adults	77	10%
Gender Identity		
▪ Female	327	45%
▪ Male	396	55%
Race/Ethnicity		
▪ African American	156	22%
▪ Asian / Pacific Islander	93	13%
▪ Hispanic/Latino	119	16%
▪ Native American	50	7%
▪ White/Caucasian	288	40%
▪ Other / Not-Identified	17	2%
Linguistic Group		
▪ English	612	85%
▪ Spanish	40	6%
▪ Other, Asian	26	4%
▪ Arabic or Farsi	0	0%
▪ Other non-English	45	5%

Cost per Client

Number Served	**Total Expenditures**
723	$5,726,461
Average Annual Cost	**Average Monthly Cost**
$7,920	$660

Client Projections

Clients Served/Projected			
2019-20	**2020-21**	**2021-22**	**2022-23**
723	725	750	800

CSS Project 4: Older Adult FSP

Project Description

The Gaining Older Adult Life Skills (GOALS) FSP provides individualized and focused treatment to older adults 60 and over with serious mental illness and/or co-occurring substance use disorders. The Older Adult FSP focuses on older adults with serious and persistent mental illness who require more extensive services and supports to successfully engage in treatment services, including linkages to other needed services, such as primary health care, supportive housing, transportation assistance, nutrition care, and services to prevent isolation and depression. The Older Adult program works collaboratively with consumers, family members, housing providers, and other service providers to ensure that consumers can live safely and independently within their community.

Target Population

- *Older Adults 60 and over,* with serious mental illness and one or more of the following:
  - Homeless or at imminent risk of homelessness
  - Recent arrest, incarceration, or risk of incarceration
  - At risk of being placed in or transitioning from a hospital or institution
  - Imminent risk of placement in a skilled nursing facility (SNF) or nursing home or transitioning from a SNF or nursing home
  - At-risk for suicidality, self-harm, or self-neglect
  - At-risk of elder abuse, neglect, or isolation

Project Components

- There is one FSP team working with Older Adults who have serious mental illnesses.

Project Operational Budget: $1,118,093.25

Clients Served within the Older Adult FSP Program

Client Demographics

Older Adult FSP Program 2019-2020 N=83		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	1	1%
▪ Older Adults	82	99%
Gender Identity		
▪ Female	48	58%
▪ Male	35	42%
Race/Ethnicity		
▪ African American	23	28%
▪ Asian / Pacific Islander	5	6%
▪ Hispanic/Latino	19	23%
▪ Native American	2	2%
▪ White/Caucasian	32	36%
▪ Other / Not-Identified	2	2%
Linguistic Group		
▪ English	62	75%
▪ Spanish	16	19%
▪ Other, Asian	2	2%
▪ Arabic or Farsi	0	0%
▪ Other non-English	3	4%

Cost per Client

Number Served	**Total Expenditures**
83	$825,158
Average Annual Cost	**Average Monthly Cost**
$9,942	$828

Client Projections

Clients Served/Projected			
2019-20	**2020-21**	**2021-22**	**2022-23**
83	76	80	80

CSS Project 5: Community Corrections Forensic FSP

Project Description

BHS's Justice and Decriminalization Unit works in partnership with San Joaquin County Jail, Correctional Health Services, the Collaborative Court System, the Probation Department, and other justice agencies, to provide a full spectrum of mental health services to consumers who are engaged by the criminal justice system. Unit staff work in collaboration with the justice system to reduce the criminalization of the mentally ill. Services include assessment, identification, outreach, support, linkage, and interagency collaboration in the courtroom and to supervising Probation Officers to help ensure a successful reentry and transition into the community for justice-involved individuals. Program activities align with the objectives of the Stepping Up Initiative, a national program for reducing incarcerations for people with serious mental illnesses. FSP programming is available for clients that meet the State's eligibility criteria and are among the following target populations.

Target Population 1: Re-entry Population

- *Justice-involved Adults 18 and over,* with serious and persistent mental illnesses who are being treated by Correctional Health Services within the San Joaquin County Jail and are within 30 days of release into the community.

Target Population 2: Forensic or Court Diversion Population

- *Justice-involved Adults 18 and over,* with a diagnosed mental illness or co-occurring substance use disorder, who are participating in problem-solving, collaborative courts in San Joaquin County or other formal diversion program.

Project Components

There are several FSP teams working with justice-involved adults who have serious mental illnesses.

1. **Intensive FSP**
   BHS contracts with two community partners to provide intensive FSP programming using an Assertive Community Treatment program model to engage justice-involved clients with a historic reluctance to engage in treatment services. The Intensive FSP program for justice-involved individuals with serious mental illnesses is described as CSS Project#8 in order to better define and account for the specialized services provided by these teams.

2. **Standard FSP**
   Forensic FSP Team

Project Operation Budget: $1,394,357.75

Clients Served within the Community Corrections FSP Program

Client Demographics

Community Corrections FSP Program 2019-2020 N=253		
	Number	**Percent**
Total by Age Group Served		
▪ Transitional Age Youth	32	13%
▪ Adults	213	84%
▪ Older Adults	8	3%
Gender Identity		
▪ Female	96	38%
▪ Male	157	62%
Race/Ethnicity		
▪ African American	67	26%
▪ Asian / Pacific Islander	16	6%
▪ Hispanic/Latino	61	24%
▪ Native American	15	6%
▪ White/Caucasian	84	33%
▪ Other / Not-Identified	10	4%
Linguistic Group		
▪ English	233	92%
▪ Spanish	5	2%
▪ Other, Asian	2	1%
▪ Arabic or Farsi	0	0%
▪ Other non-English	13	2%

Cost per Client

Number Served	**Total Expenditures**
253	$713,425
Average Annual Cost	**Average Monthly Cost**
$2,820	$235

Client Projections

Clients Served/Projected			
2019-20	**2020-21**	**2021-22**	**2022-23**
253	283	280	280

CSS Project 6: InSPIRE FSP

Project Description

The Innovative Support Program in Recovery and Engagement (InSPIRE) program serves individuals between the ages of 18-59 who are hesitant or resistant to engaging in mental health treatment. InSPIRE strives to find additional pathways to mental health services for hesitant or reluctant clients to improve individual well-being and create a safer community. A key element of InSPIRE is *Enthusiastic Engagement*.

Enthusiastic Engagement can be defined by daily contacts to build rapport and provide a framework for voluntary mental health treatment. The goal is to engage clients, improve client stability, self-sufficiency, maintain engagement in outpatient treatment services, support placement in safe and stable housing environments, and provide individualized safety plans for clients and their family as needed.

Target Population

- *Adults,* between the ages of 18-59 (some exceptions) who have a serious mental illness and are substantially deteriorating, gravely disabled, or unable to care for themselves. InSPIRE clients may pose a serious risk to themselves or others, have a history of reluctance to engage in traditional mental health treatment, may have a history of multiple living situations, may have co-occurring disorders, or may have a history with law enforcement.

Project Components

- There is one InSPIRE FSP team.
- This team provides *Intensive FSP* services for adults.

Project Operational Budget: $669,367.85

Clients Served within the InSPIRE FSP Program

Client Demographics

InSPIRE FSP Program 2019-2020 N=33		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	33	100%
Gender Identity		
▪ Female	11	33%
▪ Male	22	67%
Race/Ethnicity		
▪ African American	3	9%
▪ Asian / Pacific Islander	4	12%
▪ Hispanic/Latino	1	3%
▪ Native American	1	3%
▪ White/Caucasian	24	73%
▪ Other / Not-Identified	0	0%
Linguistic Group		
▪ English	33	100%
▪ Spanish	0	0%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	0	0%

Cost per Client

Number Served	**Total Expenditures**
33	$291,759
Average Annual Cost	**Average Monthly Cost**
$8,841	$736

Client Projections

Clients Served/Projected			
2019-20	**2020-21**	**2021-22**	**2022-23**
33	30	35	35

CSS Project 7: Intensive Adult FSP

This Intensive Adult FSP will work with adult consumers, aged 18 and older, with serious and persistent mental illnesses or co-occurring substance use disorders that are at risk for institutionalization. Intensive Adult FSP Program services will use an Assertive Community Treatment (ACT) Model to provide team based services that produce positive outcomes and reduce the need for hospitalizations or institutionalization.

ACT is an evidence based program designed to support community living for individuals with the most severe functional impairments associated with serious mental illnesses. The ACT model utilizes a multi-disciplinary team, which is available around the clock, to deliver a wide range of services in a person's home or community setting. Additional information regarding Assertive Community Treatment can be found through:

- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345
  - https://store.samhsa.gov/shin/content/SMA08-4345/EvaluatingYourProgram-ACT.pdf
  - https://www.centerforebp.case.edu/client-files/pdf/act-dacts.pdf (Fidelity Criteria)

Target population

- *Adults,* between the ages of 18-59 (some exceptions) who have a serious mental illness and are substantially deteriorating, gravely disabled, or unable to care for themselves. The target population for the program is consumers who are at risk of acute or long term locked facility placement and/or have had multiple failed transitions from locked facilities to lower level of care. Intensive Adult FSP clients may pose a serious risk to themselves or others, may have co-occurring disorders, and/ or may have other chronic health concerns.

Project Components

- There will be two Intensive Adult FSP teams.
- Teams provide *Intensive FSP* services for adults.

Project Operational Budget: $1,424,859.52

Clients Served within the Intensive Adult FSP Program

Client Demographics

Intensive Adult FSP Program 2019-2020 N=68		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	35	92%
▪ Older Adults	2	5%
▪ Transitional Aged Youth	1	3%
Gender Identity		
▪ Female	14	37%
▪ Male	24	63%
Race/Ethnicity		
▪ African American	4	11%
▪ Asian / Pacific Islander	2	5%
▪ Hispanic/Latino	3	8%
▪ Native American	2	5%
▪ White/Caucasian	15	68%
▪ Other / Not-Identified	1	3%
Linguistic Group		
▪ English	38	100%
▪ Spanish	0	0%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	0	0%

Cost per Client

Number Served	**Total Expenditures**
68	$1,388,630
Average Annual Cost	**Average Monthly Cost**
$20,421	$1702

Client Projections

Clients Served/Projected			
2019-20	**2020-21**	**2021-22**	**2022-23**
68	100	100	100

CSS Project 8: Intensive Justice Response FSP

This Intensive Justice Response FSP will work with adult consumers, aged 18 and older, with serious and persistent mental illnesses that have co-occurring substance use disorders. Intensive Justice Response FSP Program services will use an Assertive Community Treatment (ACT) Model to provide team based services that produce positive outcomes and reduce re-offending.

This program will provide a range of mental health treatment services within the ACT model, including case management and cognitive behavioral interventions to address criminogenic thinking with an emphasis on antisocial behaviors, antisocial personality, antisocial cognition, and antisocial associations; and lifting up protective factors associated with family, meaningful activities, or social connections. Other anticipated program services include substance use disorder treatment services; housing support services; and re-entry coaching and support.

Additional information regarding Assertive Community Treatment can be found through:

- Substance Abuse and Mental Health Services Administration (SAMHSA)
  - https://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345
  - https://store.samhsa.gov/shin/content/SMA08-4345/EvaluatingYourProgram-ACT.pdf
  - https://www.centerforebp.case.edu/client-files/pdf/act-dacts.pdf (Fidelity Criteria)

Target population

- *Adults,* between the ages of 18-59 who have a serious mental illness. The target population for this project is adults, between the ages of 18-59 who have a serious mental illness; may pose a serious risk to themselves or others; have a history of reluctance to engage in traditional mental health treatment services; and have a history of repeated contact with law enforcement with multiple involuntary holds (CA Penal Code §5150). Some participants may have more serious offense histories, including violent crimes.

Project Components

- There are two Intensive Justice Response FSP teams.
- Teams provide *Intensive FSP* services for adults.

Project Operational Budget: $1,742,928.72

Clients Served within the Intensive Justice Response FSP Program

Client Demographics

Intensive Justice Response FSP Program 2019-2020 N=66		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	59	89%
▪ Transitional Aged Youth	7	11%
Gender Identity		
▪ Female	32	48%
▪ Male	34	52%
Race/Ethnicity		
▪ African American	12	18%
▪ Asian / Pacific Islander	5	8%
▪ Hispanic/Latino	14	21%
▪ Native American	5	8%
▪ White/Caucasian	29	44%
▪ Other / Not-Identified	1	1%
Linguistic Group		
▪ English	66	100%
▪ Spanish	0	0%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	0	0%

Cost per Client

Number Served	**Total Expenditures**
66	$923,108
Average Annual Cost	**Average Monthly Cost**
$13,986	$1,166

Client Projections

Clients Served/Projected			
2019-20	**2020-21**	**2021-22**	**2022-23**
66	100	100	100

CSS Project 9: FSP Housing Empowerment Services

Project Description

Permanent supportive housing programs offer voluntary, flexible supports to help people with psychiatric disabilities choose, get, and keep housing that is decent, safe, affordable, and integrated into the community. Housing Empowerment Services helps mental health consumers enrolled in an FSP to attain and retain permanent housing. Supportive services empower consumers to live independently within their homes and communities.

Project Goal*: The overall goal of the program is to increase the numbers of mental health consumers who have safe, stable and affordable permanent housing. The measurable goal of this project is to increase the capacity of participants to maintain stable housing over time.*

The project is intended to result in:

- Increases in residential stability among mental health consumers;
- Reductions in incidences of homelessness among mental health consumers;
- Increased satisfaction with housing among mental health consumers;
- Increased number of housing units available to mental health consumers;
- Reductions in hospitalizations among mental health consumers

Target Population

The target population will be seriously mentally ill adults (ages 18 and older) enrolled in an FSP program and referred by BHS and/or their families. Participants will have symptoms of serious mental illness and be at risk of homelessness, chronic housing instability, mental health crisis, and/or hospitalization. A large portion of the target population is anticipated to have co-occurring mental health and substance abuse disorders.

Priority will be to serving individuals who are homeless, frequent users of crisis and emergency services, and/or those who have a chronic history of housing instability. In keeping with the County's MHSA Plan, the project will also provide services to unserved, underserved, and inappropriately served populations in San Joaquin County including African-American, Latino, Muslim/Middle Eastern, Native American, Southeast Asian, and Lesbian, Gay, Transgender and Bi-Sexual (LGBT) populations. Participation in services provided under this project will be voluntary.

Project Components

The Housing Empowerment Services project is based on the Evidence-Based Practice Kit on Permanent Supportive Housing issued by the federal Substance Abuse and Mental Health Services Administration (SAMHSA). (For more information, see: http://store.samhsa.gov/product/Permanent-Supportive-Housing-Evidence-Based-Practices-EBP-KIT/SMA10-4510.)

The project is a partnership between BHS and the contractor(s). BHS provides all mental health services, including assessments, treatment plans and case management services. Selected contractor(s) provide:

1. Individualized Consumer Interviews: Conduct individual interviews with each consumer to determine their preferences for location of housing (specific city or neighborhood), type of housing desired (independent, shared with roommates), desired proximity to services, transportation needs, and cultural and other preferences to assist in locating suitable housing. The interview will also be used to collect information on consumers' rental history, income, and financial situation.

2. Individualized Housing Stabilization Plans: Information collected will form the foundation of Housing Stabilization Plans, which will address both housing needs and recommended voluntary support services related to maintaining permanent housing. Contractor staff will work in partnership with FSP staff to encourage consumer participation in services designed to achieve the goals of the Housing Stabilization Plan.

   Housing Stabilization Plans will focus on identifying the minimal support necessary for the consumer household to achieve housing stability. Plans that indicate the need for continuing support will be reviewed at least every three months.

   Periodic reviews of needs and progress toward stabilization will be completed at least every three months for households requiring extended support. Contractor staff will make monthly contact with assisted households during their enrollment with an FSP. Forms used for periodic reviews will be designed to track progress toward consumer-established goals.

3. Housing Related Support Services: Designed to increase consumer's ability to choose, get and keep housing:

   a. Help consumers search for suitable scattered site housing, complete housing applications and meet with landlords to discuss possible concerns.

   b. Assist consumers in increasing independent living skills focusing on housing stability, such as paying rent on time, managing money, locating community amenities, buying furnishings and household goods, and maintaining the cleanliness of the apartment.

   c. Provide at least four informational presentations to consumers and family members on issues related to fair housing laws, tenant rights and responsibilities, landlord/tenant conflict resolution, and resolving problems with neighbors.

   d. Provide assistance for consumers in moving their furniture and belongings into their new homes.

4. Financial Assistance for Consumers: Provide financial assistance with rental deposits, initial months' rent, critical utility payments, essential furnishings, and property damage coverage in order to sustain and/or maintain stable housing in urgent situations. Contractor will submit payments for rental deposits, initial months' rent, and property damage coverage directly to landlords; subsequent assistance, as warranted and approved through the assessment process and continued re-evaluation of consumer needs, will also be made directly to landlords. Other payments will be made directly to vendors on behalf of enrolled consumers.

5. Housing Standards: Housing for each consumer will be decent, affordable and safe. Contractor will conduct property inspections prior to providing housing assistance. Determination of Housing Quality Standards will be based on standardized forms used by the federal Department of Housing and Urban Development (HUD). All housing options will also meet federal and local codes for safety and habitability. Resources will not be used to provide housing assistance in facilities that do not meet local codes or that compromise consumer health and/or safety. In keeping with identified best practices, all leases signed by consumers will be required to be standard, written rental agreements, and consumers and landlords would retain all normal rights of lease extension/termination; assistance will not be provided without a valid rental agreement in place.

Project Operational Budget: $1,029,610.16

CSS Project 10: High-Risk Transition Team FSP

This project provides services to individuals being discharged from inpatient hospitals, crisis residential placements, or other acute care facilities (including out-of-county placements) as they transition back to the community with a goal of avoiding re-emergence of symptoms and readmission to a psychiatric hospital. The target population for this program is individuals with serious mental illness who are: (1) disconnected from the mental health system of care and have minimal knowledge of how to access resources, and/or (2) are considered at high risk of symptom re-emergence or readmission due to their level of engagement or understanding of the mental health system of care.

Target Population

Individuals enrolled in FSP programs or eligible for enrollment in FSP programs due to symptom severity. Most participants will have one or more failed transitions from a higher level of care into the community.

Program Components

BHS will contracts with an organizational provider to conduct outreach with referred program participants, assess client needs, and conduct intensive case management and provide 24/7 wraparound supports as needed to prevent the reemergence of symptoms or readmission to a psychiatric facility. Services will be offered for a minimum of 90 days depending on the assessed client needs. Services should be provided through an Assertive Community Treatment (ACT) team approach – by a range of professionals with differing life skills and professional competencies to meet client needs.

- Outreach: Meet with clients while they are still in an inpatient hospital, crisis placement, or other acute care facility. Visit on a daily basis prior to discharge to establish rapport, complete a client assessment, and develop a case plan.
- Assessment: Develop an assessment of client needs and strengths. Include both long term and short term mental health needs. Include assessment of alcohol and other drugs.
- Discharge Planning: Work with BHS staff to develop suitable housing placement upon discharge. For some clients this may include developing a plan to reunify them with their families.
- Continuing Care Planning: Work with client and or family members to develop a plan for continued engagement in treatment. This may include obtaining assistance with needed medications or arranging transportation to appointments.
- Client Engagement: Provide frequent, low demand contacts with clients where they live or are most comfortable.
- Intensive Case Management: Assist clients in accessing primary and behavioral health care services, peer-based services, financial, educational, prevocational, rehabilitative or other community based services and supports needed by clients to meet their personal goals.
- Provide 24/7 “on-call” services for clients in crisis.

Project Operational Budget: $727,200.00

Clients Served/Projected			
2019-20	**2020-21**	**2021-22**	**2022-23**
0	Services Began FEB 2021		

CSS Project 11: FSP Adult Residential Treatment Services

Project Description

The Adult Residential Treatment Services (ARTS) program will provide long-term transitional housing with assisted living services to FSP consumers who are not able to live independently or in a supported housing environment. ARTS are rehabilitative services provided in non-institutional residential settings licensed as Social Rehabilitation Facilities under the provisions of the California Code of Regulations. ARTS will provide long-term interventions (18-24 months) in order to support and address the needs of individuals demonstrating severe impairment in general social functioning. Target program participants are adults and older adult FSP clients who require assistance with daily living, or are otherwise unable to maintain and manage treatment in more independent settings.

Program Requirements

BHS will partner with one or more Adult Residential Treatment Service providers to provide housing and supportive services to adults, ages 25 and older with serious and persistent mental illnesses that require assistance with daily living activities including self-care and hygiene, meal preparation, housekeeping/chores, and medication maintenance. A minimum ongoing caseload of 15 consumers shall be housed at any one time.

The purpose of the program is to facilitate a safe and timely transition from a higher level care facility (for example a crisis residential facility, psychiatric health facility, or an Institution for Mental Diseases) to a community home-like setting. ARTS services may also be used to stabilize an individual to prevent placement in a higher level of care.

The Adult Residential Treatment Services must meet all license and certification requirements established by the Department of Social Services, Community Care Licensing.

Per state licensing requirements, services will include:

- Provision and oversight of personal and supportive services
- Assist with self-administration of medication
- Provide three meals per day plus snacks
- Housekeeping and laundry
- Transportation or arrangement of transportation
- Activities
- Skilled nursing services as needed

Program Components

Provide ARTS for individuals with severe and persistent mental illnesses who are able to participate in community –based programs but require the support of therapeutic and counseling professionals to avoid transitioning to a higher level of care. It is expected that residents will move towards a more independent living setting within approximately nine (9) months to twenty-four (24) months from the date of their admission.

Project Operational Budget: $1,010,000.00

General System Development Programs

"General System Development Service Category" means the service category of the Community Services and Supports component of the Three-Year Program and Expenditure Plans under which the County uses Mental Health Services Act funds to improve the County's mental health service delivery system for all clients and/or to pay for specified mental health services and supports for clients, and/or when appropriate their families. *CA Code of Regulations §3200.170*

San Joaquin County provides funding for ten System Development projects, see list below. Project activities that provide mental health services and supports for clients entering, enrolled into, or transitioning out of full service partnership programs are included on a pro-rated basis to meet the requirement that the majority of CSS funds benefit and support Full Service Partnership activities. Funded projects include:

Outreach and Engagement

- Mental Health Outreach and Engagement
- Mobile Crisis Support Team
- Peer Navigation

General System Development

- Wellness Center
- Project Based Housing
- Employment Recovery Services
- Community Behavioral Intervention Services
- Housing Coordination Services
- Crisis Services Expansion
- System Development Expansion

CSS Project 12: Mental Health Outreach & Engagement

Expanded Mental Health Engagement services reaches out to individuals with mental illnesses who are unserved by the mental health system and to individuals for whom disparities in access to treatment are prevalent. Mental Health Engagement services will conduct brief outreach activities to engage individuals with mental health illnesses and link them into specialty mental health services. Peer partners, or outreach workers, will conduct targeted outreach to consumers of unplanned services, who meet the target population criteria and for whom there is a risk that they will not return for follow-up treatment. Outreach workers will provide information on available treatment services and the benefits of recovery within the cultural context of the individual and their family or community.

The goal of the project is to retain consumers of specialty mental health services in planned, outpatient treatment services. All consumers referred to Specialty Mental Health Engagement services are required to have an evaluation for specialty mental health care services through San Joaquin County Behavioral Health Services. Evaluations and referrals may be received through any of the BHS specialty mental health outpatient clinics or 24-hour crisis services, including the mobile crisis team, inpatient psychiatric facility, and crisis residential services.

Target populations

- *Unserved Individuals,* with an emphasis on individuals living in geographic areas with fewer mental health services and Hispanic and Latino neighborhoods to increase utilization of specialty mental health services amongst individuals with mental illness.
- *Inappropriately Served Consumers,* as evidenced by disproportionately high rates of participation in crisis or emergency services (compared to rates of participation in scheduled outpatient treatment services) including Native American and African American consumers.
- *Homeless Individuals,* including individuals that are living in a place not intended for human habitation, in an emergency shelter, in transitional housing, or are exiting a hospital, jail, or institution and do not have a residence in which to return and lack the resources or support networks to obtain housing.
- *Justice-involved Consumers*, including individuals released from jail or prisons with diagnosed mental illnesses.
- *Linguistically- and Culturally-Isolated Consumers,* for whom English is not their first language, and/or is not the first language of their parents, caregivers, or guardians.
- *Individuals with serious mental illnesses who are LGBTQI, Veterans, have developmental disabilities, or other experiences which may isolate them from the existing system of care,* including any individual who is not well-engaged by the outpatient specialty mental health clinics, and not otherwise eligible for FSP program services (i.e. lower acuity or need).

Mental Health System Outreach and Engagement

- *Provide Case Management, Engagement and Support Services* for individuals with co-occurring SMI and developmental disabilities, older adults and veterans living alone under isolated conditions who are suffering from untreated mental illnesses, including depression, grief, loneliness, post-traumatic stress disorder, or who are experiencing a loss of mobility or independence.
  - Engage and link individuals to public mental health system.
  - Provide screening, referrals and support to link participants to additional services and supports, especially as pertaining to health and safety needs.
  - Provide one-on-one support, connection and engagement to reduce depression.
  - Facilitate access to support groups at senior, veterans, and community centers.
  - Conduct two to four home visits to each participant on a monthly basis (seniors only).
  - Match funding for SAMHSA Block grant providing case management services for homeless individuals with SMI.

- *Consumer and family engagement and advocacy* helps consumers and family members navigate the system, helps consumers understand their rights and access to services, including dispute resolution. All providers (staff, contractors, and volunteers) serve as a liaison between consumers and family members and the mental health system of care. Specific activities include:
  - Family advocacy
  - Veteran outreach and engagement

Project Operational Budget: $643,073.06

CSS Project 13: Mobile Crisis Support Team

Project Description

Mobile Crisis Support Teams (MCSTs) provide on-site mental health assessment and intervention within the community for individuals experiencing mental health issues and to avert a mental health related crisis. MCST help avert hospitalizations and incarcerations by providing early interventions to individuals who would not otherwise be able to seek help at traditional service locations.

MCSTs transition individuals to appropriate mental health crisis interventions in a timely fashion, reducing dependency on law enforcement and hospital resources. Comprised of a clinician and a peer- or parent-partner, MCSTs provide a warm handoff to services and help educate and introduce individuals and their family to the most appropriate services in a calm and supportive manner.

Target Population

- Individuals who are known to have serious mental illness and are substantially deteriorating or experiencing an urgent mental health concern.

- Individuals who are suspected of having a serious mental illness who may be unconnected to a mental health care team.

Project Components

- BHS operates four mobile crisis support teams.
- Services are available daily (Monday – Sunday), and into the evening hours most days of the week.

Mobile Crisis Support Teams conduct same day and follow-up visits to individuals that are experiencing a mental health crisis and require on-site, or in-home, support and assistance. MCSTs conduct mental health screenings and assessments to determine severity of needs and help transition individuals into routine outpatient care services.

Project Operational Budget: $1,102,261.13

CSS Project 14: Peer Navigation

Project Description

The Peer Navigation program serves TAYs, Adults, and Older Adults recovering from a mental health crisis. The program provides recovery-focused post-crisis intervention, peer support, navigation and linkages to community services and supports. Peer Navigators work with individuals recently served by 24-hour crisis response services, including the Crisis Unit, Crisis Stabilization Unit, Crisis Residential Facility, the Post-PHF Clinic, and the Mobile Crisis Support Team. Peer Navigators provide a warm and caring follow-up to the crisis service and help ensure that there is appropriate follow-up care, including any necessary safety plans. Peer Navigators also provide support and education to individuals and their family members to help prevent a relapse back into crisis.

Peer Navigators have lived experience in mental health recovery and are capable of meaningfully helping others despite their disabilities with an approach based on mutual experience.

Project Goal: *Assist individuals with serious mental illnesses and their families to gain access to specialty mental health care services and community supports.*

Project Components

BHS will works with an organizational provider to provide services. The Community partner will hire and train individuals, with lived experience in mental health recovery, to serve as Peer Navigators. Community Partners will use an evidence based curriculum to train Peer Navigators. Some training activities occur in partnership with BHS, in order to ensure that Peer Navigators are familiar with BHS services. Examples of curriculum include:

- Latino Peer Navigator Manual, developed by the Chicago Health Disparities Project
- African American Peer Navigator Manual, developed by the Chicago Health Disparities Project

Program partners develop (or update) a set of resource guides and train peer navigators on the resources that are available in San Joaquin County and to BHS clients. Examples of likely resources or support services that peer navigators should be prepared to discuss include housing, food pantries, primary health care services, and transportation. Peer Navigators should also receive training on how to use the County's 211 telephone information and referral service.

Peer Navigation teams work with BHS Crisis Services to engage clients following a crisis encounter. Duties and responsibilities of the Peer Navigators may include but are not limited to:

- Provide warm outreach and engagement to clients following a crisis episode
- Provide information about community services available to support consumers
- Provide education on mental illnesses and recovery opportunities

- Provide information on client rights
- Assist clients in developing a plan to manage their recovery – this should include a safety plan to prevent relapse and a Wellness Recovery Action Plan to identify longer term recovery goals and strategies for maintaining recovery
- Encourage compliance in the treatment plan developed by the client and their clinical team
- Encourage clients to attend any follow-up appointments, and recommended groups or activities

Skills and Competencies:

- Lived experience in mental health recovery
- Reflective Listening
- Motivational Interviewing
- Wellness Recovery Action Planning (WRAP)
- Strong interpersonal skills
- Ability to maintain a self-care plan

Project Operational Budget: $303,000

CSS Project 15: Wellness Center

Project Description

Wellness Centers are consumer-operated programs that provide an array of recovery support services. Wellness Centers provide classes and information on services and supports available in the community, self-help and peer-support group activities, and trainings and workshops to promote long term recovery and well-being on a variety of topics: from positive parenting, to nutrition and active lifestyles, to job development skills. Wellness Centers provide scheduled and drop-in services and programming that is respectful and representative of the diversity of consumer members.

Project Goal

The primary objectives for this program will be to:

- Provide a consumer-driven self-help service center in close collaboration with consumers, family members and BHS.
- Increase opportunities for consumers to participate in activities that promote recovery, personal growth and independence.
  Increase leadership and organizational skills among consumers and family members.

Target Population

The target population is consumers with mental illness and their family members and support systems.

Project Components

The Wellness Center will provide the following services:

- *Consumer Leadership:* Foster leadership skills among consumers and family members, and include the use of consumer surveys to determine necessary training and supports to assist consumers and family members in providing leadership. Wellness Center(s) will develop and maintain:
  - Consumer Advisor Committee
  - Consumer Volunteer Opportunities
- *Peer Advocacy Services:* Peer Advocates or Wellness Coaches listen to consumer concerns and assist in the accessing of mental services, housing, employment, child care and transportation. Peer Advocates or Wellness Coaches train consumers to provide self-advocacy and conflict resolution. Peer Advocates or Wellness Coaches address day to day issues consumers face such as life in board and care homes and negotiating the mental health system to obtain services and understanding medications. Issues and information addressed include:
  - *Legal Advocacy:* Information regarding advanced directives and voter registration and securing identification documentation
  - *Housing Information and Advocacy:* Information on housing resources will be provided. Consumers will be assisted in developing skills needed in finding affordable, well maintained housing options and alternatives, such as finding compatible roommates.

- *Employment Advocacy*: Information on employment, the impact of SSI benefits, available resources and programs and resume and interview preparation will be provided. Assistance will be given in finding suitable clothing and transportation for job interviews. Services will be provided in collaboration with the BHS Career Center.
- *Childcare Advocacy:* Childcare advocacy will be available to consumers who have children under the age of 13 and will include the provision of information, assessing problems of access and providing vouchers to pay for childcare when needed to access mental health services, medical services or attend a job interview.
- *Transportation Advocacy:* Consumers will be trained on accessing available public transportation options. When situations arise where there are no public transportation options, the Center will provide transportation to stakeholder activities, clinic appointments, medical appointments, peer group classes, employment interviews and urgent situations.

- *Peer-Led Classes and Coaching:* The average group class size should be five to seven consumers. The following consumer-led services will be provided at the Wellness Center:

  - Independent Living Skills classes to teach cooking skills, budgeting, banking, nutrition, healthy living and exercise, grocery shopping, and use of community resources such as the library and the Food Bank.
  - Coping skills classes to teach time management, personal safety, communication skills, medication information, socialization skills, decision making and goal oriented task completion.
  - Serenity exploration to allow consumers to explore individual spirituality and growth as part of recovery.
  - Wellness and Recovery Action Planning (WRAP).
  - Computer skills coaching to assist peers in the use of computers and internet access. Computers and internet access will be available at the center.

- *Outreach Services:* Outreach services will be provided to consumers and family members to increase awareness of the availability of the Wellness Center and to encourage the use of its services. Outreach efforts will include unserved, underserved and inappropriately served populations. Cultural activities will be organized on a regular basis to introduce new community members to the Wellness Center.

- *Volunteer Program*: A volunteer program for peer advocates and peer group class facilitators will be developed and maintained. The volunteer program may also include the development of a speakers' bureau to address stigma and discrimination and to relay stories of those recovering from mental illness.

Project Operational Budget: $540,293.44

CSS Project 16: Project Based Housing

Project Description: BHS, in partnership with the Housing Authority of San Joaquin, will create Project-Based Housing Units dedicated towards individuals with serious mental illnesses for a period of twenty years.

Under federal regulations, public housing agencies operate and distribute housing choice vouchers (formerly Section 8). Up to 20% of the vouchers may be set aside to specific housing units. Project-Based Housing Units are housing units that have vouchers attached to units.

Under state regulations, MHSA funding may be used to create Project-Based Housing Units, provided that the units have the purpose of providing housing as specified in the County's approved Three-Year Program and Expenditure Plan and/or Update for a minimum of 20 years.

General System Development Funds may be used to create a Project-Based Housing Program which is defined as a mental health service and support. *CA Code of Regulations §3630(b)(1)(J)*

The regulations and requirements for the creation of a Project Based Housing Program and a Capitalized Operating Subsidy Reserve were added to the California Code of Regulations in 2016, in response to the No Place Like Home Act. See: *CA Code of Regulations §36330.05; §36330.10; §36330.15;*

Project Components

Under a partnership agreement, upon approval by the San Joaquin County Board of Supervisors and the Board of the Directors of the Housing Authority of San Joaquin, BHS and the Housing Authority shall leverage MHSA funding for the following purposes.

1) Establish a Project Based Housing Fund:
   $1.13 million will be transferred to the Housing Fund for the purpose of acquisition, construction or renovation of Project Based Housing Units.

   This fund shall be an irrevocable transfer of money from San Joaquin County Behavioral Health Services to the Housing Authority of San Joaquin for the purpose of creating future Project Based Housing Programs. Previous funded housing projects were completed on March 2021 with a total of 37 housing units completed; exceeding the previous Three Year Program and Expenditure Plan goal of developing 34 units of housing for the mentally ill.

   In partnership, Behavioral Health Services (BHS) and the Housing Authority of the County of San Joaquin (HACSJ), will acquire property, renovate and construct Sonora Square to provide 37 units of much-needed permanent supportive housing. Delta Community Developers Corporation (DCDC), the non-profit development arm of HACSJ, will convert the commercial building at 401 S. El Dorado Street, Stockton, CA, into ten (10) one-bedroom units. Further, it will construct a three-story building containing an additional 27 one-bedroom units and a

community space containing an office for programing, space for social activities, and a laundry room on adjacent land at 2 E. Sonora Street, Stockton, CA.

2) Establish a Capitalized Operating Subsidy Reserve:
Up to $500,000 will be deposited into a County-administered account prior to occupancy of the Project-based housing. The actual amount deposited in the reserve account shall be based on the difference between the anticipated tenant portion of the rent minus revenue lost from anticipated vacancies and the estimated annual operating expenses of the Project Based Housing.
    - BHS and Housing Authority mutually acknowledge that the anticipated tenant population may require *more intensive* property management services requirements than typical for a population without serious mental illnesses. Cost projections for the estimated annual operating expenses will be based on reasonable assumptions and procurement of an onsite property management team.
    - The Operating Subsidy Reserve may also be used to repair any major damages resulting from tenant occupancy beyond normal wear and tear and other scheduled property maintenance.

3) Funding shall be used in strict accordance to Regulatory Requirements:
Project-Based Housing purchased, constructed and/or renovated with General System Development funds shall comply with all applicable federal, state, and local laws and regulations including, but not limited to:
    - Fair housing law(s)
    - Americans with Disabilities Act
    - California Government Code section 11135
    - Zoning and building codes and requirements
    - Licensing requirements (if applicable)
    - Fire safety requirements
    - Environmental reporting and requirements
    - Hazardous materials requirements

    Project-Based Housing purchased, constructed and/or renovated with General System Development funds shall also:
    - Have appropriate fire, disaster, and liability insurance
    - Apply for rental or other operating subsidies
    - Report any violations to DHCS if a violation is discovered
    - Maintain tenant payment records, leasing records, and/or financial information

4) Eligibility and Target Population
All tenant residents within a Project Based Housing Unit created with General System Development Funds must be diagnosed with a serious mental illness.

5) Veteran Status
   Veterans are recognized as an underserved population. BHS and the Housing Authority will work jointly to ensure that there are more housing opportunities for veterans with serious mental illnesses.

6) Term
   Project units must remain dedicated towards housing the mentally ill for a period of no less than 20 years. Upon completion of the pilot program, BHS and the Housing Authority will mutually review evaluation and program data to determine the target population of tenants from within the population of individuals with serious mental illnesses.

7) Leasing, Rental Payments and Eviction Processes
   BHS reserves the right to make tenant referrals for placement into the Project-Based Housing Units and to develop referral policies and procedures in partnership with the Housing Authority.

   Rents will be subsidized *Project-Based Housing Vouchers,* which will be assigned by the Housing Authority and shall be specific to the Unit currently being occupied. Vouchers are non-transferable, though clients may be eligible for *Housing Choice Vouchers*, following successful completion of program services.

   The Housing Authority reserves the right to make tenant evictions and to develop tenant eviction policies and procedures in partnership with BHS.

   In all instances access to housing and housing eviction policies and procedures will be guided by applicable laws and regulations including Fair Housing Laws.

   BHS and Housing Authority will meet regularly to review policies, procedures, and practices pertaining to the operations of the Project Based Housing Units created with General System Development Funds.

Prior to the release of MHSA funds, an agreement will be created between BHS and the Housing Authority and duly executed by the San Joaquin County Board of Supervisors and the Board of Directors of the Housing Authority of San Joaquin.

Project Operational Budget: $1,646,300.00

CSS Project 17: Employment Recovery Services

Project Description

Supported Employment is an approach to vocational rehabilitation for people with serious mental illnesses that emphasizes helping them obtain competitive work in the community and providing the supports necessary to ensure their success in the workplace. The overriding philosophy of Supported Employment is the belief that every person with a serious mental illness is capable of working competitively in the community if the right kind of job and work environment can be found. Supported Employment is not designed to change consumers, but to find a natural "fit" between consumers' strengths and experiences and jobs in the community.

Project Goal*: The goal of this project is to increase the numbers of mental health consumers that are employed and/or involved in education.*

The project is intended to result in the following outcomes for mental health consumers participating in the project:

- Increased competitive employment among consumers;
- Increased independent living;
- Increased educational involvement;
- Increased self-esteem; and
- Increased satisfaction with finances.

Target Population

The target population will be seriously mentally ill adults (ages 18 and older) that are enrolled in or are transitioning to or from the County's Full-Service Partnership programs and their families. Participants will have symptoms of serious mental illness and be at risk of homelessness, chronic housing instability, mental health crisis, and/or hospitalization. A large portion of the target population is anticipated to have co-occurring mental health and substance use disorders.

Project Components

The Employment Recovery Services project will be based on the *Evidence-Based Practices Kit on Supported Employment* issued by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) located at: http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365

- *Assertive Engagement and Outreach:* Make multiple contacts with consumers as part of the initial engagement and at least monthly on an ongoing basis when consumers stop attending vocational services.

- *Vocational Profiles:* Conduct individualized interviews with each consumer to determine their preferences for type of employment, educational and work experiences, aptitudes and

motivation for employment. Vocational profiles will be consumer driven and based on consumers' choices for services. Vocational assessment will be an ongoing process throughout the consumer's participation in the program.

- *Individual Employment Plans:* In partnership with each consumer, prepare an Individual Employment Plan, listing overall vocational goals, objectives and activities to be conducted. Assist consumers with resume development and interviewing skills as needed.

- *Personalized Benefits Counseling:* Provide each consumer with personalized information about the potential impact of work on their benefits.

- *Job Search Assistance:* Help consumers explore job opportunities within one month after they enter the program. Provide job options in diverse settings and that have permanent status. Employer contacts will be based on consumers' job preferences.

- *Continuous Supports:* Provide continuous support for employed consumers that include the identification and reinforcement of success as well as coaching when concerns arise. Help consumers end jobs when appropriate and then find new jobs.

Project Operational Budget: $370,777.25

CSS Project 18: Community Behavioral Intervention Services

Project Description

The project will provide behavioral intervention work in the community to consumers who are having a hard time managing behaviors and impulses. The services are based on the foundation and principles of Applied Behavior Analysis and intended to address behaviors or symptoms that jeopardize mental health consumers' recovery, wellness and quality of life. The interventions are not intended as a "stand alone" service. They will supplement other mental health services provided to consumers.

Project Goal: *The goal of the project is to provide behavioral interventions in order to increase mental health consumers' stability, social functioning and recovery-focused behaviors.*

The project is intended to promote long-lasting functional change among consumers by decreasing the incidence of dysfunctional and maladaptive behaviors and increasing the incidence of functional and adaptive behaviors. Successful change may result in the following outcomes among participating consumers:

- Prevention of or reductions in psychiatric hospitalizations and re-hospitalizations;
- Reduction in incidences of homelessness, disruption in housing and/or out-of-home placements; and
- Reduction of the stigma and distress experienced by many consumers as a result of maladaptive behaviors.

Target Population

The target population will be seriously mentally ill adults (ages 18 and older that are enrolled in or are transitioning to or from County's Full-Service Partnership programs and their families. Participants will have symptoms of serious mental illness and be at risk of homelessness, chronic housing instability, mental health crisis, and/or hospitalization. A large portion of the target population is anticipated to have co-occurring mental health and substance use disorders.

Project Components

The contractor will use a behavior analysis model in which procedures are systematically applied to improve socially significant behavior to a meaningful degree. Treatment strategies will be flexible and individualized. In general, treatment strategies will include instruction to increase appropriate alternative behaviors. The treatment methodology will include:

- Individualized goals developed to meet the needs of each consumer;
- Teaching skills that are broken down into manageable, easy-to-learn steps;
- Opportunities for consumers to practice each step;
- Acknowledgement of successes using a tangible reward system; and

- Continuous measurement of individual consumer progress so that treatment may be adjusted as needed.

Additional project components include:

- *Behavior Assessment (Functional Analysis):* Comprehensive assessments of each consumer's behavior will be conducted to determine target behaviors that need to be addressed, the antecedents of those behaviors, and the consequences of maintaining them. The contractor staff is expected to include BHS staff, the consumer, family members and other relevant treatment team members in the behavior assessments. Behavior assessments must be completed within 30 days of the service authorization from BHS.

- *Individual Recovery Plans (Behavior Plans):* Specific and measurable Individual Recovery Plans will be completed within 30 days of the service authorization from BHS. All Individual Recovery Plans will include:

    - Definition of the target behavior;
    - Alternative behaviors to be taught;
    - Intervention strategies and methodologies for teaching alternative behaviors;
    - Methods for collecting data on and measuring target behaviors to ensure they are being reduced; and
    - An emergency management section providing detailed instruction for staff and family members on how to address the target behavior when it reoccurs.

  Individual Recovery Plans will be coordinated with and approved by BHS.

- *Individualized Progress Reports*: Progress reports on the accomplishment of goals for each consumer will be provided to BHS on a schedule as determined by BHS, but no less than monthly. Progress reports will be based on systematic data collection and evaluation of data on each consumer's progress towards their goals.

Project Operational Budget: $694,133.61

CSS Project 19: Housing Coordination Services

Project Description: BHS recognizes that a safe and stable place to live is a necessary component for mental health wellness and recovery. Housing Coordination and Placement Teams will assess housing placement needs for individuals with serious mental illness and link clients to housing services and supports appropriate to the treatment needs of each consumer. Team members work with housing providers to stabilize consumers in their placements and provide regular home visits to encourage consumers to remain engaged in treatment and to take medications as prescribed.

Project Goal: *The goal of this project is to reduce the incidence of homelessness or housing instability among consumers and to increase participation in routine treatment.*

Project Components

Project 1: Housing Referral and Linkage

Dedicated staff will coordinate housing placement recommendations for BHS consumers with serious mental illnesses. Located within the outpatient Community Adult Treatment Services division, teams manages client placement within a continuum of housing placement options. In general the task is to evaluate each client and determine the type of housing best suited to the treatment needs of the individual. Housing options will range from "intensive" such as provided by a crisis residential or adult residential care facility; to more independent or supported living options.

Project 2: Housing-based Case Management

The *Placement Team* provides case management services to consumers, for extended periods of time while placed in out of county residential enhanced board and care homes. They will work briefly with newly referred consumers, not yet open to outpatient services, until linked and stable in housing. The *Housing Coordination Team* works with clients in designated housing programs to provide socialization and rehabilitation groups and linkage to behavioral health and community resources. Both teams work closely with housing operators to ensure that placements are a good fit between the client, the program, and other tenants. Case managers work with clients to help them maintain treatment compliance, attend routine appointments, and participate in groups and socialization activities.

Project 3: Housing Stabilization Resources

MHSA funding will be used to provide "patches" to board and care and other residential care facility operators providing housing to individuals with serious mental illnesses, including consumers exiting institutions that require extra stabilization supports to prevent decompensation.

MHSA funding will be used for short-term emergency "housing stabilization funds" to assist consumers who are determined to be at imminent and immediate risk of homelessness due to displacement to procure new housing.

Project Operational Budget: $3,098,344.20

CSS Project 20: Crisis Services Expansion

Project Description

Through MHSA funding, BHS has expanded and enhanced crisis services. The Crisis Unit provides a 24/7 crisis response for any individual experiencing a mental health emergency in San Joaquin County. New Crisis Services fully or partially funded through MHSA funds include:

Project Components

Project 1: Capacity Expansion

Prior to the passage of the Mental Health Services Act in November 2004, the BHS Crisis Unit operated M-F from 7am – 11pm. Staffing was limited and wait times were very long. MHSA funding created a full-service Mental Health Crisis Unit for San Joaquin County that is open 24/7, 365 days a year.

The expanded crisis unit boasts more robust staffing, reducing wait times. It has a new medication room, eliminating the need to wait for the pharmacy to open for the team to dispense medications. Services are expanded with a new triage unit, ensuring all clients receive a warm welcome and a brief screening within a timely fashion. Enhanced discharge services make it possible for clients to receive aftercare support and a warm connection to continuing services through the Outpatient Clinics. New discharge services include: post-crisis or -hospitalization transportation home, and transport to initial outpatient appointments, if necessary.

Project 2: Warm Line

The BHS Warm Line is a 24-hour service that provides consumers and their family members with 24/7 telephone support to address a mental health concern. The Consumer Support Warm-Line is a friendly phone line staffed with Mental Health Outreach Workers who provide community resources and give support and shared experiences of Hope and Recovery. Consumers and their families can obtain referrals, share concerns, receive support, and talk with a Mental Health Outreach Works who generally understands their perspective, and is willing to listen and talk with them.

Project 3: Crisis Community Response Teams (CCRT)

CCRT clinicians respond to emergency requests from law enforcement for immediate, on-site mental health crisis services, including mental health evaluations for temporary, involuntary psychiatric inpatient care in situations where the mental health consumer is a danger to self, danger to others or gravely disabled.

The CCRT also works in coordination with local hospital emergency rooms. Hospitals providing medical care may call the CCRT to request a crisis evaluation for any person at the hospital who has already been medically cleared (ready for discharge), and who may be a danger to self, others or gravely disabled due to a mental disorder. CCRT clinicians work with hospital staff to determine the appropriate level of intervention needed, including transport to a crisis stabilization unit and/or a

psychiatric health facility. BHS operates two Crisis Community Response Teams. Services are available 24/7.

Project Operational Budget: $3,985,211.24

CSS Project 21: System Development Expansion

Project Description

System Development Expansion Services include the outpatient clinic system that provides planned mental health treatment services (scheduled appointments). Prior to the provision of the MHSA, specialty mental health services served a smaller population of consumers. During the original CSS planning process in FY 2005/06, BHS estimated that 11,000 consumers received mental health services. Since 2004, and in accordance with MHSA, BHS has conducted assertive community outreach and engagement to increase access to mental health services amongst unserved and underserved individuals. Over the past ten years, the number of consumers served annually has increased 25%, to over 16,000.

MHSA funding is used to expand mental health services and/or program capacity beyond what was previously provided (*CA Code of Regulations:* § 3410 (a)(1)).

Areas of expansion include:

- Expanded range of outpatient specialty mental health services available.
- Increased program capacity to serve an estimated 5,000 additional clients.
- Enhanced consumer-friendly and culturally-competent screening, assessment and linkage to services
- Development of consumer and family driven services, including the use of peer partners, recovery coaches, and consumer or family member outreach workers throughout the mental health system of care.
- Expanded use of nurses and psychiatric nurse practitioners to strengthen linkages between specialty mental health and primary care providers.
- Expanded use of Independent Living Skills programming.

Project Operational Budget: $4,618,694.65

V. Prevention and Early Intervention

Overview

The Mental Health Services Act (MHSA) allocates funding for Prevention and Early Intervention (PEI) programs that help prevent the onset of emotional and behavioral disorders and mental illnesses and improve timely access to mental health services for underserved populations. PEI services include education, information, supports, and interventions for children, youth, adults, and older adults.

The purpose of prevention and early intervention programs is to prevent mental illnesses from becoming severe and disabling. Characteristics of Prevention and Early Intervention Programs are guided by regulation. At a minimum, each county must develop at least one Prevention program; one Early Intervention program; one program of Outreach for Increasing Recognition of Early Signs of Mental Illness; one Access and Linkage to Treatment Program; and one Stigma and Discrimination Reduction Program. Counties may also include one or more suicide prevention programs. (California Code of Regulations §3705)

Each program must further be designed to help create access and linkage to treatment and to be designed and implemented in such a way as will improve timely access to mental health services. This means that services must also be provided in a range of convenient, accessible, acceptable and culturally appropriate settings. (California Code of Regulations § 3735)

Finally, all PEI programs shall apply effective methods likely to bring about intended outcomes, such as the use of evidence based or promising practices. (California Code of Regulations §3740) Desired outcomes include a reduction of negative outcomes and an increase in correlated positive outcomes associated with housing, education, employment, stability, and wellness.

Negative Outcomes: Counties shall develop programs that are designed to prevent mental illnesses from becoming severe and disabling. Programs shall emphasize strategies to reduce negative outcomes that may result from untreated mental illness. (Welfare and Institutions Code § 5840)

- Suicide
- Incarcerations
- School failure or dropout
- Unemployment
- Prolonged suffering
- Homelessness
- Removal of children from their homes

Prevention Program: a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The purpose of prevention programs is to bring about mental health, including a reduction in applicable negative outcomes, for individuals whose risk of developing a mental illness is greater than average. Examples of risk factors include, but are not limited to adverse childhood experience, chronic medical conditions, experience of severe trauma or ongoing stress, poverty, family conflict or domestic violence, etc. (California Code of Regulations § 3720)

San Joaquin PEI Prevention Programs – Children, Youth, and their Families

- Skill Building for Parents and Guardians
- Mentoring for Transitional Age youth

San Joaquin County PEI Prevention Program – Adults and Older Adults

- LEAD Program

Early Intervention Program: treatment and other services or interventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including addressing the applicable negative consequences that may result from an untreated mental illness.

San Joaquin PEI Early Intervention Programs – Children and Youth

- Early Mental Health Services
    - CARES Project
- School Based Interventions
- Early Interventions to Treat Psychosis

San Joaquin PEI Early Intervention Programs – Adults and Older Adults

- Community Trauma Services for Adults
- Recovery Services for Non-Violent Offenders
- Forensic Access and Engagement Project

Access and Linkage to Treatment Program: A set of related activities to connect children, youth, adults, and older adults with severe mental illnesses to medically necessary care and treatment, as early in the onset of these conditions as practical. Examples of Access and Linkage to Treatment Programs, include programs with a primary focus on screening, assessment, referral, telephone help lines, and mobile response. (California Code of Regulations §3726)

- Whole Person Care Project

Outreach for Increasing Recognition of Early Signs of a Mental Illness: Outreach is the process of engaging, encouraging, educating, training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. "Potential Responders" includes families, primary care providers, school personnel, community

service providers, peer providers, law enforcement personnel, etc. (California Code of Regulations § 3715)

- Increasing Recognition of Mental Illnesses

Stigma and Discrimination Reduction Program: Activities to reduce negative feelings, attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services. Examples of Stigma and Discrimination Reduction Programs include social marketing campaigns, speakers' bureaus, anti-stigma advocacy, targeted education and trainings, etc. (California Code of Regulations §3725)

- Information and Education Campaign

Suicide Prevention: Suicide prevention programs aim to prevent suicide as a consequence of mental illness. Programs may include public and targeted information campaigns, suicide prevention networks, screening programs, suicide prevention hotlines or web-based resources, and training and education.

- Suicide Prevention with Schools
- Suicide Prevention for the Community

Prevention and Early Intervention Priority Areas Fiscal Year 2021-22							
PEI Project #	**Name of Program**	**1-Child Trauma PEI**	**2-Early Psychosis**	**3-Youth Outreach**	**4-Culturally Comp**	**5-Older Adults**	**6- Justice and/or Homeless PEI Programming**
1	Skill Building for Parents and Guardians	X					
2	Mentoring for Transitional Aged Youth	X		X			
3	Early Mental Health Services	X		X			
4	School-Based Interventions	X		X			
5	Early Interventions to Treat Psychosis		X				
6	Community Trauma Services for Adults				X		

7	Recovery Services for Non-Violent Offenders						X
8	Whole Person Care Project						X
9	Increasing Recognition of Mental Illness			X			
10	Information and Education Campaign			X		X	
11	Suicide Prevention with Schools and School Community			X			
12	Suicide Prevention in the Community					X	
PRIORITY AREAS							
1 - Childhood Trauma							
2 - Early Psychosis and Mood Disorder Detection and Intervention							
3 - Youth Outreach and Engagement Strategies Targeting Secondary School and TAY, Priority on College MH Program							
4 - Culturally Competent and Linguistically Appropriate Prevention and Intervention							
5 - Strategies Targeting the Mental Health Needs of Older Adults							
6 - Homeless and Justice Involved PEI Programming							

All MHSA funded prevention programs utilize evidence based practices. Evaluation findings from the 2019-20 fiscal year is included in the appendix.

PEI Project 1: Skill-Building for Parents and Guardians

Community Need
Research demonstrates that some of the risk factors associated with a higher than average likelihood of developing mental illnesses include adverse childhood experiences, trauma and ongoing stress, family or domestic violence, and prior self-harm or suicide attempts. Developing ways to empower parents with the skills necessary to mitigate stress within the family unit is essential to reducing risk and building resiliency among children and youth.

Project Description
Community-based organizations will facilitate evidence based parenting classes or groups in communities throughout San Joaquin County. Parenting classes or groups will target underserved populations and be conducted in multiple languages.

Project Goal: *To prevent and reduce risk factors for mental illness and increase protective factors associated with social connectedness, parent and family resilience, and knowledge of child development.*

Project Components
Community-based organizations will convene parenting classes or groups at one or more sites within San Joaquin County. Parenting classes will address parent and family resiliency, knowledge of child development, and support pro-social interactions and social connectedness.

Potential evidence-based parenting classes include:

Nurturing Parenting Program is a series of 10-12 independent 60-90 minute lessons designed to teach parents alternatives to physical punishment and improve parenting skills, including: 1) understanding feelings; 2) alternatives to spanking; 3) communicating with respect; 4) building self-worth in children; 5) praising children and their behavior; 6) ages and stages of growth for infants and toddlers; 7) the philosophy and practices of Nurturing Parenting; 8) learning positive ways to deal with stress and anger; 9) understanding and developing family morals, values and rules; and 10) ways to enhance positive brain development in children and teens. For more details about the evidence-based Nurturing Parenting Program see: http://www.nurturingparenting.com

Strengthening Families is a 20-session program designed to engage parents in meaningful conversations about research based protective factors that mitigate the negative impacts of trauma. Protective factors include: 1) parental resilience; 2) social connection; 3) knowledge of parenting and of child and youth development; 4) concrete support in times of need; 5) children's social and emotional development; and 6) parent-child relationships. For more details about the evidence-based Strengthening Families program see: http://www.strengtheningfamiliesprogram.org

Parent Cafes is a model derived from the Strengthening Families Initiative, and is a distinct process that engages parents in meaningful conversations about what matters most – their family and how to strengthen that family by building protective factors. Parent Cafés are focused on building the 5 research based protective factors that mitigate the negative

impacts of trauma. See: http://www.bestrongfamilies.net/build-protective-factors/parent-cafes/

Positive Parenting Program (Triple P) is an evidence-based 12-hour program, delivered in six 2-hour group meetings with between 8 and 12 parents. The goal of Triple P is to prevent behavioral, emotional and developmental problems by teaching parents skills to reduce parental stress and increase confidence in parenting. The success of Triple P is demonstrated by increased knowledge, skills and confidence, as measured by a Parenting Task Checklist and decreased levels of stress, over-reactivity and hostility, as measured by the Parenting Scale. For more details about the Positive Parenting Program see: http://www.triplep.net/glo-en/home/

Project Operational Budget: $2,560,669.35

PEI Project 2: Mentoring for Transitional Age Youth

Community Need

Research demonstrates that some of the risk factors associated with a higher than average likelihood of developing mental illnesses include adverse childhood experiences, trauma and ongoing stress, family or domestic violence, and prior self-harm or suicide attempts. Early intervention services, including mentoring, are critical to support the ability of youth and young adults to develop resiliency and learn to cope effectively with adverse childhood experiences.

Project Description

Public agencies or community-based organization(s) serving at risk-youth ages 16-25 will provide intensive mentoring and support to transitional-age youth with emotional and behavioral difficulties who do not meet the criteria for specialty mental health care. The program will target very high-risk youth, including youth who are gang involved or at risk of gang involvement, have been sexually exploited as minors or transitional age youth, or have other exposures to violence, criminality, or emotional abuse that have depleted their resiliency.

Project Goal: *To reduce the risk of transitional-age youth developing serious and persistent mental illnesses which are associated with adverse childhood experiences, severe trauma or ongoing stress, family or domestic violence, and/or self-harm or suicidal thoughts.*

Project Components

Program Referrals: BHS clinicians may refer youth needing additional mentoring and support to prevent the onset of serious mental illness. Youth may also be referred from the Mobile Crisis Support Team, the Juvenile Justice Center clinical team, or the Children and Youth Services crisis team. Other referral sources may include local police departments, the County Probation Department, the City of Stockton's Ceasefire program, schools, hospitals and by self-referral utilizing a referral form.

Mentoring and Support Services: Agencies or community-based organization(s) will provide intensive mentoring and other supportive services to high-risk transitional age youth who require counseling to prevent the onset of a serious emotional disorder but do not otherwise meet the criteria for specialty mental health services. Potential evidence based approaches include:

- *Transitions to Independence (TIP):* TIP is an evidence-based practice designed to engage youth with emotional and/or behavioral difficulties in making a successful transition to adulthood. TIP programs provide case management services and supports to engage youth in activities to help resolve past traumas and achieve personal goals.

  TIP mentoring:
  - engages youth in their own futures planning process;

- provides youth with developmentally-appropriate, non-stigmatizing, culturally-competent, and appealing services and supports; and
- involves youth and their families and other informal key players in a process that prepares and facilitates them in their movement toward greater self-sufficiency and successful achievement of their goals related to relevant transition domains (i.e., employment/career, educational opportunities, living situation, personal effectiveness/wellbeing, and community-life functioning).
    - For more details on the TIP model, see: http://tipstars.org

- *Gang Reduction and Intervention Programs:* The Gang Reduction and Intervention Programs (GRIP) empower youth to leave or avoid gang life. Programs works closely with local law enforcement, schools and other nonprofits to help at-risk young people develop a positive self-image and a hopeful vision for the future.

  GRIP programs are highlighted as promising strategies by the Office of Juvenile Justice and Delinquency Prevention and GRIP programs across the country are currently undergoing evaluation to demonstrate their effectiveness and reliability.

  In general GRIP programs are multi-agency collaborations that include strong community- and faith-based organizational participation and that provide interventions and support services to help gang-involved youth and their families (including younger siblings) make positive choices. Often this work requires addressing and healing past traumas. For more details see: http://www.ojjdp.gov/programs/ProgSummary.asp?pi=38

Project Operational Budget: $886,372.97

PEI Project 3: Early Mental Health Services

Community Need
Research suggests that children and adolescents who have experienced trauma or abuse, and who do not receive early interventions, are at a greater risk for developing serious mental illnesses later in life. Children who have experienced trauma or abuse require tools to cope with adverse life events and interventions to reduce the long-term effects these events can cause.

Project Description
This project serves children and youth who are engaged by or at risk of engagement by the Child Welfare system. Projects operate in partnership with San Joaquin Child Welfare Services and other child-serving systems. Services are designed to align with statewide mandates to provide early mental health support services to high-risk youth.

Project Goal: *Reduce risk of Post-Traumatic Stress Disorders (PTSD) and other manifestations of trauma exposure, and improve access to treatment for those experiencing symptoms of trauma.*

Program Components

Coping and Resiliency Education Services (CARES)

Children and youth involved in the child welfare system are more likely to have been exposed to traumatic incidents, and those who are placed in foster care have undoubtedly experienced traumatic situations based on the fact that they have been separated from their family, and by the circumstances that led to their removal. Recognizing trauma and the effects of trauma among child welfare-involved children, minimizing additional trauma, and providing timely interventions to address trauma symptoms are core responsibilities of public agencies.

Behavioral Health and other child serving systems should work together to ensure that children and youth receive comprehensive trauma screening and timely referrals to the most appropriate level of care, and depending on care needs, short-term behavioral interventions or longer-term treatments. This continuum of care should be offered within children's homes or in other community-based settings.

Furthermore, in alignment with AB 403, Behavioral Health and Child Welfare Systems should work collaboratively to ensure that youth in foster care have their day-to-day physical, mental and emotional needs met. Towards this end, public agencies should offer training and support to foster families (now referred to as resource families) to better prepare them to care for children who've experienced traumatic situations, and whose experiences may result in trauma-related mental health symptoms.

This project provides screening, assessment, individual and group rehabilitative interventions, and referrals to higher levels of care for children that have formal or informal involvement with child welfare or the juvenile justice system. This project is responsive to California's Welfare Reform Act (AB 403) and creates an Integrated Core Practice Model to deliver timely, effective, and collaborative services to children/youth and their families.

- ***Project Activities:*** San Joaquin County Behavioral Health Services will:

- Develop formal collaboration with San Joaquin's Child Welfare Services Department to 1) identify Child Welfare-involved children and youth who are at risk for trauma-related illnesses; and 2) develop and implement strategies to meet their ongoing needs.
- Screen Child Welfare-involved children and youth for trauma and trauma-related symptoms.
- Refer children and youth to appropriate levels of care, including comprehensive behavioral health assessment, as appropriate.
- Provide short-term problem solving, safety planning, coping and resiliency skill-building to children who do not meet medical necessity for Specialty Mental Health Services.
- Provide ongoing services and supports for all children and youth who meet prevention and early intervention criteria as they transition from Mary Graham or other temporary placements to permanent homes.
- Provide trauma-informed support and training to resource families who are linked with Foster Family Agencies.
- Provide early intervention services for children/youth that are screened out of Pathways to Wellbeing due to a decreased level of acuity.

Timely Trauma-Informed Screening: Children and youth ages, 6-17, who do not meet medical necessity for specialty mental health services, but who are referred by Child Welfare, or other child serving agencies, will be screened by BHS Clinicians and Mental Health Specialists using the Traumatic Stress Symptoms Module of Child and Adult Needs and Strengths Assessment (CANSA). The CANSA is a locally-developed, validated assessment, treatment planning, and evaluation tool adapted from Praed Foundation's Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths (ANSA) instruments to serve San Joaquin County's behavioral health consumers across the age spectrum. A copy of the entire CANSA instrument may be found at www.praedfoundation.org.

Based on screening results and the child or youth's age, he or she will be linked to a variety of trauma-informed interventions. Screenings may be provided off-hour and on weekends in home-based and community settings..

Trauma-Informed Interventions: Once screened, children and youth will be linked to supportive short-term evidence-based interventions to address previous traumas and sustain them through difficult transitions. Interventions will be provided at clinic, community-and or home-based locations, and may include the following:

- *PRAXES (Parents Reach Achieve and eXcel through Empowerment Strategies) Empowerment for Families*—Training and education by behavioral health providers to help resource families and other caregivers cope with expectations; develop stress management techniques; reintegrate children and youth with their families; and handle child's trauma. For more information see http://www.praxesmodel.com/. Trained staff will provide one on one and group support and education.

- *Child Intensive Model —12 session program for children ages 5-11. This curriculum mirrors the PRAXES components but is interactive and configured for younger children.*

- *Youth Intensive Model—12 session program for youth ages 12-18. This curriculum mirrors the PRAXES components but is interactive and configured for adolescents.*

- *Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems* – MATCH-ADTC is individualized Clinical therapy for children, ages 6-12, using a collection of therapeutic components to use in day-to-day practice. The components include cognitive behavioral therapy, parent training, coping skills, problem solving and safety planning. The modules are designed to be delivered in an order guided by clinical flowcharts based on primary area of concern (e.g., trauma-related issues). For more information, see http://nrepp.samhsa.gov/ProgramProfile.aspx?id=64

Child Family Team: A Child Family Team (CFT) is a group of individuals who are engaged in a variety of processes to identify strengths and needs of the child or youth and his or her family, to help achieve positive outcomes for safety permanency, and well-being. For children and youth engaged into ICPM services, BHS provides CFT facilitators that coordinate the therapeutic, medical and rehabilitative care that is directed through the CFT process.

Resource Family Supports: BHS will offer Resource families, including kinship families, training in the causes and effects of adverse childhood experiences such has child abuse and neglect, strategies for dealing with trauma reactions; and strategies for self-care. BHS will use an evidence-based curriculum such as:

- *Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents* – This is a PowerPoint-based training designed to be taught by mental health professionals and a foster parent co-facilitator. The curriculum includes case studies of representative foster children, ages 8 months – 15 years, and addresses secondary traumatic stress in caregivers. The training includes a Participant Handbook with extended resources on Trauma 101; Understanding Trauma's Effects; Building a Safe Place; Dealing with Feelings and Behaviors; Connections and Healing; Becoming an Advocate; and Taking Care of Yourself. For more information, see http://www.nctsn.org/products/caring-for-children-who-have-experienced-trauma

BHS reviews best practices for supporting resource families on an ongoing basis. Additional support strategies may be incorporated as new promising practices are identified statewide.

Collaborative Meetings: San Joaquin County BHS participates in ongoing meetings with other child serving systems and committees. Meeting objectives will include the ongoing development of seamless referral processes to support timely trauma screenings and interventions. The collaborative will explore community needs, service gaps, and effective strategies for addressing childhood and adolescent trauma within the County.

Project Operational Budget: $1,199,533.49

PEI Project 4: School-based Interventions

Community Need
Research suggests that children and adolescents who have experienced trauma or abuse, and who do not receive early interventions, are at a greater risk for developing serious mental illnesses later in life. Children who have experienced trauma or abuse require tools to cope with adverse life events and interventions to reduce the long-term effects these events can cause.

Project Description
This project will provide group and individual skill building and rehabilitative prevention services for children and youth who have been impacted by adverse childhood experiences, have social-emotional or behavioral issues, and/or are at risk of severe emotional disturbance. The objective is to reduce risk factors and improve protective factors. This program will also focus on the improvement of social and emotional regulation for children and youth. Services may be provided in the school or in the classroom but may extend into the home, which will increase the child's ability to learn and develop. The project focuses on a team concept, partnering school personnel with clinical staff in the classroom to solidify the collaborative approach to the project.

This project will operate in schools that provide public education services (including public charter schools) to children and youth who may be at a greater than average risk of developing a potentially serious mental illness. The students from the eligible schools may receive these services at school site, or under special circumstances at an alternate location (provider clinic, compliant remote methods etc.) as appropriate during off school periods due to school closure, student illness, or a national emergency, in order to ensure continuation of services to the students. Examples of risk factors include but are not limited, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic violence, experiences of racism and social inequality, etc.

Funding will be allocated through rate based contracts to qualified Organizational Providers that agree to provide desired on-site school based interventions and other support services. In the event of a public health emergency, in order to ensure the support services are still available to students in need, the BHS Director will have the option to recommend a temporary change of funding structure of the program to the Board of Supervisors. Contracts will be developed through a public procurement process to identify qualified vendors. BHS intends to contract with multiple qualified vendors. School Districts will be able to request school-based mental health early intervention services from BHS approved providers for schools that meet criteria through an application process.

Target Population: Public schools in San Joaquin County that are eligible for program activities must meet one or more of the following criteria:

High School Criteria (9-12):

- At least 60% of enrolled students are eligible for free meals; or
- At least 65% of enrolled students are eligible for free or reduced price meals (FRPM)

Elementary / Middle School Criteria (K-8):

- At least 70% of enrolled students are eligible for free meals; or
- At least 75% of enrolled students are eligible for free or reduced price meals (FRPM)

Exceptions: A school district may contact BHS to request school-based intervention services following a traumatic event that affects the majority of students in the school and/or a public health emergency

Project Goal: *Reduce risk of Post-Traumatic Stress Disorders (PTSD) and other manifestations of trauma exposure, and improve access to treatment for those experiencing symptoms of trauma.*

Project Components

Qualified Organizational Providers shall assign dedicated clinicians to work with participating schools. Dedicated clinicians are participants of a school-team that helps every student achieve their best educational potential. The purpose of clinical staff on campus is to provide mental health interventions for children and youth who are determined to have mental health concerns that cannot be addressed through the school's usual behavior management policies or through an individual education plan.

Clinical staff will provide:

1. ***Therapeutic or Rehabilitative Groups:*** Facilitate age-appropriate cognitive behavioral or other therapeutic groups to help children and youth practice impulse control, emotional regulation, positive & affirming relationships with peers and adults, etc. Group activities will follow an approved evidence based curriculum. Groups should be offered on campus and at times appropriate for school-age children, such as during lunch or after school, in order to minimize loss of classroom time.

2. ***Short-term Interventions for Children***: Provide short-term, evidence-based, trauma interventions for children believed to be suffering from the effects of traumatic incidents. These interventions will include assessments, case management, Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), and linkages to alternate or additional services as needed.

    a. **Assessment:** Assess and evaluate the behavioral health needs of students referred by school-site personnel. The assessment will be conducted by a clinician and will include a diagnostic impression, mental status exam, and developmental history. The assessment process will also include the development of a Client Plan with the student and/or the legal guardian and/or primary caregiver.

    b. **Case Management:** Targeted case management services to help children reach their mental health goals, by providing education on mental health issues, and linking children to services such as more intensive services on campus, or referral to more appropriate services within the community or to BHS.

    c. **Mental Health Services:** As clinically appropriate, services may include: Individual counseling (with or without family present), collateral contacts, individual rehabilitative services, and group rehabilitative services.

    d. **Referrals:** All children screened will be assessed to determine if they are appropriate for the short-term intervention or whether they should be immediately referred to more specialized services. All children receiving short-term interventions will be monitored to determine if, during the services or at completion, they should be referred to more intensive services. Referrals can come from school staff or caregivers of the students.

3. **Training:** Project staff will educate and inform school staff and caregivers on relevant issues or topics including mental health services, signs and symptoms of mental health issues, the effects of trauma, and trauma-informed behavioral interventions. Staff time spent on staff/caregiver training, building relationships with school staff specific to beginning the program implementation, developing program policies/procedures/protocols, whole classroom observations (not related to a specific child), referral management, and other school wide case management/coordination support will be identified and billed as training, not to exceed 20 hours per school site, per year.

4. **Indirect Services:** Project staff will provide indirect services as appropriate to ensure successful implementation and integration of the program and available services on to campuses. Examples of indirect activities include: Follow up on referrals for clients that are not yet open, including field based travel to connect with potential referrals, school meetings for potential clients who are not yet open, clarifying services with school staff, exploring if potential referrals are appropriate, referral and linkage for clients who don't open to services.

5. **Program Operations and Supervision:**
    - Clinical and operational supervision of all program staff; including tracking of hours and activities conducted through this project.
    - Convene meetings of the clinical team at least twice a month to share lessons learned and discuss strategies for improving services at school sites.
    - Documentation and billing to Medi-Cal of reimbursable services for children and youth.
    - Participation in quarterly services meetings with BHS and School Districts' project coordinators.
    - Submission of quarterly reports, participation in ongoing data collection, and compliance with all evaluation and contract monitoring activities

Project Operational Budget: $2,604,017.35

PEI Project 5: Early Interventions to Treat Psychosis

Community Need

Research suggests that it is possible to prevent the acute onset of major psychotic disorders through a systematic approach to early identification and treatment. Identifying and responding appropriately to the condition early can prevent disability and may prevent the onset of the acute stage of illness. Psychotic disorders rarely emerge suddenly. Most often, the symptoms evolve and become gradually worse over a period of months or even years. Early symptoms of cognitive and sensory changes often go undiagnosed which can cause significant disability before the illness becomes acute and is diagnosed.

Project Description

The Early Interventions to Treat Psychosis (EITP) program to provide an integrated set of promising practices that research has indicated will slow the progression of psychosis, early in its onset. The EITP program will offer a combination of outreach, engagement, and evidenced-based treatments and supports, delivered to individuals throughout San Joaquin County, age 14-34, who have experienced their first full psychotic episode in the past two years or who are showing prodromal symptoms of psychosis.

Promising models include, but are not limited to:

1. Early Assessment and Support Alliance (EASA)
   Refer to: http://www.easacommunity.org/

2. Portland Identification and Early Referral Program (PIER)
   Refer to: http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/10/early-detection-and-intervention-for-the-prevention-of-psychosis.html

Project Goal: *To identify and provide treatment to individuals who have experienced their first full psychotic episode in the past two years or who are showing prodromal symptoms of psychosis in order to prevent disability and the onset of the acute stage of illness.*

Project Components

- **Program Referrals -** Referrals to the EITP can come by a variety of resources, however, approval for program enrollment will be the responsibility of BHS.
- **Outreach and Engagement -** Trained clinicians and peers will provide presentations to community agencies and organizations, service providers, and community members about early identification of schizophrenia and the services available to promote remission and recovery. Assessments will be provided in peoples' homes and in locations of their choosing. Active engagement efforts will aim to discourage individuals from dropping services once they are enrolled.
- **Assessment and Diagnosis –** Trained clinicians will conduct a strength-based, recovery-oriented assessment using formal clinical assessment tools. There will be a follow up conducted every 12 months to determine exit readiness using an evidenced-based or promising practice tool or method.
- **Cognitive Behavioral Therapy (CBT) –** CBT has been demonstrated in numerous research studies to be effective for depression, anxiety disorders, substance abuse, bipolar disorder, and schizophrenia (as an adjunct to medication), and for a variety of medical problems with psychological components.

Cognitive Behavioral Therapists use a wide variety of techniques to help patients change their cognitions, behavior, mood, and physiology. Techniques may be cognitive, behavioral, environmental, biological, supportive, interpersonal, or experimental. Cognitive-behavioral techniques include psycho-education, relaxation, social problem solving and cognitive restructuring.

- **Education and Support Groups –** Provide rehabilitation and support groups, based on evidence based or promising practices, for consumers and family members. These groups will be designed to inform consumers and family members about mental illness, educate on how to access services needed, techniques of developing coping skills, and creating a social support system.
- **Medication Management:** Provide medication management services to educate consumers regarding their psychiatric medications, symptoms, side effects and individualizing dosage schedules. Medications must be deemed effective and follow the current accepted standards of practice in the psychiatric community.
- **Individualized Support and Case Management:** Case managers will work with clients and family members to address depression, substance abuse, family issues, and other challenges that impede recovery. Case managers will work to ensure that clients find and keep meaningful work, education, and permanent housing.

Project Operational Budget: $672,770.09

PEI Project 6: Community Trauma Services for Adults

Community Need

Adults who have experienced (or are currently experiencing) childhood trauma, sexual trauma, domestic violence, community violence, traumatic loss, racism-related trauma, sexual-identity related trauma, or military trauma are at heightened risk for post-traumatic stress reactions, severe anxiety disorders, depression, and/or co-occurring trauma and substance use disorders.

Project Description

PEI funding will be awarded to one or more community partners with expertise in providing licensed, clinical mental health treatment services to individuals with mild to moderate post-traumatic stress disorder (PTSD) and associated stress disorders. Partner organizations must also be able to demonstrate a capacity to provide culturally competent services that address the needs of unserved and underserved populations, especially those from disadvantaged communities with compounded negative social determinants of health.

The target populations for this program are adults who are especially vulnerable to the adverse consequences of mental health challenges. Vulnerable populations include, but are not limited to immigrants, refugees, uninsured adults, Veterans, LGBTQ individuals, those with Limited English Proficient (LEP), and adults with disabilities.

Particular focus shall be on individuals from low-income communities and communities of color where systemic oppression and social determinants of health have resulted in negative life outcomes.

Additional priority populations are:

- Victims of intentional trauma (gunshot wounds, assaults, and stabbings) identified by the San Joaquin General Hospital's *Victim Services Coordination Team*.

Organizations will provide trauma informed care and create trauma informed cultures and organizational practices.

Program Goal: *Address and promote recovery amongst adults with emerging PTSD and/or associated stress disorders to improve functioning and reduce negative outcomes associated with untreated mental health conditions.*

Project Components

At a minimum, the following activities will be conducted by all projects within this program.

1. **Screening and Assessment:** Use of a validated screening or assessment tool to screen for trauma, anxiety, depression, or other behavioral health concerns. Examples of validated tools include, but are not limited to, the PHQ-9, PTSD Checklist, Life Event Checklist, Abbreviated PCL-

L, Trauma Symptom Checklist -40, Los Angeles Symptom Checklist (Adult Version), etc. Screening and assessment tools must be approved by BHS prior to beginning services.

2. **Case Plan:** Each individual shall have an individualized case plan, based upon the findings of the assessment.

3. **Benefit Assistance:** Each individual shall meet with a benefit assistance specialist to determine eligibility for health care coverage and or other benefits and receive application assistance. Benefit assistance should also include ongoing consumer education on the importance of maintaining coverage and address misconceptions about coverage and confidentiality.

4. **Case Management:** Targeted case management services to help adults and older adults reach their mental health goals, by providing education on mental health issues and linking individuals to available community services and supports, including primary health care.

5. **Rehabilitative Services:** As clinically appropriate, services may include skill building groups and activities or other group rehabilitative services provided by trained (bachelor's level) social workers, nurses, or other health professionals.

6. **Short-term Clinical Treatments** (**Early Interventions):** Individual or group counseling using one or more trauma-responsive evidence-based practices for which a substantial body of research evidence exists. Approaches are implemented by trained (master's level) clinicians or mental health professionals. Examples of evidence based practices include, but are not limited to:

    - Seeking Safety
    - Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
    - Trauma Affect Regulation: Guide for Education & Therapy (TARGET)

    A further listing of evidence based programs and practices may be found at:
        - National Registry of Evidence Based Programs and Practices
        - California Evidence Based Clearinghouse

7. **Referrals:** All participants screened will be assessed to determine if they are appropriate for the short-term intervention or whether they should be immediately referred to more specialized services.

8. **Staffing:** At least one of the staff dedicated to each project will be a licensed mental health clinician, two years post licensure, to supervise the work of other clinical staff.

Project Operational Budget: $1,380,000.00

PEI Project 7: Recovery Services for Nonviolent Offenders

Community Need

A small population of nonviolent offenders with emerging behavioral health concerns is having a significant impact on the community. These repeat offenders are having difficulty stabilizing in recovery and are receiving inappropriate treatment interventions in jail. Better behavioral health engagement and early interventions are needed to support recovery efforts and divert individuals with behavioral health concerns away from subsequent contact with the criminal justice system.

Project Description

BHS will work with San Joaquin County Courts, District Attorney, and local law enforcement agencies to provide targeted outreach and engagement, screening and assessment, and linkage to appropriate services and supports. Brief interventions will be offered to individuals identified with emerging mental health concerns such as PTSD or associated disorders. A significant portion of the target population is assumed to be homeless and/or have co-occurring disorders.

Project Goal: Engage individuals with behavioral health concerns that are repeat non-serious, nonviolent offenders and provide recovery and rehabilitation services to increase functioning in order to reduce negative outcomes associated with untreated mental health concerns such as arrest, incarceration, homelessness, and prolonged suffering.

Project Components

Project 1: Law Enforcement Assisted Diversion (LEAD)

The Law Enforcement Assisted Diversion is a program of the Stockton Police Department's Special Patrol Unit. BHS staff work with LEAD Patrol Officers to engage individuals identified as non-serious, non-violent law violators with likely mental health concerns. Activities conducted by the team may include, but are not limited to street outreach, communication and coordination with law enforcement partners, engagement and screening for behavioral health concerns, transport to clinic or other location for psychosocial assessment, ongoing case management, navigation support to transition into treatment services, and family engagement / reunification opportunities.

Project 2: Offender Assessment Services

Provide screenings and assessment for individuals released from incarceration to determine if further mental health and/or co-occurring substance use disorder treatment is warranted. May include linkages to mental health, substance use disorder treatment, and/or other community services.

Project Operational Budget: $461,258.10

PEI Project 8: Whole Person Care Project

Community Need

Individuals with mental illnesses are at high risk of becoming homeless. Individuals who are homeless are at greater risk of being unserved or underserved by mental health services. In San Joaquin County approximately 30% of homeless individuals are believed to have some level of mental health concern. Targeted efforts are needed to help homeless individuals, and those at risk of homelessness upon discharge from an institution, access services including behavioral health treatment.

Project Description

This project provides match funding for San Joaquin County's Whole Person Care Pilot Project, approved by DHCS in 2016. Match funding will be allocated (at a minimum) for the five years of the project.

The purpose of San Joaquin County's Whole Person Care pilot project is to test interventions and create a care management infrastructure to better support individuals who are at high risk of untreated mental illness *and* are high utilizers of health care services. Program services target adult Medi-Cal beneficiaries who over-utilize emergency department services, have a mental health and/or substance use disorder, or are currently, or are homeless or at risk for homelessness upon discharge from an institution.

Project Components

Whole Person Care, Outreach, Engagement, and Linkage to Treatment

- *Homeless Outreach Team* provides outreach and engagement to individuals experiencing homelessness in San Joaquin County. Chronic and persistent homelessness is correlated to serious mental illness. An existing homeless outreach team will be expanded through MHSA expenditures. Outreach team members will conduct outreach and engagement to enroll individuals into program services and offer non- Medi-Cal reimbursable services such as transportation, meals, information and other supports to stabilize individuals and build rapport.
    - Conduct outreach and engagement to enroll individuals into program services.
    - Offer non- Medi-Cal reimbursable services such as transportation, meals, information and other supports to stabilize individuals and build rapport.
    - Conduct outreach, engagement, and follow-up with homeless individuals referred by the Mobile Crisis Support Team for further mental health treatment interventions.

- *MHSA Integration Team* will provide integrated care coordination and case management across county agencies, health plans, providers, and other entities. Care coordination will be expanded through MHSA expenditures to ensure intensive and appropriate care coordination for designated project target populations.
    - Provide integrated care coordination and case management across county agencies, health plans, providers, and other entities.

- Provide services where individuals are located and best served, whether within the community, shelter, or hospital setting.
- Conduct, research, data collection, and analysis to ensure project activities are effective and improving outcomes for consumers.

Project Operational Budget: $967,041.90

PEI Project 9: Increasing Recognition of Mental Illnesses

Community Need

Mental illnesses are common, and failure to provide appropriate and timely treatment can have serious and detrimental consequences for individuals, families, and communities. Community trainings to increase the recognition of early signs of mental illnesses and to effectively respond and link individuals to services are needed to improve timely access to mental health services for all individuals, and especially for individuals and/or families from underserved populations.

Project Description

Trainings will reach out to community leaders, service providers, college instructors, religious or spiritual leaders, and consumers and family members to provide information on how to increase recognition and respond effectively to the signs and symptoms of potentially severe and disabling mental illness. Trainings are also offered to consumers, parents/guardians, and other family members in order to provide information about mental health conditions that encourage individuals and families to overcome negative attitudes or perceptions about mental illnesses, recent diagnosis, and/or help seeking behavior.

Project Goal: *To develop community members as effective partners in identifying individuals in need of treatment interventions early in the emergence of a mental illness and preventing the escalation of mental health crises and promoting behavioral health recovery.*

Project Components

Trained instructors will provide evidence-based classes to service providers, consumers and family members. For more information see: http://www.nami.org/ and www.mentalhealthfirstaid.org

Project 1: Community Trainings for Potential Responders

- **Provider Education Program (PEP):** PEP was developed by NAMI and helps providers who work with individuals living with mental illness to understand the experiences of mental illness from the perspective of the individual and family member. The five 2.5 hour sessions help participants increase their empathy and professional skills. Two PEP classes will be offered per year.

- **Parents and Teachers as Allies:** The Parents and Teachers as Allies is a 2-hour in service program that helps school professionals identify the warning signs of early-onset mental illness in children and adolescents in school.

- **Crisis Intervention Training for Law Enforcement:** BHS works in partnership with the Sheriff and local police departments to offer crisis intervention trainings for law enforcement. Courses include an 8-hour POST-certified training curriculum (POST is the Peace Officer Standard and Training Commission for the State of California.) A 40-hour training is also available for officers designated as Mental Health Liaisons.

- **Mental Health First Aid:** Mental Health First Aid is an 8-hour course that teaches how to help someone who may be experiencing a mental health or substance use challenge. The training teaches community members who to identify, understand, and respond to signs of addictions and mental illness. Two trainings are offered in San Joaquin County. Mental Health First Aid and Youth Mental Health First Aid.

- **Trauma-Informed Care:** Training will assist responders in recognizing trauma-related symptoms and concerns and in the interventions helpful to individuals affected by trauma.

Project 2: Community Education:

- **In Our Own Voices (IOOV):** IOOV are 60-90 minute presentations to illustrate the individual realities of living with mental illness. The objective is to change attitudes, preconceived notions and remove stereotypes regarding mental illness. Each year, 40 presentations are planned throughout the county (32 in English and 8 in Spanish).

- **Family to Family (F2F):** F2F is a 12-session educational program designed for family members of adults living with mental illness. The program is taught be trained teachers who are also family members and offers hope, inspiration, and practical tips for families supporting recovery and wellness efforts. It is a designated evidence based practices that has been shown to significantly improve coping and problem-solving abilities of the people closest to an individual living with a mental illness.

- **Peer to Peer (P2):** P2P program provides up-to-date research on brain biology, a personalized relapse prevention plan, tools to prepare for interactions with health care providers, and skills for decision-making and reducing stress. Classes are 10, 2-hour sessions designed for adults living with mental illness. Classes are offered in English and Spanish.

- **NAMI Basics:** A six-session class for parents and caregivers of children and adolescents who are experiencing symptoms of a mental illness or who have been diagnosed. The program offers facts about mental health conditions and tips for supporting children and adolescents at home, school, and when they are getting medical care.

Project Operational Budget: $301,865.77

PEI Project 10: Information and Education Campaign

Community Need

Too many individuals remain unserved by community mental health services owing to negative feelings attitudes, beliefs, perceptions, stereotypes, and/or discrimination related to being diagnosed with a mental illness, having a mental illness, or seeking mental health services. The overarching purpose of the *PEI Information and Education Campaign* is to increase acceptance and understanding of mental illnesses and seeking mental health services; to increase help seeking behaviors; and to promote equity in care and reduce disparities in access to mental health services.

Project Description

BHS will work with a contracted program partner to develop, host, and manage a public information and education campaign intended to reduce multiple stigmas that have been shown to discourage individuals from seeking mental health services. The information and education campaign will include language, approaches, and social/media markets that are culturally and linguistically relevant and congruent with the values of underserved populations.

Project Goal: *To reduce stigma towards individuals with a mental illness and increase self-acceptance, dignity, inclusion and equity for individuals with mental illness and members of their family.*

Project Components

To develop and promote a public information and education campaign using: (1) positive, factual messages and approaches with a focus on recovery, wellness, and resilience; (2) culturally relevant language, practices, and concepts geared to the diverse population of San Joaquin County; and (3) straightforward terms – not jargon – to explain when, where, and how to get help.

Self-Acceptance: Understanding and accepting a mental health diagnosis can be a lengthy process for consumers and their family members; one made more difficult by a lack of relevant information. The primary focus of the *Information and Education Campaign* will be a re-imagining of how information about mental illness, treatment options, and pathways to services are made available to consumers and family members. Currently BHS and others rely heavily on website pages and brochures which provide relatively static information. With today's technology, there are better and more easily navigable ways to provide individualized information on mental illnesses and how to get the help needed. Accepting a diagnosis is easier when there are meaningful examples of recovery; accessible pathways to services; tangible recovery milestones; and clarity on when, why, and how treatment is escalated. A secondary purpose of this work will be to increase *timely* access to services for those first accepting a diagnosis of a mental illness.

Dignity: Promoting dignity in the delivery of mental health services is a fundamental value of San Joaquin County Behavioral Health Services. At BHS, consumer driven services are a fundamental tenant of how treatment and recovery plans are developed. The *Information and Education Campaign* will include the development of simple step-by-step instructions for consumers to develop their own recovery pathway. Specific education campaign items will be accessed through the web-site, touch screen portals, and informational brochures. Examples of the types of items that will be addressed

include, but are not limited to: developing and updating a Wellness Recovery Action Plan (WRAP), having a peer partner assigned; asking for a second opinion; patient rights, expectations for timely access to services; and escalating questions or concerns to a consumer advocate.

Inclusion: The target population for the *Information and Education* campaign will be all residents of San Joaquin County and it is important to provide education to people who are not actively seeking information on mental health issues such that there is broader acceptance of behavioral health concerns as a normalized experience; and a broader acceptance of people with mental illnesses in classrooms, workplaces, on playgrounds, and in the community. Hence, some efforts are needed to ensure that the education materials designed to reduce stigma towards mental illness are broadly accessible in the community: on billboards, information kiosks, and prominently posted in public locations such as libraries, community colleges, post offices, court houses.

Equity: Equity means equal access to services; but it also means equal inclusion in the development of services and supports, the information that is generated about services and supports, and in the distribution of information and education materials. In developing a stigma and discrimination reduction campaign that is linguistically competent and culturally congruent to the values of the population the developers of the *Information and Education Campaign* will engage consumers, family members, youth, and underserved communities to provide guidance and feedback on the development of the *Information and Education Campaign.* At a minimum it is anticipated that *Information and Education Campaign* materials will be developed in English and Spanish and that a targeted information and education campaign will be developed for Spanish-speaking residents of San Joaquin County which may include billboards, social media, or other public or direct-contact approaches.

Projection Operational Budget: $1,756,521.30

PEI Project 11: Suicide Prevention with Schools

Community Need

Suicide is a preventable consequence of untreated mental illnesses. Suicide prevention campaigns can effectively reduce the stigma associated with seeking mental health services and provide and promote suicide prevention resources, including alert helpers to link individuals to services. Broad suicide prevention strategies are needed to reduce stigma for help seeking behaviors and to increase awareness of suicide risk in San Joaquin County amongst children, youth, and adults.

Project Description

The suicide prevention project will include both universal and targeted suicide prevention efforts.

- Comprehensive school-based suicide prevention programs for students and school personnel in San Joaquin County. Targeted suicide prevention activities will include:
  - Evidence-based suicide education campaigns.
  - Depression screenings and referrals to appropriate mental health interventions.

Project Goal: *The project is designed to identify and refer individuals at risk of self-harming and suicidal behaviors and to reduce stigma for help-seeking behavior.*

Project Components

Suicide Prevention with Schools – Develop comprehensive school-based suicide prevention and education campaign for school personnel and students. Activities include depression screening and referral services which will result in the timely identification and referral of students at risk of self-harming and/or suicidal behaviors to mental health services. Programs must operate in partnership with one or more schools or school districts. At a minimum the program will include:

- School personnel will be trained in an evidence-based practice to understand suicide, recognize suicide risk behavior in students, and to refer students for assistance, and
- Students at participating schools will receive evidence-based suicide prevention education.

<u>An Evidence-Based Suicide Education Campaign</u>
Implement one or more of the following evidence-based practices for both school personnel and students:

- Yellow Ribbon Suicide Prevention Campaign
  Implement the evidence-based *Yellow Ribbon Campaign* with its four essential stages:
  - Planning sessions with school leaders;
  - *Be a Link® Adult Gatekeeper Training* for school personnel and *Ask 4 Help® Youth Gatekeeper Training* for youth leaders, followed by school-wide student assemblies;
  - Booster training and training for new staff members and students; and
  - Establishment of community task forces to ensure ongoing resource connections, awareness reminders, event coordination, and expanded gatekeeper training.

The *Yellow Ribbon Suicide Campaign* will be implemented in accordance with the evidence-based practice. See: http://www.mhawisconsin.org/Data/Sites/1/media/gls/yellow_ribbon.pdf

Suicide Prevention Education and Awareness Training
CAPC will coordinate planning conversations with participating schools to evaluate and select an education model suitable to that school and student population. Options to select from include but are not limited to: QPR and/or SafeTalk.

- Question, Persuade, Refer (QPR)
  Provide QPR Gatekeeper Training for Suicide Prevention to school personnel to train them to engage and intervene with youth who are displaying or discussing suicidal or self-harming behaviors. QPR will be implemented in accordance with the evidence-based practice described at: http://www.qprinstitute.com

- SafeTALK Workshops
  Provide *SafeTALK* workshops for individuals ages 15 and over at participating schools to assist in the recognition and identification of individuals with thoughts of suicide, and to connect them to mental health resources. *SafeTALK* will be implemented in accordance with the evidence-based program detailed at: https://www.livingworks.net/programs/safetalk/

  SafeTALK workshops teach youth to be "alert helpers" who are better able to move beyond common tendencies to miss, dismiss, or avoid suicide; to identify individuals with suicidal thoughts; and to help connect a person with suicidal thoughts to suicide intervention responders.

  SafeTALK includes the following practice requirements:
  - Workshops must be conducted by a registered safeTALK trainer and held over three consecutive hours;
  - A community support resource (such as a trained volunteer, safety officer, or mental health professional) must be present to support any participants who experience difficulty;
  - Each workshop will have between 10 and 30 participants.

  Workshop materials, including participant workbooks, wallet cards, and stickers, are available from LivingWorks (https://www.livingworks.net/programs/safetalk/).

Depression Screening and Referral
Provide depression screenings and referrals on school sites for high-school students throughout San Joaquin County. Screenings will be delivered by qualified personnel and provided to adolescents exhibiting signs of depression. An evidence-based screening tool will be used. Potential depression screening tools include but are not limited to:

- *Patient Health Questionnaire-9 for Adolescents* **-** Depression is common among adolescents. In response to the growing evidence for effective treatments for depression among adolescents, the US Preventive Services Task Force now recommends screening for depression among adolescents in primary care settings. The PHQ-9 has good sensitivity and specificity for detecting major depression among adolescents in the primary care setting. For more information on the PHQ-9 see: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495268/
- *Center for Epidemiological Studies Depression Scale for Children -* (CES-DC) is a 20-item self-report depression inventory used as initial screener and/or measure of treatment progress.

Scores may indicate depressive symptoms in children and adolescents as well as significant levels of depression. For more information on CES-DC see: http://www.brightfutures.org/mentalhealth/pdf/professionals/bridges/ces_dc.pdf

Following the screenings, youth may be referred to one or more of the following: individual therapy with a qualified mental health clinician; further assessments and screenings for medication evaluation; and/or school-based depression support groups including but not limited to:

The CAST curriculum is a high school-based suicide prevention program targeting youth 14 to 19 years old. CAST delivers life-skills training and social support in a small-group format (6-8 students per group). The program consists of twelve 55-minute group sessions administered over 6 weeks. CAST serves as a follow-up program for youth who have been identified through screening as being at significant risk for suicide. CAST's skills training sessions target three overall goals: increased mood management (depression and anger), improved school performance, and decreased drug involvement. Group sessions incorporate key concepts, objectives, and skills that inform a group generated implementation plan for the CAST leader. Sessions focus on group support, goal setting and monitoring, self-esteem, decision making skills, better management of anger and depression, "school smarts," control of drug use with relapse prevention, and self-recognition of progress through the program. Each session helps youth apply newly acquired skills and increase support from family and other trusted adults. Detailed lesson plans specify the type of motivational preparation, teaching, skills practice, and coaching activities appropriate for at-risk youth. Every session ends with "Lifework" assignments that call for the youth to practice the session's skills with a specific person in their school, home, or peer-group environment.'

Break Free from Depression is a school-based curriculum designed to increase adolescents' awareness and knowledge about depression, enhance their ability to recognize signs and symptoms in themselves and their friends, and increase students' skills and strategies for finding help for themselves and their peers. This 4-session curriculum for high school students combines didactic and interactive activities. The cornerstone of the curriculum is a documentary that focuses on a diverse group of real adolescents (not actors) talking about their struggles with depression and suicide in their own words. They discuss stigmas often associated with depression, their symptoms, the course of their illness, and the methods they have used to manage their depression. Each session lasts 45 to 60 minutes.

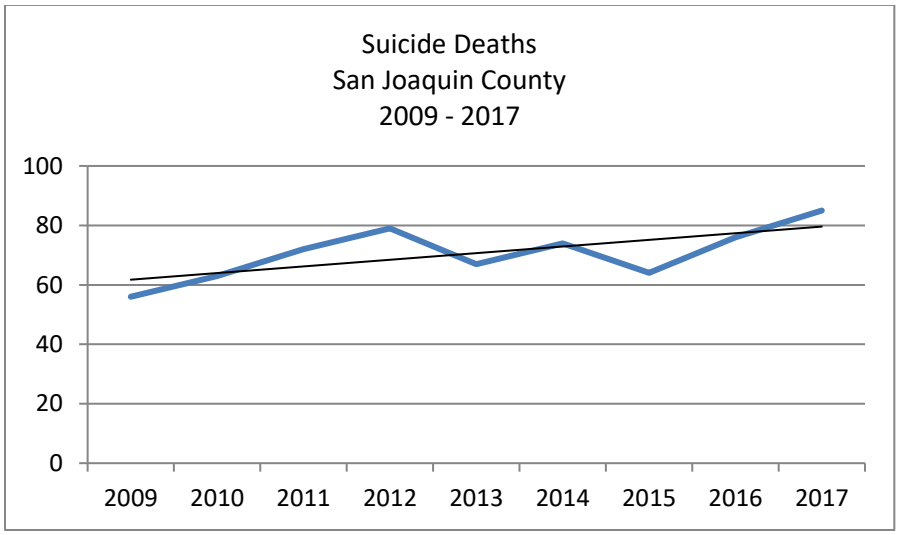
Groups related to any other trends on campus that may perpetuate self-harming or suicidal behavior but are not necessarily directly related to depression. These groups may include topics like bullying, stress management, etc.

Project Operational Budget: $610,139.52

PEI Project 12: Suicide Prevention and Education in the Community

Community Need

There is an increase in the numbers of suicide deaths occurring over the past 10 years, according the Office of the Coroner, and as shown in the chart below. Increases are somewhat higher than the prior 10 years in which suicides deaths were relatively flat, accounting for between 50 – 60 deaths annually. This is consistent with national research which shows that while suicide rates remained relatively stable between the late nineties and mid-2000's there is a significant increase in suicide deaths in the last ten years[1].



Suicide is the preventable consequence of untreated mental illness. PEI currently funds a suicide prevention campaign in local schools. Additional resources are needed for a suicide prevention campaign targeting adults and older adults.

National data also indicates that the suicide prevention activities need to better target males, who account for the majority of suicide deaths (75% of suicides nationally, and 85% of San Joaquin's suicide deaths, in 2017); and need to better target young men and adults between the ages of 15 – 64 with special outreach to young men and adults living in non-urban areas.

Project Description

[1] See: Centers for Disease Control and Prevention, National Center for Health Statistics, *Suicide Mortality in the United States 1999 – 2017.* https://www.cdc.gov/nchs/products/databriefs/db330.htm

In coordination with the PEI *Information and Education Campaign* BHS will work with a contracted program provider to develop a local suicide prevention campaign targeting young men and adults between the ages of 15-64. Suicide prevention campaign information will align its messaging with existing major suicide prevention initiatives, including national suicide prevention hotline and text lines, while simultaneously promoting local resources for a range of wellness concerns including depression, anxiety, and stress management.

Project Goal: Increase awareness and understanding of suicide as an illness and how to connect with a mental health professional in the community to address suicide thoughts or planning for yourself or a friend.

Project Components

Suicide Prevention for the Community

Develop and promote a suicide prevention and information campaign using a range of multi-media platforms, including billboards, websites, social media and/or smart-device applications which will guide users to local resources in San Joaquin County. Gun violence is the most prevalent mode of suicide death in San Joaquin County. Suicide prevention and information campaign efforts will include facts about non-homicide firearm related deaths and measures that can be taken to limit easy access to a gun for someone who may be at risk for suicide. Education on suicide prevention can be provided to the community through this program.

Additionally some San Joaquin County funds are assigned to CalMHSA for statewide suicide prevention programs.

Project Operational Budget: $658,695.74

VI. Innovation

Innovation Component Funding Guidelines:

INN Projects are novel, creative, and/or ingenious mental health practices/approaches that contribute to learning and that are developed within communities through a process that is inclusive and representative, especially of unserved, underserved and inappropriately served individuals.

Innovation funding may be used for the following purposes:

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

The primary purpose of an Innovation Project is to contribute to learning, rather than a primary focus on providing services. Contributions to learning can take any of the following forms:

- Introduce new mental health practices /approaches, including prevention and early intervention
- Adapt or change an existing mental health practice/ approach including adapting to a new setting or community
- Introduce a new application for the mental health system of a promising practice or an approach that has been successful in a non-mental health context or setting

INN Projects must also consider the following general standards, though the extent to which they are addressed will vary by INN Project:

- Community Collaboration
- Cultural Competence
- Client Driven Mental Health System
- Family Driven Mental Health System
- Wellness Recovery and Resilience Focus
- Integrated Service Expansion

BHS received approval by the Mental Health Services Oversight and Accountability Commission in January 2018 to implement two INN programs.

Project 1: Assessment and Respite Center

Project 2: Progressive Housing

BHS is currently planning two additional INN Programs slated for presentation to the Mental Health Services Oversight and Accountability Commission in 2021-22.

Project 3: Home To Stay - Engaging homeless individuals who have symptoms of Mental Illness with Co-Occurring disorders; outreach to local shelters and link to treatment

Project 4: Multi-County FSP Innovation Project - to develop and implement new data-driven strategies with participating cohort counties to better coordinate FSP service delivery, operations, data collection, and evaluation

INN Project 1: Assessment and Respite Center

Community Need

There are significant barriers to accessing mental health treatment services for vulnerable and underserved populations. BHS utilization data reveals significant disparities in accessing timely and appropriate mental health treatment services, including: low penetration rates amongst Latinos; over utilization of emergency and crisis services by African Americans; and low engagement of individuals that have had at least one episode of homelessness within the past year.

Systemic Challenges, many associated with the initial assessment process, continue to impede access and linkages to services amongst unserved and underserved individuals.

(1) There exists a confusing system whereby some services are only available through the primary healthcare system and others through a separate mental health system - depending on diagnosis and medical necessity. For most people, where to get help can be confusing;
(2) Some underserved and unserved populations are untrusting of County operated services and are reluctant to engage in public mental health services;
(3) Some individuals may not attend mental health services due to stigma; this bias usually does not apply to primary health care services;
(4) The assessment process is reported to be onerous, stigmatizing, and difficult to navigate – often requiring multiple appointments; and
(5) The clinical assessment process is less responsive to the presenting needs of individuals that are homeless and/or are under the influence than is recommended by consumers, case managers, and clinical staff.

The Solution: Community-based health centers are emerging as new partners in the provision of mild to moderate mental health treatment and substance use recovery services. Community clinics are less stigmatizing, and neighborhood based, making them easier to access for many individuals. Community health centers and mental health departments need to develop: (1) seamless protocols for joint screening and assessment – creating a no wrong door approach to services; and (2) a new approach to the assessment process that is responsive to the most pressing concerns expressed by individuals who are homeless, hungry, and/or under the influence – many of whom are unable or unwilling to complete the assessment process until their basic needs are met.

The Project: Integrate assessment and stabilization services within a community health clinic in order to provide timely, walk-in assessments, respite, brief interventions, medication assisted treatment services, mild-moderate mental health services, and other needed health care services. Re-design the assessment process so that is more flexible, culturally responsive, and appropriate for those with co-occurring disorders and/or basic needs that must be initially met. Offer direct linkages to a range of stabilization services including withdrawal management, housing, respite, and case management in order to stabilize high-risk individuals and successfully engage them into treatment services.

This project will operate within a continuum of services that includes:

(1) Whole Person Care Homeless Outreach Teams;

(2) Proposition 47 funded Withdrawal Management and Case Management Services; and

(3) Progressive Housing and two other MHSA funded projects to increase the availability of housing for individuals with mental illnesses.

The project also aligns with the recommendations of the County's Homelessness Taskforce and the Stepping-Up Initiative Steering Committee.

The Partner: Community Medical Center is a federally qualified health center operating in San Joaquin County for over forty years. With over a dozen neighborhood clinics, they offer a range of linguistically and culturally competent primary health, behavioral health, and dental care services to over 80,000 low-income individuals annually. Over 80% of employees are racial and ethnic minorities.

The Goal: The Assessment and Respite Center (ARC) will begin operations at the CMC Waterloo Clinic. Within the first year it is anticipated that the ARC will serve 20 individuals a day. It is anticipated that demand will quickly exceed the facility capacity – a second program site will be created after the first year of operations. Simultaneously, CMC intends to adapt protocols for joint BHS-CMC screening and assessment processes throughout all of their CMC San Joaquin Clinics. This will allow CMC to offer coordinated mental health screening, assessment, and linkages to services amongst any of the existing 80,000 patients by the third year of the project.

The Learning Question: BHS seeks to understand whether the new assessment processes will result in more at-risk individuals completing assessments and successfully linking to services and supports. Additionally, the evaluation will determine if the new model of collaborative assessments within a primary care setting will result in greater utilization of mental health services by individuals from unserved/underserved communities. Program objectives are to:

(1) increase access to services among underserved populations, as measured by:
- increase the number of completed assessments,
- successful linkages to services,
- increase in planned service utilization, and
- increase service retention for underserved populations.

(2) Reduce the negative consequences of untreated mental illness, as measured by:
- improve consumer well-being as measured by the *Adult Needs and Strengths Assessment*
- reduce the number and/or duration of hospitalizations, jail stays, or homelessness among participants of intensive stabilization services provided through the ARC.

Sustainability: CMC's financial projections anticipate that within five years, the increased number of patients brought into CMC services through the expansion of behavioral health services will create a self-sustaining program over time. However, this project is a test of a method for improving access and linkages to services. Should the model prove successful, BHS may consider ongoing funding to support improved access and linkage to services through other MHSA component funding.

Project Operational Budget: $2,165,512.72

INN Project 2: Progressive Housing

Community Need: Individuals with a serious mental illness require a safe and stable place to live in order to engage in treatment services and meet recovery goals. However affordable housing options are scarce, putting many individuals with mental illnesses at risk of homelessness, jeopardizing recovery goals.

The Challenge: Housing rents have skyrocketed in San Joaquin County, (by 92% over the last five years), squeezing many individuals into an increasingly competitive rental market. Further, 257 beds in fifteen board and care homes have been lost due to facility closure over the past two years – nearly a quarter of the previously available housing opportunities. The challenge of finding solutions for homeless individuals with mental illnesses is also growing in San Joaquin County. The 2017 Point-in-Time Homelessness Count found over 1,550 homeless individuals, with 31% reporting a mental health concern.

For low-income individuals with co-occurring mental illnesses and substance use disorders, and with recent experiences of homelessness, finding a safe, affordable and stable place to live can be next to impossible. Many of these individuals end up homeless, living in motels, or living in substandard housing. This challenge is faced by counties throughout the State who struggle to secure housing for their mental health consumers.

The Solution: Develop a model of cost-effective recovery-oriented housing that moves individuals out of homelessness while simultaneously addressing substance use recovery, mental health treatment needs, and preparing individuals to live more independently.

The Project: Progressive Housing is a modified approach to Housing First, a promising practice of placing mentally ill consumers in housing as a precursor to treatment services. The Housing First model shows mixed results with reductions in arrests and emergency hospitalizations but no significant changes in recovery outcomes.

Progressive Housing places individuals in shared housing, with each home representing a different stage on the recovery continuum, including contemplation; active treatment; and sober living houses. This will help create a no fail approach by which individuals can move up and down the housing continuum based on their current stage within the recovery process. The shared housing approach also reduces per-person housing costs, reduces isolation, and introduces a peer support component.

Shared recovery oriented housing will further promote wellness, by reducing isolation and creating a supportive environment. Consumer choice programming will fund group recreation, learning, and wellbeing activities for residents to improve socialization and behavioral skills. Case management and treatment services will be leveraged through other MHSA component funding.

Progressive Housing will leverage additional program services in order to create a comprehensive program. Mental health services will be provided for all consumers with serious mental illnesses through existing programs. Individuals identified with mild/moderate mental health concerns may be treated through a partnership with Community Medical Centers. Primary health care services, case management, and other wraparound services will also be leveraged through existing programs. Clients will be asked to contribute a nominal portion of their personal income from Social Security or General Assistance to their own cost of living for food and sundries; this helps build personal responsibility and prepare consumers for more independent living arrangements. All houses will keep basic pantry supplies and necessities stocked to assure no one is hungry. Contributions to the general food budget will vary based on the recovery stage of the clients in the house.

The Partner: Stockton Self Help Housing has over 30 years-experience in creating housing opportunities for homeless individuals.

The Goal: Progressive Housing hopes to open six houses annually for the first three years, serving approximately 90 enrolled clients by project termination. Program goals include increased access to and participation in treatment services, increased housing stability, and decreased the negative consequences of untreated mental illnesses.

The Learning Question: BHS will test whether this adaptation results in increased retention in services, successful client outcomes; is more cost effective than other models of developing new affordable housing (such as purchase, lease or construction); and whether the model can be replicated and rapidly deployed such that it can be expanded to other jurisdictions depending on need and market conditions.

Sustainability: Over the long term BHS seeks to determine if the Progressive Housing model will result in improved outcomes for consumers, including better engagement with treatment services, for a target population of consumers with co-occurring disorders, homelessness or prior incarcerations which limit access to other affordable housing solutions.

The evaluation will seek to determine which components of the program model are most linked to the outcomes realized. For example, will the emphasis on peer partners, consumer choice programming, etc. result in better outcomes than Housing First as usual. Based on evaluation findings, BHS will evaluate which program components need to be sustained over the long term, although the primary project components (e.g. rent for housing and mental health treatment services) will continue for all individuals that remain engaged in the program.

Project Operational Budget: $1,665,118.32

VII. Workforce Education and Training

The Mental Health Services Act (MHSA) allocates funding to promote professional growth and development, including recruitment and retention programs, in order to remedy the shortage of qualified individuals to provide services to address severe mental illness.

"Workforce Education and Training" means the component of the Three-Year Program and Expenditure Plan that includes education and training programs and activities for prospective and current Public Mental Health System employees, contractors and volunteers. *CA Code of Regulations § 3200.320*

Workforce Education and Training program planning is intended to provide opportunities to recruit, train, and retain employees broadly into the public mental health system, including employees of private organizations that provide publically funded mental health services. As such BHS has included a range of training opportunities within this Workforce Education and Training (WET) component section that are intended for both BHS and non-BHS employees, in order to promote the growth and professionalism of the entire mental health system of care. Additionally this WET Plan outlines an approach to promote professional growth and to recruit and retain highly qualified clinical staff into the public mental health care system.

Significant Considerations in Workforce, Education and Training

- ***Competition in Hiring:*** The new California Health Care Facility in Stockton, providing mental health treatment for seriously mentally ill inmates, has increased competition for highly qualified clinicians and mental health care providers, especially psychiatrists, clinicians, and psychiatric technicians.
- ***Shortage of Psychiatrists:*** The San Joaquin Central Valley has a severe shortage of trained psychiatrists, especially licensed child and geriatric psychiatrists, to meet the general population demand. Recruitment and retention of child psychiatrists continues to be challenging.
- ***Expanding Consumer Positions***: BHS has significantly increased hiring of consumer and peer employees. Additional training and support services are required to continue this expansion.
- ***Workforce Development***: BHS continues to recruit and train talented graduates of mental health programs and additional clinical supervisors are needed to help ensure that interns receive high caliber training and supervision, in order to provide evidence based treatment interventions with fidelity and to pass licensure examinations.
- ***New and Emerging Research:*** BHS is committed to providing treatment interventions that reflect best practices in recovery and in training practitioners throughout the County.

The MHSA Workforce Education and Training component contains five funding categories:

(1) Training and Technical Assistance

The Training and Technical Assistance Funding Category may fund: programs and/or activities that increase the ability of the Public Mental Health System workforce to support the participation of consumers and family members; increase collaboration and partnerships; promote cultural and linguistic competence; develop and deliver trainings; and promote and support the *General Standards* of specialty mental health care services.

(2) Mental Health Career Pathway Programs

The Mental Health Career Pathway Programs Funding Category may fund: programs to prepare clients and/or family members of clients for employment; programs and that prepare individuals for employment in the Public Mental Health System; career counseling, training and/or placement programs; outreach and engagement in order to provide equal opportunities for employment to culturally diverse individuals; and supervision of employees in Public Mental Health System occupations that are in a *Mental Health Career Pathway Program*.

(3) Residency and Internship Programs

The Residency and Internship Programs Funding Category may fund: time required of staff to supervise psychiatric or physician assistant residents and clinician or psychiatric technicians interns to address occupational shortages identified in the *Workforce Needs Assessment*.

(4) Financial Incentive Programs

The Financial Incentive Programs Funding Category may fund: financial assistance programs that address one or more of the occupational shortages identified in the County's *Workforce Needs Assessment*. Financial Incentive Programs may include scholarships, stipends, and loan assumption programs.

(5) Workforce Staffing Support

The Workforce Staffing Support Funding Category may fund: Public Mental Health System staff to plan, recruit, coordinate, administer, support and/or evaluate Workforce Education and Training programs and activities; staff to provide ongoing employment and educational counseling and support to consumers and family members entering or currently employed in the Public Mental Health System workforce, and to support the integration into the workforce; and other staff time, including the required Workforce Education and Training Coordinator, as necessary to implement the WET plan.

In 2020/21 BHS will refund the Workforce Education and Training projects with a transfer of funds into the WET account from CSS. Funds must be spent within 10 years from the date of transfer.

WET Project 1: Training and Technical Assistance Academy

Community Need

Consumers, family members, and program staff from public and community-based organizations throughout the County are critical partners in the delivery of mental health services. These volunteers and employees work tirelessly to promote mental health recovery and are a core component of the public mental health workforce and intricate to the BHS belief and commitment to consumer and family driven mental health care services. These professionals and community volunteers require ongoing training and education to promote their competencies and to improve the capacity of the entire workforce to provide culturally competent, high quality mental health services and supports.

Project Description

BHS will coordinate the delivery of trainings throughout San Joaquin County. Trainings will support the delivery of high quality, culturally competent, and consumer- and family-driven mental health services and supports. Trainings will also help establish and re-affirm a core practice model by establishing the baseline knowledge and competencies required to participate in the delivery of recovery oriented mental health service and supports.

Project Components

- *Trainings for Volunteers, Peer Partners, Case Managers, and Community Partners.* All volunteers, peer partners (consumers and family members), case managers and non-clinical community partners contracted to provide direct mental health services and supports shall be trained in the fundamentals of mental health, including how to engage and refer individuals for further assessment and interventions. Trainings for BHS staff, volunteers and community partners may include, but are not limited to, the following:
    - *Suicide Prevention and Intervention Trainings*
    - *Mental Health First Aid*
    - *Wellness Recovery Action Plans*
    - *Crisis Intervention Training (for Law Enforcement and first responders)*
    - *Trauma Informed Care*
    - *Addressing the needs of Commercially and Sexually Exploited Children*
    - *Motivational Interviewing*
    - *Stigma Reduction*
- *Specialty Trainings in Treatment Interventions.* Specialty trainings are provided to increase the competencies of staff in core practice modalities. These modalities include the delivery of evidence-based interventions, to fidelity, and as described throughout this MHSA plan. Trainings may include, but are not limited to, the following treatment interventions:
    - *Seeking Safety*
    - *Cognitive Behavioral Therapies*
    - *Dialectical Behavioral Therapy*
    - *Multisystemic Therapy*

- *Medication Assisted Treatment.* Medication Assisted Treatment (MAT), combines psychosocial modalities, including behavioral therapies and counseling, with medications for the treatment of substance use disorders. MAT is indicated for individuals with co-occurring mental health and substance use disorders. Funding will be allocated for BHS and some community partners to attend national medical conferences on the treatment of substance use, and co-occurring substance use, disorders in order to improve physician/psychiatrist knowledge and familiarity with MATs and the recommended prescribing protocols. The conferences' MAT training modules are designed to increase prescriber confidence and comfort in using MATs in conjunction with other psychotropic medications ordered for mental health illnesses.

- *MHSA General Standards Training and Technical Assistance.* BHS managers will receive training, guidance, and supervision to support and promote the MHSA and the General Standards of the MHSA. The Medical Director will provide training, guidance, and supervision to support and promote the MHSA and the General Standards of the MHSA amongst the medical staff. Training, guidance and supervision is provided to support and promote:
    - *Community Collaboration,* including efforts to integrate primary and mental health services and to provide mental health services within community-based locations throughout San Joaquin County.
    - *Cultural Competence,* including the use of culturally competent prevention, intervention, treatment and recovery approaches and culturally and linguistically appropriate discourse with consumers and family members.
    - *Client Driven Services*, including the incorporation of WRAP activities and plans within the clinical model, and practices which embraces the client as having the primary decision-making role in identifying his/her needs and preferences in service delivery.
    - *Family Driven Services,* including practices which incorporate the input of families within the development of treatment plans and in which the families of children and youth with SED/SMI have the primary decision-making role in the care of their own children.
    - *Wellness, Recovery, and Resiliency,* including supervision and guidance to ensure that all medical staff promote and support clients on their pathways to wellness and recovery.
    - *Integrated Service Experience,* including training or support to ensure that medical staff have the tools, training, and resources to access a full range of services provided by multiple agencies and programs in a comprehensive and coordinate manner.
    - *Leadership Training* for program managers to improve capacity for program design, management, and oversight, including contract compliance and evaluation.
    - *Compliance with Applicable Regulations.* As statewide regulations are updated to improve services staff require briefings and trainings to ensure that services continue to meet all standards and expectations.
    - *Electronic Health Records.* WET funding may be allocated to train BHS staff on the new electronic health information system.

BHS Training Coordinator. The BHS Training Coordinator manages the increasing training needs for BHS staff and community partners, including law enforcement. The training coordinator is responsible for working with the training divisions of local police and Sheriff and school districts to ensure that mental health related trainings are offered concurrent to professional growth and training plans of partner agencies. The training coordinator also develops and tracks participation in a range of MHSA related trainings for BHS staff and community partners as identified elsewhere in this Plan or as deemed necessary by BHS.

The Training Coordinator will also ensure that notifications about additional training opportunities will be distributed to the public mental health workforce, including consumers and family members of consumers who are interested in entering the mental health workforce.

Project Objective: MHSA Training programs will increase the ability of BHS, and its community partners in mental health services, to deliver high quality, recovery oriented, and consumer- and family-driven specialty mental health care services by a culturally competent workforce throughout San Joaquin County. (See also, MHSA General Standards, *CA Code of Regulations §3320*.)

Project Operational Budget: $364,454.55

WET Project 2: Internship and Financial Assistance Program

Community Need:

The San Joaquin Central Valley has a severe shortage of mental health professionals. BHS also encounters challenges locating community providers for mental health and substance use disorder services. This shortage is particularly high for public mental health practitioners with adequate competencies to work effectively with individuals with serious mental illness (SMI) or serious emotional disturbance (SED) across the lifespan of age groups as well as diverse racial, ethnic and cultural populations.

Project Description:

BHS will coordinate an internship and financial assistance program to meet the shortage within our community. This project will enhance BHS' efforts to continue to recruit and train talented graduates of mental health programs and provide a pathway of opportunity in four distinct components.

Project Components:

- Hiring bonus for new clinicians
- Longevity bonus for existing clinical licensed staff
- Educational stipends to advance existing staff to clinician level
- Internship opportunities to engage staff through post education work commitments
- Regional collaboration with Office of Statewide Health Planning and Development (OSHPD) and the WET central region partnership to improve recruitment and training.

Project Operational Budget: $297,391.15

VIII. Capital Facilities and Technological Needs

Funding for capital facilities is to be used to acquire, construct, and/or renovate facilities that provide services and/or treatment for those with severe mental illness, or that provide administrative support to MHSA funded programs.

Funding for technological needs is to be used to fund county technology projects with the goal of improving access to and delivery of mental health services.

San Joaquin County submitted a Capital Facilities and Technology Needs (CFTN) Plan in spring 2013. The plan set aside funding for capital facilities construction and described a major capacity building project to bring the county into compliance with state and federal mandates for electronic health records.

Since 2013, additional needs have been identified and have been subsequently described in the 2017/18 Three Year Program and Expenditure Plan.

Past CFTN funding has been used to:

- Construction and Renovations to the Crisis Stabilization Unit (CSU)
    - Create a CSU for children and youth
    - Create voluntary CSU for adults

- Electronic Health Records
    - Develop new electronic health records for consumers, update electronic case management and charting system
    - Develop data capacity and partnership protocols for information sharing through new health information exchange

In 2021-22 BHS will refund the Capital Facilities and Technology Needs project fund with a transfer of funds into the CFTN account from CSS. Funds must be spent within 10 years from the date of transfer. Proposed new projects are outlined described below.

CF/TN Project 1: Two Residential Treatment Services Facilities for Individuals with Co-Occurring Disorders

There is an acute shortage of residential substance use disorder treatment services in San Joaquin County. Further, none of the existing programs are well equipped to provide recovery services for individuals with serious mental illnesses. Consumers and family members have expressed concern that recovery programs geared towards treating substance use disorders alone are not clinically the best option for the treatment of co-occurring disorders. BHS will continue to explore funding and procurement options, anticipating the use of CFTN funds to renovate, purchase, or build a residential treatment program for individuals with co-occurring disorders. Additional activities may include, but are not limited to preliminary architectural design, site mapping, procurement, and other technical assistance. Funds were allocated for project start-up in FY 2019-20 and continues in 2021-22. Budget estimates presumes additional funds will be required in subsequent years to complete the project.

Project Operational Budget: $2,767,659

CF/TN Project 2: Facility Renovations

Funding will be allocated to upgrade and renovate Behavioral Health facilities. Capital Facility funds will be used for projects that have been identified as critical to ensuring clean, safe, and accessible access to services for all populations. Projects include: installation of security cameras, dedicated parking for the Children's Crisis services, restroom upgrades (for ADA compliance and safety), exterior painting to prevent structural damage, and other facility renovations.

Project Operational Budget: $0

CF/TN Project 3: Facility Repair and Upgrades

Funding will be allocated for a variety of facility repairs and upgrades to ensure facilities remain in good working order and provide comfortable and effective workspaces for all program activities. Projects include, but are not limited to: repairs or upgrades to roofing, flooring, workstations, meeting rooms, waiting rooms, and other public spaces; repairs or upgrades to heating and ventilation equipment, lighting, alarms, windows, acoustics, etc.; and other projects as needed to ensure that BHS facilities are in good repair and working order. Projects may include additional refurbishments to ensure that all clinical spaces are warm and inviting places that support healing and recovery. Upgrades may include interior re-configurations to accommodate increased staffing, new technologies, or other changes to "back-office" services needed to improve overall service delivery.

Project Operational Budget: $3,789,070.05

CF/TN Project 4: Technology Equipment and Software

Additional technology upgrades are needed. Software upgrades and equipment are necessary to ensure compatibility with the latest versions of financial, HR, project, and client case management systems, and to ensure all information is protected and retained in the event of an emergency. CF/TN funds will be used for a range of software, hardware, networking, and technology consultations to improve client services.

Project Operational Budget: $505,000.00

X. MHSA Funds – Reduction of the Prudent Reserve Balance

On August 14, 2019 San Joaquin County Behavioral Health Services (BHS) received information Notice (IN) 19-037 from California Department of Health Care Services (DHCS) Mental Health & Substance Use Disorders Services (MHSUDS).

The purpose of information Notice 19-037 was to inform counties of the following:

- Requirement to establish and maintain a prudent reserve that does not exceed 33 percent of the average community services and support (CSS) revenue received for Local Mental Health Services Fund in the preceding given years, and to reassess and certify the maximum amount every five years.
- Each county must calculate an amount to establish its prudent reserve that does not exceed 33 percent of the average amount allocated to the CSS Component in FY 2013-14, FY 2014-15, FY 2015-16, FY 2016-17, FY 2017-18. To determine the average amount allocated to the CSS Component of those five years a county must calculate the sum of all distributions form the Mental Health Services Fund from July 2013 through June 2018, multiply that sum by 76, and divide that product by five.
- To determine the maximum prudent reserve level, a county must multiply the average amount allocated to the CSS component of the previous five years by 33 percent.

In San Joaquin County the maximum prudent reserve funds should be as follows:

San Joaquin County		
Prudent Reserve Maximum		
June 30, 2019 Assessment		
		MHSF Distribution
FY 2013-14		$ 20,588,023.62
FY 2014-15		$ 28,683,962.64
FY 2015-16		$ 23,778,868.00
FY 2016-17		$ 31,240,367.33
FY 2017-18		$ 34,063,364.47
	Total	$ 138,354,586.06
CSS allocation (76%)		$ 105,149,485.41
5-Year Average		$ 21,029,897.08
Prudent Reserve Maximum (33% of 5-yr average)		**$ 6,939,866.04**

XI. Attachments: Evaluation and Planning Reports

Workforce Analysis

Cultural Competency Plan

PEI Evaluation

XII. Appendix: Community Planning Documents

MHSA Public Meeting Flyer

MHSA Consumer Meeting Flyer

Community Planning Presentation

Input and Recommendations Form

Stakeholder Information Form

Stakeholder Demographic Form

Consumer and Stakeholder Survey, Summary Results

Public Hearing Presentation

Letters Received During 30-Day Public Review and Comment Period

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT:

I. By Occupational Category - page 1

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. *Unlicensed* Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers):										
Mental Health Rehabilitation Specialist	5.75	0	0							
Case Manager/Service Coordinator	103.75	1	30							
Employment Services Staff	1.00	0	0							
Housing Services Staff	1.00	0	0							
Consumer Support Staff	44.75	1	8							
Family Member Support Staff	8.75	1	4							
Benefits/Eligibility Specialist	0	0	0							
Other *Unlicensed* MH Direct Service Staff	87.25	1	0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals Only) ⬇						
Sub-total, A (County)	**252.25**	**4**	**42**	**61.75**	**78.00**	**34.25**	**20.25**	**1.00**	**15.50**	**210.75**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist	24.35	0	3							
Case Manager/Service Coordinator	35.25	0	5							
Employment Services Staff	1.00	0	0							
Housing Services Staff	4.50	0	0							
Consumer Support Staff	38.00	0	0							
Family Member Support Staff	2.00	0	0							
Benefits/Eligibility Specialist	0	0	0							
Other *Unlicensed* MH Direct Service Staff	38.27	0	0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ⬇						
Sub-total, A (All Other)	**143.37**	**0**	**0**	**40.74**	**55.24**	**15.38**	**21.70**	**2.75**	**7.56**	**143.37**
Total, A (County & All Other):	**395.62**	**4**	**42**	**102.49**	**133.24**	**49.63**	**41.95**	**3.75**	**23.06**	**354.12**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 2

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+(7)+(8)+(9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers):										
Psychiatrist, general	14.63	1	9							
Psychiatrist, child/adolescent	5.12	1	6							
Psychiatrist, geriatric	2.00									
Psychiatric or Family Nurse Practitioner	2.75	1	0							
Clinical Nurse Specialist										
Licensed Psychiatric Technician	68.25	1	8							
Licensed Clinical Psychologist										
Psychologist, registered intern (or waivered)										
Licensed Clinical Social Worker (LCSW)	14.75	1	8							
MSW, registered intern (or waivered)	27.25	1	14							
Marriage and Family Therapist (MFT)	27.00	1	8							
MFT registered intern (or waivered)	42.25	1	13							
Other *Licensed* MH Staff (direct service)	6.75	1	6							
Sub-total, B (County)	**210.75**	**9**	**72**	**56.35**	**50.50**	**19.75**	**51.75**	**0**	**19.10**	**197.45**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general	3.25	1	2							
Psychiatrist, child/adolescent	.20	1	3							
Psychiatrist, geriatric										
Psychiatric or Family Nurse Practitioner		1								
Clinical Nurse Specialist										
Licensed Psychiatric Technician	3.75	1	4							
Licensed Clinical Psychologist	2.10									
Psychologist, registered intern (or waivered)										
Licensed Clinical Social Worker (LCSW)	5.85	1	2							
MSW, registered intern (or waivered)	4.65	1	4							
Marriage and Family Therapist (MFT)	21.70	1	2							
MFT registered intern (or waivered)	13.85	1	4							
Other *Licensed* MH Staff (direct service)	0	1	2							
Sub-total, B (All Other)	**55.35**	**9**	**23**	**15.79**	**14.15**	**5.55**	**14.51**	**0**	**5.35**	**55.35**
Total, B (County & All Other):	**266.10**	**18**	**95**	**72.14**	**64.65**	**25.30**	**66.26**	**0**	**24.45**	**252.80**

(*Licensed* Mental Health Direct Service Staff; Sub-Totals Only)

(*Licensed* Mental Health Direct Service Staff; Sub-Totals and Total Only)

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 3

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes' 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+(7)+(8)+(9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers):										
Physician	0									
Registered Nurse	23.50	1	3							
Licensed Vocational Nurse	1.0									
Physician Assistant	0									
Occupational Therapist	1.0									
Other Therapist (e.g., physical, recreation, art, dance)	0									
Other Health Care Staff (direct service, to include traditional cultural healers)	25.0	1	0	(Other Health Care Staff, Direct Service; Sub-Totals Only) ⬇						
Sub-total, C (County)	**50.50**	**2**	**3**	**19.75**	**7.0**	**4.50**	**13.25**	**0**	**3.75**	**48.25**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Physician	0									
Registered Nurse	0	1	0							
Licensed Vocational Nurse	1.50	1	0							
Physician Assistant	0									
Occupational Therapist	0									
Other Therapist (e.g., physical, recreation, art, dance)	0									
Other Health Care Staff (direct service, to include traditional cultural healers)	1.20			(Other Health Care Staff, Direct Service; Sub-Totals and Total Only) ⬇						
Sub-total, C (All Other)	**2.70**	**2**	**0**	**1.20**	**1.50**					**2.70**
Total, C (County & All Other):	**53.20**	**4**	**3**	**20.95**	**8.50**	**4.50**	**13.25**	**0**	**3.75**	**50.95**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 4

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers):										
CEO or manager above direct supervisor.....	13.00									
Supervising psychiatrist (or other physician)	1.00									
Licensed supervising clinician.....	23.00	1	4	(Managerial and Supervisory; Sub-Totals Only) ⬇						
Other managers and supervisors.....	33.00	1	4							
Sub-total, D (County)	**70.00**	**2**	**8**	**33.00**	**11.00**	**5.00**	**11.00**	**2.00**	**2.00**	**64.00**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor.....	6.72									
Supervising psychiatrist (or other physician)	0									
Licensed supervising clinician.....	4.25	1	4	(Managerial and Supervisory; Sub-Totals and Total Only) ⬇						
Other managers and supervisors.....	9.98									
Sub-total, D (All Other)	**20.95**	**1**	**4**	**7.96**	**5.00**	**4.73**	**2.26**	**0**	**1.00**	**20.95**
Total, D (County & All Other):	**90.95**	**3**	**12**	**40.96**	**16.00**	**9.73**	**13.26**	**2.00**	**3.00**	**84.95**
E. Support Staff (non-direct service):										
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance.....	**27.75**	**1**	**15**							
Education, training, research	**0**									
Clerical, secretary, administrative assistants	**142.25**			(Support Staff; Sub-Totals Only) ⬇						
Other support staff (non-direct services).....	**28.75**									
Sub-total, E (County)	**198.75**	**1**	**15**	**54.00**	**50.75**	**15.25**	**18.50**	**.75**	**12.75**	**152.00**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance.....	**1.45**									
Education, training, research	**0**									
Clerical, secretary, administrative assistants	**12.95**			(Support Staff; Sub-Totals and Total Only) ⬇						
Other support staff (non-direct services).....	**2.0**									

Sub-total, E (All Other)	**16.40**	**0**	**0**	**6.15**	**2.37**	**1.00**	**1.43**	**0**	**5.45**	**16.40**
Total, E (County & All Other):	**215.15**	**1**	**15**	**60.15**	**53.12**	**16.25**	**19.93**	**.75**	**18.20**	**168.40**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 5

GRAND TOTAL WORKFORCE
(A+B+C+D+E)

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
***County (employees, independent contractors, volunteers)* (A+B+C+D+E).....**	**782.25**	**18**	**140.00**	**224.85**	**197.25**	**78.75**	**114.75**	**3.75**	**53.10**	**672.45**
***All Other (CBOs, CBO sub-contractors, network providers and volunteers)* (A+B+C+D+E) .....**	**238.77**	**12**	**27.00**	**71.84**	**78.26**	**26.66**	**39.90**	**2.75**	**19.36**	**238.77**
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	**1,021.02**	**30**	**167.00**	**296.69**	**275.51**	**105.41**	**154.65**	**6.50**	**72.46**	**911.22**

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

				Race/ethnicity of individuals planned to be served -- Col. (11)						
				White/ Cau-casion	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	All individuals **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			**6,827**	**4,609**	**3,270**	**1,814**	**518**	**791**	**17,829**

II. Positions Specifically Designated for Individuals with Consumer and Family Member Experience:

Major Group and Positions	Estimated # FTE authorized and to be filled by clients or family members	Position hard to fill with clients or family members? (1=Yes; 0=No)	# additional client or family member FTEs estimated to meet need
(1)	(2)	(3)	(4)
A. *Unlicensed* Mental Health Direct Service Staff:			
Consumer Support Staff.....	63.85	1	8
Family Member Support Staff	11.75	1	4
Other *Unlicensed* MH Direct Service Staff.....	0	1	
Sub-Total, A:	**75.60**	**3**	**12**
B. *Licensed* Mental Health Staff (direct service).....	**0**	**0**	
C. Other Health Care Staff (direct service)	**0**	**0**	
D. Managerial and Supervisory.....	**2.50**	**0**	
E. Support Staff (non-direct services).....	**9.15**	**0**	
GRAND TOTAL (A+B+C+D+E)	**87.25**	**0**	**12**

III. LANGUAGE PROFICIENCY

For languages other than English, please list (1) the major ones in your county/city, (2) the estimated number of public mental health workforce members currently proficient in the language, (3) the number of additional individuals needed to be proficient, and (4) the total need (2)+(3):

Language, other than English	Number who are proficient	Additional number who need to be proficient	**TOTAL (2)+(3)**
(1)	(2)	(3)	(4)
1. Spanish (threshold)	Direct Service Staff 126 Others 39	Direct Service Staff 52 Others 0	Direct Service Staff 178 Others 39
2. Cambodian (threshold)	Direct Service Staff 8 Others 2	Direct Service Staff 1 Others 0	Direct Service Staff 9 Others 2
3. Vietnamese	Direct Service Staff 11 Others 1	Direct Service Staff 0 Others 0	Direct Service Staff 11 Others 1
4. Hmong	Direct Service Staff 9 Others 5	Direct Service Staff 0 Others 0	Direct Service Staff 9 Others 5
5. Lao	Direct Service Staff:1 Others: 0	Direct Service Staff: 2 Others 0	Direct Service Staff: 3 Others 0
6.Thai	Direct Service Staff: 3 Others: 0	Direct Service Staff: 0 Others: 0	Direct Service Staff: 3 Ohers: 0 Others
7 Tagalog/Filipino	Direct Service Staff 23 Others 7	Direct Service Staff 0 Others 0	Direct Service Staff 23 Others 7

San Joaquin County Behavioral Health Services
2020-21 Annual Update to the 2010 Cultural Competency Plan

San Joaquin County Behavioral Health Services (BHS) continuously seeks to improve by evaluating, strategizing and enhancing service delivery. To meet the prevention, intervention, treatment and recovery needs of San Joaquin County residents, BHS provides a broad range of behavioral health services, including mental health and substance use disorder services, in a culturally competent and linguistically appropriate manner.

The 2020-21 Annual Update to the 2010 Cultural Competency Plan (Annual Update) reviews the efforts of Fiscal Year (FY) 2019-2020 and guides upcoming efforts for FY 2020-2021. The Annual Update will focus on the eight criteria laid out by the State's Cultural Competency Plan Requirements of 2010.

As a result of the COVID-19 pandemic occurrence during the second half of 2019-2020, the Cultural Competency Committee was unable to meet From March to July, 2020. Many FY 2019-2020 strategies were approved by the Cultural Competency Committee to carryover to FY 2020-2021.

Criterion 1: Commitment to Cultural Competence

(CLAS Standard 2, 3, 4, 9, 15)

FY 2019-2020 Accomplishments: Two significant strategies were implemented to enhance agency commitment to Cultural Competency. These were:

1. Measured and monitored cultural competency standards through the 2019-20 MH and SUD Quality Improvement Work Plans (See Attachment 1 & 2)
2. Agency roll out of the updated online training entitled, "Improving Cultural Competency for Behavioral Health Professionals" by the Federal Office of Minority Health. (See Attachment 3)

BHS began tracking, monitoring and measuring strategies via the BHS MH and SUD QI Work Plan. The addition of this process improved accountability by using measurable objectives in the Annual Update.

BHS was successful in implementing the new four to five hour online training entitled, "Improving Cultural Competency for Behavioral Health Professionals", The training's nine learning objectives include: 1) Describe how culture, cultural identity, and intersectionality are related to behavioral health and behavioral health care; 2) Describe the principles of cultural competency and cultural humility; 3) Discuss how our bias, power, and privilege can affect the therapeutic relationship; 4) Discuss ways to learn more about a client's cultural identity; 5) Describe how stereotypes and microaggressions can affect the therapeutic relationship; 6) Explain how culture and stigma can influence help-seeking behaviors; 7) Describe how communication styles can differ across cultures; 8) Identify strategies to reduce bias during assessment and diagnosis; and, 9) Explain how to elicit a client's explanatory model.

FY 2020-2021 Strategies:

1. Conduct a division-wide and program-specific inventory of Cultural Competency knowledge via the California Brief Multicultural Competence Scale (CMCBS) to identify gaps in the knowledge base of BHS staff members and partners by April 30, 2021. (Strategy Carryover from FY 2019-2020 Plan)

2. Develop an action plan to address findings of the CBMCS Survey by May 31, 2021 (Strategy Carryover from FY 2019-2020 Plan)

Criterion 2: Updated Assessment of Service Needs

(CLAS Standard 2)

FY 2019-2020 Accomplishments: BHS implemented a comprehensive community planning process with these components:

- Seven community discussions about the needs and challenges experienced by mental health consumers, with a focus on the diverse range of consumers served.
- Five targeted discussion groups with mental health consumers, family members and community stakeholders.
- Review of service needs including utilization, timeliness and client satisfaction.
- Cultural Competency Committee presentations to multiple stakeholder groups throughout the BHS System.

BHS reviewed service needs using two methods:

1. The Mental Health Services Act (MHSA) Community Planning Process incorporated discussion with stakeholders on the needs of diverse communities in the County, and gaps in available services. This assessment of service needs is detailed in the 2020-2023 MHSA Three Year Program and Expenditure Plan, pages 8 through 19 (See Attachment 4).
2. Review of San Joaquin County Medi-Cal Approved Claims Data for mental health (MH) and substance use disorders (SUD) utilization, provided by CALEQRO. The data provided by CALEQRO contains Medi-Cal Beneficiaries served by race and ethnicity and penetration rates by age, gender and ethnicity (See Attachment 5).

Through the MHSA Planning Needs Assessment, BHS found that the diversity of its consumers was similar to the distribution in prior years.

- African Americans are enrolled at higher rates compared to their proportion of the general population (17% of participants while comprising 7% of the population of the County).
- Latinos are enrolled at lower rates compared to their proportion of the general population (27% of participants while comprising 42% of the population) – though this rate is up slightly from prior years.
- Participation amongst children and youth is more reflective of the racial demographics of the overall population, with over a third of services provided to young Latinos (35%), suggesting that while stigma, language or cultural barriers, or access to health care services continue to impeded access for Latino adults with behavioral health needs, more services are reaching the younger Latino populations.
- Survey Input and Stakeholder feedback displayed race/ethnicity data reflective of the BHS client population. Adult survey respondents were more likely to be African American, Asian, or Native American than is reflective of the general population of the County.
- Feedback from self-reported demographics indicated that adult consumers represented 10% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQQI).

Data provided by CALEQRO for MH Medi-Cal Beneficiaries indicated the following:

- The penetration rate for individuals 60+ continues to be higher than the statewide average, similar to the previous year.
- The penetration rate for Asian/Pacific Islanders is higher than the statewide average, similar to the previous year.

- The penetration rate for Latino/Hispanic communities (2.91%) is lower than the statewide average of 4.08% but nearly on par with the rate of other medium-sized counties (3.04%).

Data provided by CALEQRO for SUD Medi-Cal Beneficiaries indicated the following:

- The penetration rate for individuals 65+ is higher than statewide average, similar to the previous year.
- The penetration rate for African-Americans is higher than statewide and medium sized counties averages, similar to the previous year.
- The penetration rate for Latino/Hispanic communities (1.03%) is higher that the statewide average (.66%).

FY 2020-2021 Strategies:

- BHS will again host a series of MHSA community planning discussions on the needs and challenges experienced by mental health consumers, with a focus on the diverse range of consumers served, by January 31, 2021.
- BHS will develop online and paper needs assessment surveys to reach individuals who are unable to attend community planning sessions, or who may be unwilling or unable to provide public comment in person at meetings, by January 31, 2021.
- BHS will distribute and collect needs assessment surveys by February 15, 2021.
- BHS will complete an annual MHSA assessment of needs by February 29, 2021.
- BHS will conduct a series of planning discussions on the needs and challenges experienced by SUD consumers, with a focus on the diverse range of consumers served by May 31, 2021.
- Develop online and paper needs assessment surveys to reach individuals who are unable to attend SUD community planning sessions or who may be unwilling or unable to provide public comment in person at meetings by May 31, 2021. (Strategy Carryover from 19-20 Plan)
- Distribute and collect SUD needs assessment surveys by June 15, 2021. (Strategy Carryover from 19-20 Plan)
- Complete an annual SUD assessment of needs by June 30, 2021. (Strategy Carryover from 19-20 Plan)
- To follow-up on its CLAS survey with a more robust survey to be administered to all staff, a division-wide and program-specific inventory of Cultural Competency knowledge via the CBMCS to identify gaps in the knowledge base of both MH and SUD staff members and community partners will be administered to all staff by April 30, 2021. (Strategy Carryover from 19-20 Plan)
- Develop strategies and an action plan to address CBMCS findings by May 31, 2021. (Strategy Carryover from 19-20 Plan)

Criterion 3: Strategies and Efforts for Reducing Racial, Ethnic, Cultural and Linguistic Disparities

(CLAS Standard 1, 10, 14)

FY2019-20 Accomplishments

- Second Year Evaluation Report was completed by the UC Davis Behavioral Health Center for Excellence to highlight successes, deficiencies and recommendations for upcoming year.

As of May 2020, a total of 748 individuals have either been referred or self-referred to receive services delivered as of part of the Homeward Bound Initiative, an increase of 303 clients (+68%).The Homeward Bound Behavioral Health Assessment and Respite Center opened in June 2018 as a "friendly front door" to services for individuals who are unlikely to access MH and SUD services from the public behavioral health system. Community Medical Centers (CMC) is a local non-profit community health care provider and a Federally Qualified Health Center (FQHC). This lead project partner was selected based on a long standing reputation in the community for serving racial and ethnic minorities, having started over forty years ago providing health care services in the fields to migrant farm workers. CMC has grown to a network of 12 community clinics serving over 80,000 patients. Ninety-seven percent of patients are low-income and 83% identify as ethnic or racial minorities.

Population rate of selected Races and Ethnicities in San Joaquin County, and Service Utilization Rates across BHS and the Homeward Bound Initiative :

Race and Ethnicity in San Joaquin County	Population rate across San Joaquin County[1]	San Joaquin BHS Service Utilization	Homeward Bound Service Utilization
White (non-Hispanic)	31%	38%	40.4%
Hispanic/Latinx	41.9%	24%	25.6%
Asian	15.7%	11%	5.5%
African American	7%	19%	10.3%
Other	4%	8%	9%

Engagement in mental health treatment and SUD counseling is relatively consistent across all racial and ethnic groups for both mental health treatment and SUD counseling. CMC has been successful at achieving equity in long-term engagement across all racial and ethnic groups so far. The number of Black/African American and Hispanic/Latinx clients referred to Homeward Bound remains lower than the population rates of these group in San Joaquin County, but engagement with these racial and ethnic groups has remained consistently close to 30% of new referrals (until a recent downturn in the first half of 2020, which may be partly a result of the ongoing pandemic's disparate effect on Black/African American and Hispanic/Latinx populations in San Joaquin County.

FY 2020-2021 Strategies:

- The Cultural Competency Committee will review data from the Second Year Evaluation Report related to race and ethnicity to provide recommendations for further engagement of the Latinx and Asian population, by April 30, 2021.
- BHS will implement any needed adjustments to the activities of the Assessment and Respite Center in the annual contract renewal process, by June 30, 2021.

Criterion 4: County Systems Client/Family Member/Community Committee:

(CLAS Standard 13)

BHS has two avenues to address the cultural competence of its staff and services:

1. The Cultural Competency Committee comprised of BHS staff, consumers/family members, and other stakeholders.
2. The MHSA Consortium, established in 2007, comprised of a variety of stakeholders: representatives of community based organizations, consumers and family members, community members and BHS staff.

The Cultural Competency committee was developed in accordance with the requirements of Title IX, CA Code of Regulations, Chap. 11, Article 4 Section 1810.410, (b). BHS policy states that:

1. BHS shall maintain a Cultural Competence Committee that has representation from management staff, direct services staff, consumer, community members and representatives of cultures from the community
2. The Cultural Competence Committee shall meet regularly to review the BHS adherence to the BHS Cultural Competency Plan by reviewing goals and objectives and make appropriate recommendations to BHS Administration regarding management and service provision as it relates to cultural and linguistic services.
3. The Cultural Competence Committee shall elicit, suggest, review, monitor and support strategies to increase penetration and retention rates for identified community groups.
4. The Cultural Competence Committee will collaborate with the MHSA Consortium and organizations representing various groups within the community.

The MHSA Consortium meets monthly to discuss community-wide behavioral health services in a framework of cultural diversity. Many meetings include presentations on services for diverse racial and ethnic communities and include agenda items focused on cultural competence and language proficiency. The Co-Chair of the Cultural Competency Committee is responsible for planning the Consortium activities along with community stakeholders. The MHSA Consortium has become a vehicle through which the Cultural Competency Committee informs stakeholders about BHS Cultural Competency efforts.

FY 2019-2020 Accomplishments: The Cultural Competency Committee achieved significant successes with the development of two major projects:

- Continuous engagement of SUD services staff at the Cultural Competency Committee
- Implemented new online Cultural Competency Training

FY 2020-2021 Strategies:

- Host a minimum of eight meetings with representation from management staff, direct services staff, consumers, community members and representatives of culture from the community, by June 30, 2021. (Strategy Carryover from 19-20 Plan)
- Elicit, suggest, review, monitor and support at least two new strategies to increase penetration and retention rates for identified community groups by June 30, 2021. (Strategy Carryover from 19-20 Plan)
- Recruit consumer representation from SUD Services to the Cultural Competency Committee
- Collaborate with the Consortium by disseminating Cultural Competency information and strategies at five Consortium meetings by June 30, 2021. (Strategy Carryover from 19-20 Plan)

Criterion 5: County Culturally Competent Training Activities

(CLAS Standard 4)

FY 2019-2020 Accomplishments:

- Implemented new online Cultural Competency Training
- Cultural Competency presentations via QAPI and the MHSA Consortium

To ensure that the cultural competence training is widely available and to track employee compliance with training participation, BHS developed an online training that could be taken at each employee's convenience, and for which participation could be tracked electronically. In an effort to enhance cultural competency training, the Cultural Competency Committee reviewed and recommended a new online training for BHS

entitled, “Improving Cultural Competency for Behavioral Health Professionals,” developed by the U.S. Department of Health and Human Services – Office of Minority Health.

The e-learning program covers:

1. Connections between culture and behavioral health
2. The impact of cultural identity on interactions with clients
3. Ways to engage, access, and treat clients from diverse backgrounds
4. Teaches how to better respond to client’s unique cultural and communication needs

FY 2020-2021 Strategies:

- Expand Cultural Competency Training agency wide by providing Train-the-Trainers for the Health Equity Multicultural Diversity Training from the California Institute for Behavioral Health Services (CIBHS). (Strategy Carryover from 19-20 Plan)

Criterion 6: County Commitment to Growing a Multicultural Workforce: Hiring and Retaining Culturally and Linguistically Competent Staff

(CLAS Standard 7)

FY 2019-2020 Accomplishments:

- BHS SUD Division increased Spanish Speaking Staff from 1.0 FTE to 4.5 FTE.
- BHS Hispanic staff members increased by 37 employees, increasing the percentage of Hispanic staff by 4% from the previous year.

BHS monitors development of a multicultural workforce via CalEQRO Data and BHS Utilization along with Staff Ethnicity and Language Reports. The table below compares proportionate BHS Employment Data to client data from CALEQRO MH and SUD Beneficiary Data, and United States Census data. Data shows that BHS Hispanic staff are lower in proportion to Hispanic clientele.

	BHS staff (Number)	BHS staff %	MH Medi-Cal Beneficiaries % (CALEQRO CY2019)	SUD Medi-Cal Beneficiaries % (CALEQRO FY18-19)	County % (Census)
Caucasian/White	221	31%	16.7%	28.8%	31.8%
Hispanic	234	33%	45.9%	46.3%	41.6%
Asian/Pacific Islander	132	18.4%	14.8%	1.5%	16.7%
Black/African American	90	13%	9.6%	14.5%	8.2%
Native American	23	3%	.3%	.4%	.5%
Other	15	2%	12.7%	8.5%	1.7%
Total	715	100%	100%	100%	100%

FY2020-2021 Strategies:

- The BHS Cultural Competency Committee in partnership with the Recruitment and Retention Committee will develop strategies for increasing the recruitment of staff from the Latinx/Hispanic communities by June 30, 2021. (Strategy Carryover from 19-20 Plan)

Criterion 7: County System Language Capacity

(CLAS Standard 5,6,8)

FY 2019-2020 Accomplishments:

- BHS continues to maintain an in-house database of language capacity of BHS Staff
- BHS showed improvement in language capacity in Southeast Asian languages.

The BHS Cultural Competency Committee reviewed the language capacity of BHS staff. The data, provided below, shows improvement in language capacity from the previous fiscal year in Cambodian, Vietnamese and Laotian Languages. American Sign Language and Korean are underrepresented languages.

Primary languages spoken by clients and staff	# of Clients	# of BHS Staff Providing Direct Services (2018-19)	Staff to client ratio	# of Clients	# of BHS Staff Providing Direct Services (2019-20)	Staff to client ratio
English	13,717	736	1:19	16,082	698	1:23
Spanish	818	80	1:10	996	68	1:15
Cambodian	391	7	1:56	257	2	1:128
Vietnamese	192	7	1:27	116	5	1:23
Laotian	87	6	1:15	48	0	n/a
Hmong	78	8	1:10	41	5	1:8
Tagalog	6	42	1:1	11	23	1:1
Arabic and Farsi	20	2	1:10	26	3	1:7
Chinese (Mandarin and Cantonese)	16	1	1:16	8	1	1:8
American Sign Language	7	0	n/a	9	0	n/a
Korean	3	0	n/a	4	1	1:4

FY 2020-2021 Strategies:

- The BHS Cultural Competency Committee will partner with the Recruitment and Retention Committee to develop strategies to recruit staff that speak Cambodian, Vietnamese, and Laotian by June 30, 2021.

Criterion 8: County Adaptation of Services

(CLAS Standard 12)

2019-20 Accomplishments:

- Contracts Management includes monitoring contract providers for completion of online Cultural Competency Training.

BHS documented the necessity of cultural and linguistic competency in its contractual requirements (Attachment 6) and monitors contractors to ensure that personnel training is implemented accordingly. BHS has additionally included the requirement for cultural and linguistic competence in each of the project descriptions in its Requests for Proposals (RFP).

FY 2020-2021 Strategies:

- Quarterly reviews of contractor provider services include monitoring the provision of staff training in the areas of cultural and linguistic competency. (Attachment 7)

Attachments:

1. BHS MH QAPI Work Plan
2. BHS SUD QAPI Work Plan
3. Online Cultural Competence Training
4. 2019-20 Annual Update to the Three Year Mental Health Services Act Program and Expenditure Plan, pages 10-21
5. San Joaquin County-specific Data provided by CALEQRO for MH and SUD
6. 2020-21 Boilerplate Contract Language – Cultural Competency
7. 2020-21 Contract Monitoring Tool – Item 6b/6d

Attachment 1: BHS MH QAPI Work Plan

5. Structure and Operations									
5.H. Cultural Competency- The MHP incorporates cultural competency principles in the systems of care to address the beneficiaries' cultural, ethnic, racial, and linguistic needs.									
	Target	Baseline	FY 19/20	FY 20/21	Status (Met/Not Met)	Data Source	Action Plan	Evaluation	Person Responsible
5.H.1	By 6/30/2021, BHS will increase the Hispanic/Latino proportion of staff to 45%.	31% FY18/19	32%			Human Resources	Enact recruitments for language-specific positions. Assess opportunities for recruitment in cultural arenas of the community and implement two strategies.		Administration
5.H.2	As described in the Cultural Competence Plan, 100% of staff and contractors hired during FY19/20 will receive online Cultural Competency Training within 12 months of employment	66% FY18/19 for FY17/18	81% FY 19/20 for 18/19			Department Managers	Managers and supervisors will require new staff to complete online cultural competence training during the initial probationary period.		Ethnic Services Manager/Administration

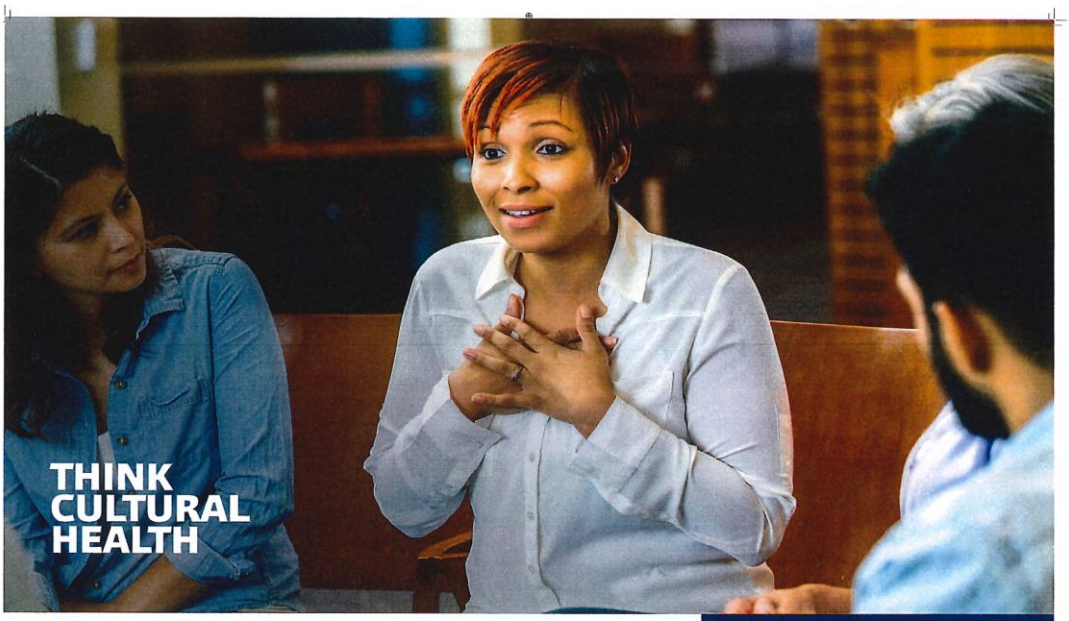
Attachment 2: BHS SUD QAPI Work Plan

Initiative 2: Ensure Access to Care								
#	Target	FY 19/20	FY 20/21	Status (Met/Not Met)	Data Source	FY20/21 Action Plan	Evaluation	Person Responsible
2d	By 6/30/2021 increase penetration rates of Hispanic beneficiaries to 0.82%	0.70%			Penetration data	Maintain the penetration rate at .70% of Hispanic beneficiaries and continue to address ways to increase the penetration rate. Strategies include but are not limited to: 1. Increase the or continue Increase number of Spanish-speaking staff to improve access for monolingual Spanish-speaking clients. 2. Provide staff training on use of Language Line - including additional training on using Language Line for telephone contacts. 3. Provide advertising and resources in Spanish for distribution in prominent		Cultural Competence Committee

Initiative 3: Improve quality of service delivery and beneficiary satisfaction								
#	Target	FY 19/20	F 20/21	Status (Met/Not Met)	Data Source	FY20/21 Action Plan	Evaluation	Person Responsible
3a	By 6/30/2021 increase consumer/family member participation in Cultural Competence Committee, Consumer Advisory Council, and QAPI Council by at least two members each.	CCC - 1 QIC - 1 CAC - 1			Meeting minutes and sign in sheets	BHS will meet with the Consumer Advisory Committee and develop a strategies to increase participation in the Cultural Compliance Committee and Quality Assessment and Improvement Council.		SAS Coordinator Cultural Competency Committee
	By 6/30/2021 at least 50% of "open" BHS SUD clients receiving treatment will participate in Consumer Perception Survey.	21%			UCLA Survey Results	Survey beneficiaries at least annually. Establish improvement objectives based on findings from the survey,		QAPI

Initiative 6: Staff Development and Cultural Competence								
#	Target	FY 19/20		Status (Met/Not Met)	Data Source	FY19/20 Action Plan	Evaluation	Person Responsible
6a	By 6/30/2021 increase number of Spanish-speaking direct-service staff from one FTE to three FTEs.	4.5 FTE			NACT	Review findings in QAPI Council and Cultural Competency Committee to establish recruitment objectives for fiscal year.		Ethnic Services Manager
6b	By 6/30/2021 100% of staff will be trained in Cultural Competence and new staff will complete it within 12 months of hire.	100%			TPS	SUD managers and supervisors to track required staff trainings - including Cultural Competence - and document staff completion. Contractors will be monitored for completion		SAS Coordinator SAS Managers
6c	By 6/30/2021 Cultural Competence Committee will add four new members.	2			Cultural Competence Committee meeting minutes and sign in sheets	BHS will actively promote Cultural Competence Committee, providing increased opportunity for staff participation, and posting information in public areas soliciting consumer/family member participation.		Ethnic Services Manager

Attachment 3:



NEW!

Improving Cultural Competency for Behavioral Health Professionals

Improving Cultural Competency for Behavioral Health Professionals is a FREE e-learning program designed to help behavioral health providers build knowledge and skills related to culturally and linguistically appropriate services (CLAS).

This e-learning program covers:

- Connections between culture and behavioral health
- The impact of cultural identity on interactions with clients
- Ways to engage, assess, and treat clients from diverse backgrounds

AT A GLANCE

- Learn how to better respect and respond to your client's unique cultural and communication needs
- Complete the program on your own time
- Earn up to 5 contact hours at no cost
- Accredited for Licensed Alcohol and Drug Counselors, Nurses, Psychiatrists, Psychologists, and Social Workers

READ MORE:
ThinkCulturalHealth.hhs.gov/education/behavioral-health

OMH U.S. Department of Health and Human Services Office of Minority Health

Attachment 4: 2020-23 Three Year Mental Health Services Act Program and Expenditure Plan, pages 8-19

Community Program Planning and Stakeholder Process

Community Program Planning Process

The BHS community planning process serves as an opportunity for consumers, family members, mental health and substance abuse service providers and other interested stakeholders to discuss the needs and challenges for consumers receiving mental health services and to reflect upon what is working for the diverse range of consumers served. The following activities were conducted to gather information regarding current services and to provide recommendations on the need for updates and revisions.

Quantitative Analysis:

- Program Service Assessment: September 2019 – March 2020
  - Utilization Analysis
  - Penetration and Retention Reports
  - External Quality Review
- Workforce Needs Assessment
- Evaluation of Prevention and Early Intervention Programs for 2018-19

Community Discussions:

- MHSA Showcase of Programs and Services Event
  - September 26, 2019
- Behavioral Health Board Agenda Items
  - December, 2019 Discussion of Revision to the 2019-20 MHSA Plan
  - January, 2020 MHSA Community Planning Meeting
- Public Forums
  - January 8, 2020 at the Behavioral Health Services Campus in Stockton, CA
  - January 21, 2020 at the Larch Clover Community Center in Tracy, CA
  - January 28, 2020 at El Concilio (Spanish) in Stockton, CA
  - February 11, 2020 at the Lodi Police Department in Lodi, CA

Targeted Discussions:

- Consumer Focus Groups
  - January 7, 2020 at the Wellness Center
  - January 14, 2020 at the Martin Gipson Socialization Center
- Key Informant Interviews
  - County Administrator Monica Nino
  - Supervisor Miguel Villapudua
  - Supervisor Chuck Winn
  - Supervisor Katherine Miller

Consumer and Stakeholder Survey:

- 2019-20 MHSA Consumer and Stakeholder Survey

Assessment of Mental Health Needs

Population Served

BHS provides mental health services and substance use disorder treatment to nearly 18,550 consumers annually. In general program access is reflective of the diverse population of San Joaquin County, with a roughly even division of male and female clients. An analysis of services provided in 2018-19 demonstrates the program participation compared to the county population.

Mental Health Services Provided in 2018-19

Services provided by Age	Number of Clients*	Percent of Clients
Children	2,901	17.5%
Transitional Age Youth	3,234	19.5%
Adults	8,601	52.0%
Older Adults	1,812	11%
Total	**16,548**	**100%**

*Source: BHS Client Services Data

Program participation is reflective of the anticipated demand for services, with the majority of services being delivered to adults ages 25-59 years of age. .

Services provided by Race/Ethnicity	County Population by Race/Ethnicity**	Percent of County Population	Clients Served*	Percent of Clients
White	233,639	31%	5,788	35%
Latino	315,571	42%	4,450	27%
African American	53,488	7%	2,832	17%
Asian	116,745	16%	1,467	9%
Other	25,563	3%	1,431	9%
Native American	3,296	0%	514	3%
Pacific Islander	4,358	1%	66	0%
Total	**752,660**	**100%**	**16,548**	**100%**

*Source: BHS Client Services Data
**Source: http://www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1/

Diversity of participants is similar to the distribution in prior years. African Americans are disproportionately over-represented amongst consumers compared to their proportion of the general population (17% of participants, though comprising 7% of the population of the County). Native Americans are also over-

represented within the service continuum (3% of clients are Native American) and data indicates that nearly one-third of the Native Americans in the County received services from BHS at least one time during the past year. Latinos are enrolled in mental health treatment services at rates lower than is to be expected, compared to their proportion of the general population (27% of participants versus 42% of the population). Asian participants are also underrepresented by 7%.

Services provided by City	County Population by City**	Percent of County Population	Clients Served*	Percent of Clients
Stockton	316,410	41%	10,939	66%
Lodi	68,272	9%	1,398	8%
Tracy	92,800	12%	991	6%
Manteca	83,781	11%	1,079	7%
Lathrop	24,936	3%	309	2%
Ripon	16,613	2%	119	1%
Escalon	7,765	1%	98	1%
Balance of County	159,808	21%	1,615	10%
Total	**770,385**	**100%**	**16,548**	**100%**

*Source: BHS Client Services Data
**Source: http://www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1/

The majority of clients are residents of the City of Stockton. Stockton is the County seat and the largest city in the region, accounting for 41% of the county population. The majority of services and supports for individuals receiving public support benefits (including mental health) are located in Stockton.

Discussion Group Input and Stakeholder Feedback

Several different types of community forums and discussion groups were convened in the Fall of 2019 to provide opportunities for a range of community stakeholders to participate in the Community Program Planning Process.

Community Program Planning for 2019-20:

MHSA Showcase of Programs and Services Event

The MHSA Showcase of Programs and Services Event took place on September 26, 2019. The purpose of the Showcase Event was to provide a venue for consumers, family members, stakeholders and interested community members to learn more about the programs and services funded in San Joaquin County through MHSA Program funds. The Showcase Event featured individual program booths for all MHSA funded programs including those operated by BHS as well as those managed by contracted community partners.

The MHSA Planning Booth at the Showcase included a poster and flyers of upcoming community planning meetings, Consumer and Stakeholder surveys, comment cards, and additional information about how to participate in the Community Program Planning Process.

Behavioral Health Board Agenda Items

An announcement was made during the public comments portion of the December 2019 Behavioral Health Board Meeting, that community program planning discussion groups were convening in January 2020. The Director's Report included additional details regarding the proposed methodology and timeline for the community program planning process conducted to inform the 2020-23-20 Three Year Program and Expenditure Plan. Meeting flyers for upcoming Community and Consumer Discussion Groups were distributed.

Community and Consumer Discussion Groups

Community and Consumer Discussion Groups were held during January and February 2020 and included five community forums and two groups specifically targeting participation by consumers ages 18 and older. A Community Discussion Group was held in conjunction with the Behavioral Health Board Meeting, providing an opportunity for stakeholders to directly provide input to the members of the Behavioral Health Board.

All community discussion groups begin with a brief training on the Mental Health Services Act, a summary of the five components, and information about the intent and purpose of the different components including:

- Funding Priorities
- Populations of Need
- Regulations guiding the use of MHSA funding

Stakeholder participation at meetings was tracked through sign-in sheets and the collection of anonymous demographic forms. Findings from the demographic forms suggest that a diverse group of stakeholders participated in the community program planning process, including representatives of unserved and underserved populations.

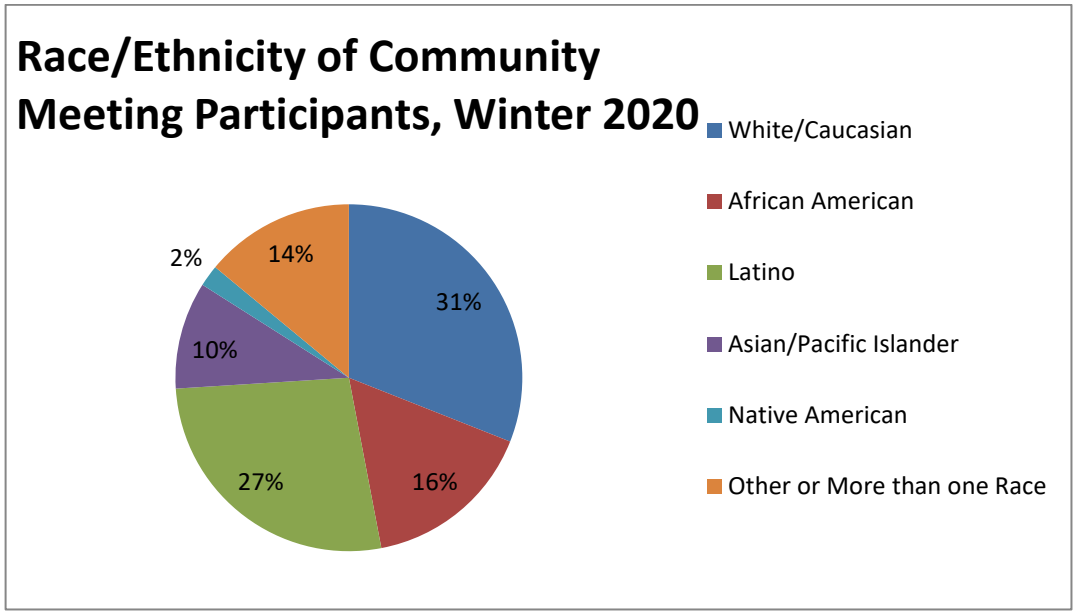
One hundred and seventy-one individuals (171) participated in the Community Discussion and Focus groups. Of these, 53% self-identified as a consumer of public mental health services or as a family member of a consumer. The majority of participants identified as adults ages 26-59, 24% were older adults and 5% were youth ages 18-25.

Community Discussion Groups were also attended by the following individuals representing the following groups:

- County mental health department staff
- Substance use disorder treatment providers
- Community-based organizations
- Children and family services
- Law Enforcement
- Veterans services
- Senior services
- Housing providers
- Health care providers
- Advocates for consumers

Community Discussion and Focus Groups were attended by a broad range of individuals representing diverse racial/ethnic backgrounds. Similar to the County population and BHS services, no one racial or ethnic group comprised a majority of participants. Also, in line with BHS service delivery patterns, there was a slight overrepresentation of African American participants, compared to the County population, and a slight underrepresentation of Latinos. These rates are consistent with service utilization at BHS.

Ten percent (10%) of meeting participants reported speaking a language other than English at home.



Survey Input and Stakeholder Feedback

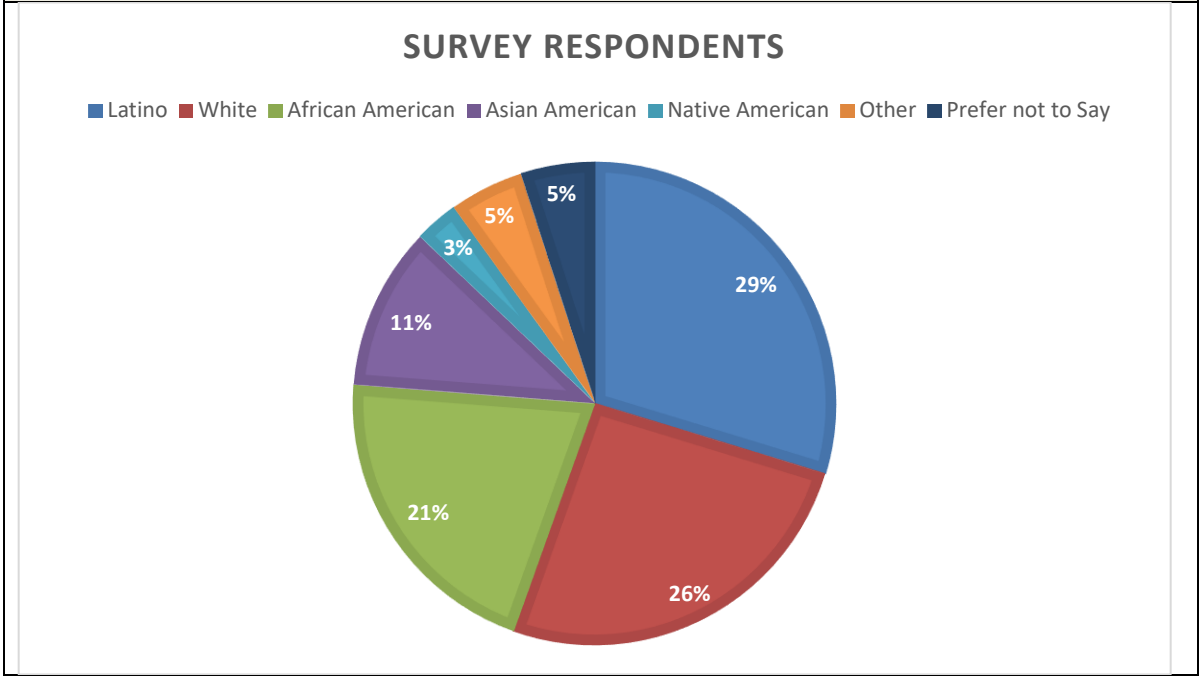
BHS distributed a Consumer and Stakeholder survey to consumers and family members in September 2019 and February 2020 to learn more about the perspectives, needs, and lives of the clients served through mental health programs. The MHSA Consumer and Stakeholder Survey was distributed at the MHSA Showcase Event, at BHS Crisis Services and various outpatient clinics. Five hundred and two (502) respondents completed the 2019-2020 survey. Surveys were paper-based with limited choice answers. Responses were scanned into a software program that uses a proprietary technology to match checked answers with corresponding data fields. Survey instruments can be reviewed in the Appendix.

BHS consumers and their family members reported high levels of satisfaction with the services provided to address mental health and/or substance use disorder concerns, with 90% of the respondents reporting that they would recommend BHS services to others. Respondents to the surveys reported that the greatest service challenge is the length of time it takes to get an appointment. Satisfaction for all respondents was highest in reference to the location where services are provided. Respondents to the surveys reported that the more work is needed in the area of cultural competency, to make the lobbies and reception areas feel welcoming and friendly. Respondents highest levels of agreement were with statements regarding staff courtesy and professionalism, respect of cultural heritage, and the capacity to explain things in an easily understood manner.

BHS was interested in learning more about the populations of people that use mental health, and asked survey respondents to anonymously self-report additional demographic information. The goal of these questions was to receive a more nuanced understanding of the clients served, separate from the data stored and reported in standardized BHS intake forms. The respondent data revealed interesting findings about client demographics, criminal justice experiences and living situations that has not been reported elsewhere.

Race/ethnicity data from the survey is depicted below. Adult survey respondents were more likely to be Latino, African American, Asian, or Native American than is reflective of the general population.

Self-Reported Race/Ethnicity of Stakeholder Respondents
MHSA 2019-20 Consumer and Stakeholder Surveys



Self-Reported Age/Gender of Stakeholder Respondents

Age Range	Percent
18-25	10%
26-59	73%
60 and over	15%
Other or decline to state	1%

Gender	Percent
Male	42%
Female	57%
Non-binary	1%

The 502 respondents surveyed represent the broad diversity of stakeholders and consumers served by Behavioral Health Services. Most consumers have children, with 55% describing themselves as parents. Consistent with the general population, 10% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQQI). Many have a disability, with 38% describing themselves as having a physical or developmental disability. Few are military veterans, with only 7% reporting that they had served in the US Armed Forces. Twenty percent (20%) of consumers reported experiencing homelessness more than

four times or being homeless for at least a year; thirty five percent (35%) of respondents reported having been arrested or detained by the police.

Community Mental Health Issues

Key Issues for Children and Youth (Birth to 15 Years of Age)

Strengthening services and supports for children, youth and their families remains a major concern in San Joaquin County. Stakeholders recognize the increased coordination between Behavioral Health Services and Child Welfare Services to address the needs of children and youth in the foster care system. Stakeholders continue to assert that more needs to be done to support and strengthen families, particularly those where risk factors for mental illness are present. In several of the Community Discussion and Focus groups, stakeholders discussed the importance of earlier interventions for children and families.

- Early Education mental health programs are needed to meet the needs of families of children under the age of five. Family model services, parents strengthening programs and services to address maternal mental health were mentioned.
- The biggest gap in services is early intervention for children and families following the identification of a social-emotional risk factor. Schools are seeking more behavioral health consultation in the classroom to assist teachers in working with students (including pre-school age students) that display behaviors suggestive of an emerging emotional disorder.
- Stakeholders identified family supports such as parenting classes, family strengthening activities and family peer partners as being pivotal early interventions to help empower parents, stabilize families, and reduce tension and anxiety among children. Stakeholders suggested targeting resources towards parents with self-identified behavioral health concerns of their own, and parents with more than one child under the age of five in the home.

Recommendations to Strengthen Services for Children and Youth:

- BHS Adult Outpatient Clinics should offer services and supports pertaining to family strengthening including referral to PEI funded parenting classes.
- BHS should collaborate with San Joaquin County Human Services Agency to review child welfare cases of families with children under five in the home; offer parenting classes, services and supports to families of young children; engage families of young children and make referrals to existing parenting classes funded through PEI programming.
- The PEI school-based interventions program providing behavioral health interventions on school campuses should be available to all children, including those in pre-school or transitional kindergarten programs.

Key Issues for Transitional Age Youth (16 to 25 Years of Age)

Stakeholders expressed the most concern for transition age youth who are easily missed by system partners such as those that have exited the foster care system, are college-age, or are from communities that are historically unserved or underserved by mental health services. Stakeholders identified some existing resources for transition age youth, but overall stated that outside of a few specialty treatment programs, most

interventions target either children and youth, or adults. Despite these gaps, stakeholders remain optimistic that current resources can be leveraged in a better way to serve transitional age youth.

- University of the Pacific and Delta College have student mental health programs. These programs are not well articulated to off-campus services and supports, especially those available through the primary health care system to address mild to moderate behavioral health concerns. Better linkages are needed to prevent the escalation of mental illness that can benefit from early intervention, such as depression and anxiety.
- Lesbian, gay, bisexual, transgender, queer/questioning, intersex, asexual, or allied youth were also identified as being at higher risk for untreated behavioral health concerns, including using alcohol of other substances as a coping mechanism for depression or anxiety related to social stigma and discrimination. LGBTQI youth have few resources or supports in San Joaquin County, though an emerging allies movement is increasing awareness of the need for more deliberate and integrated approaches to supporting LGBTQI youth in the county.

Recommendations to Strengthen Services for Transition Age Youth

- More and more apps for smart devices are emerging on the marketplace. Solicit the assistance of young people to identify which apps and tools are being used to support mindfulness, wellness, and mental health.
- Work with local colleges to develop a pathway for referrals for student mental health concerns. Convene a workshop for college mental health professionals on the prevention and early interventions services available in the community, and tips for accessing services for mild to moderate behavioral health concerns.
- Work with Veterans Services to support young adults exiting the military and returning to San Joaquin County. Convene a workshop for Veterans Services counselors on the prevention and early interventions services available in the community, and tips for accessing mental health interventions for mild to moderate behavioral health concerns.
- Develop smart graphics posters in English and county threshold languages with navigation guidance and advice to access behavioral health services for self or friends. Posters would address high risk topics such as suicide ideation and gun violence.
- BHS Transitional Age Youth services programs should demonstrate capacity for delivering culturally competent and trauma informed services, including services for transition age youth who do not have English as a first language, and for youth that are especially vulnerable to stigma, discrimination, and marginalization such as LGBTQI youth. In 2017/18 BHS reserved funding for programs to address the behavioral health needs of transition age youth and adults experiencing or recovering from traumatic situations.

Key Issues for Adults

Consumers and stakeholders discussed the challenges of being homeless while recovering from a mental illness, and the need to develop more housing for people with mental illnesses. Criminal justice partners echoed the frustrations of consumers and family members regarding the need for increased housing options to prevent homelessness. Consumers expressed frustration that it is still difficult to find reliable information on

the services and supports that are available, and asked BHS to consider different approaches to talking about mental health and the services available in the community .

- Individuals with mental illnesses, who have been arrested and charged with offenses, are at high risk of homelessness and re-offending upon re-entry in the absence of coordinated services and supports including housing. More efforts are needed to strengthen re-entry services for people with serious mental illnesses to prevent homelessness and decompensation from untreated illness. More coordination is needed to assess all individuals who are exiting custody with mental illnesses and link them to existing community services prior to release.
- Public information messages should directly address access to services and be tailored for consumers, family members, and partner service providers. Information should be developed that is responsive to diverse cultural communities, understanding that consumers come from diverse backgrounds and have a range of experiences. Messages should address populations with mental illnesses who are parents, identify as LGBTQI, and have a first language other than English.
- Veterans and Latino communities are underrepresented in the adult mental health service system. Education is needed to reduce stigma towards mental illness that may prevent self and family help-seeking behavior. Education is also needed to address suicide risk and ideation, especially targeting adult men.
- BHS should work with community partners to better serve Southeast Asian clients as there is low language proficiency among BHS staff to serve some Southeast Asian clients in their native languages.

Recommendations to Strengthen Services for Adults

- BHS should continue to strengthen the housing continuum for people with serious mental illnesses.
- BHS should strengthen outreach and engagement to Latinos by adopting new public information and education strategies that are better designed for the target audience and more specifically address stigma and discrimination.
- BHS should expand suicide prevention efforts beyond the school-based prevention program, develop a public information and education campaign for adults with a focus on adult men and veterans.
- BHS should create more treatment and residential programs that work specifically with individuals diagnosed with co-occurring disorders.

Key Issues for Older Adults

Older adults with mild to moderate mental health concerns remain at-risk for untreated depression and suicide ideation. More articulation is needed with senior and older adult service providers to offer interventions for older adults that have escalating behavioral health challenges. More public information and education about the risk of suicide in adults and older adults is needed; particularly focusing on adult men who are at the highest risk for suicide in San Joaquin County. Stakeholders identified increased use of alcohol as a coping mechanism for depression, and suggested that behavioral health programming should better target older adults and more urgently address alcohol and depression as co-morbid conditions. Finally stakeholders identified the biggest risk among older adults living independently as social isolation. Community members from Tracy/South County stated that there are few resources for older adults in South County. The Director of the Larch Clover Community Center in Tracy, which hosted the Community Discussion Group, encouraged

more behavioral health services co-located at county community centers that provide senior activities, services, and supports throughout the County.

- There are few behavioral health prevention services for older adults in San Joaquin County.
- There are few evidence based substance use disorder treatment programs designed for older adults in San Joaquin County, of serious concern because alcohol abuse is strongly correlated with older adult depression.
- Older adult behavioral health prevention services should work in partnership with local community centers.
- Vulnerable older adults include those that are homeless (10% of the total homeless population), and living alone.

Recommendations to Strengthen Services for Older Adults:

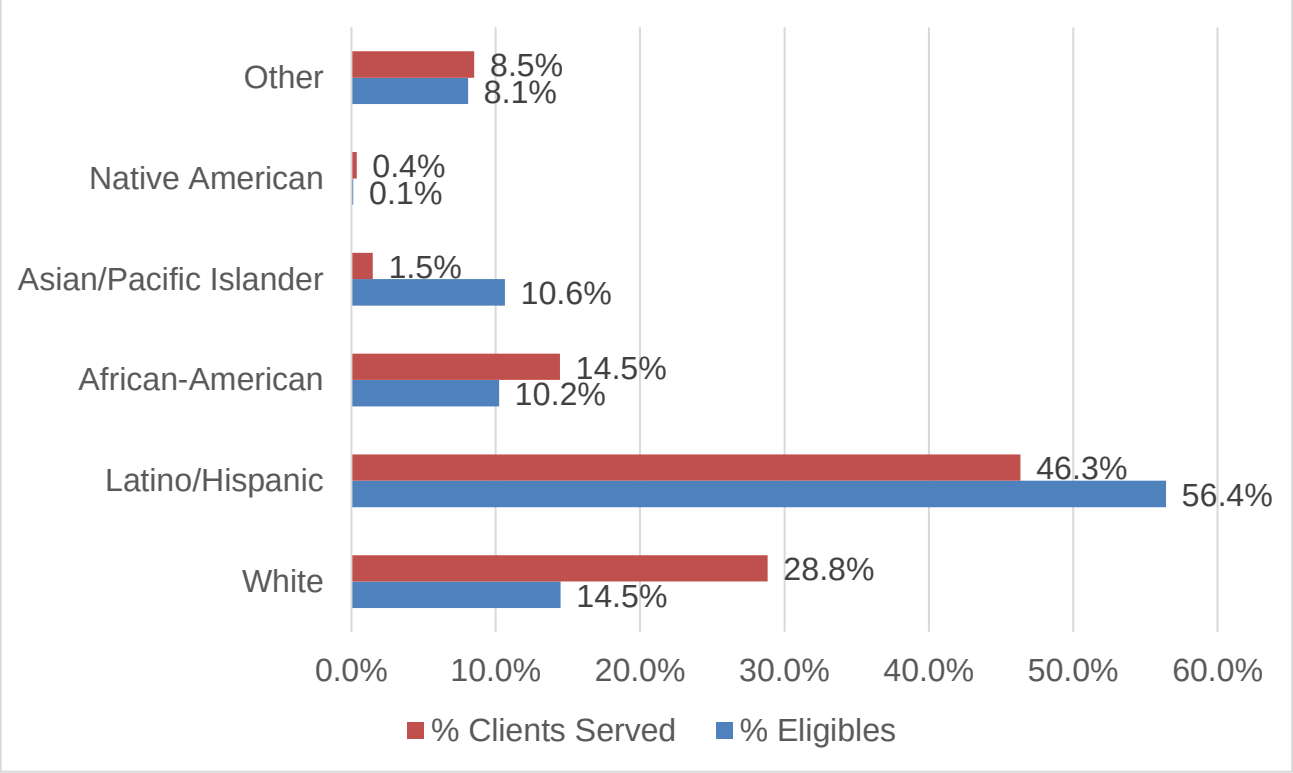
- BHS Older Adult services should provide meaningful alternatives for daily living that combat depression and isolation including more socialization activities and more activities that prevent memory deterioration or loss of cognitive functioning.
- Co-locate senior peer counseling programs at community centers one day a week. Ensure that senior peer partners have training in recognizing signs and symptoms of alcohol abuse and have an array of tools and resources to refer older adults who are requesting assistance with behavioral health concerns, including co-occurring disorders.
- Work with Human Services Agency to identify isolated older adults with escalating mental health symptoms. Convene a workshop for Adult Protective Services staff on the prevention and early interventions services available in the community, and tips for accessing mental health interventions for mild to moderate behavioral health concerns.
- Broaden suicide prevention efforts to target the adult community. Include targeted prevention information for middle age and older adult men. Address handgun and firearm safety when living with loved ones experiencing depression.

Attachment 5: San Joaquin County Specific Data provided by CALEQRO for MH and SUD

CALEQRO PERFORMANCE MEASURES FY19-20 – SAN JOAQUIN MHP

San Joaquin MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Beneficiaries**	**Percentage of Medi-Cal Beneficiaries**	**Unduplicated Annual Count of Beneficiaries Served by the MHP**	**Percentage of Beneficiaries Served by the MHP**
White	48,114	16.7%	3,364	29.6%
Latino/Hispanic	132,150	45.9%	3,843	33.8%
African-American	27,776	9.6%	1,602	14.1%
Asian/Pacific Islander	42,503	14.8%	1,083	9.5%
Native American	795	0.3%	51	0.4%
Other	36,551	12.7%	1,417	12.5%
Total	**287,887**	**100%**	**11,360**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

Figure 1: Percentage of Eligibles and Clients Served by Race/Ethnicity, CY 2018-19 (SUD)



Attachment 6: 2020-21 Boilerplate Contract – Cultural Competency Language - Item #15

15. Cultural and Linguistic Proficiency:

a. To ensure equal access to quality care by diverse populations, CONTRACTOR shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards.

b. When the consumer served by CONTRACTOR is a non-English or limited-English speaking person, CONTRACTOR shall take all steps necessary to develop and maintain an appropriate capability for communicating in that consumer's primary or preferred language to ensure full and effective communication between the consumer and CONTRACTOR staff. CONTRACTOR shall provide immediate translation to non-English or limited-English speaking consumers whose conditions are such that failure to immediately translate would risk serious impairment. CONTRACTOR shall provide notices in prominent places in the facility of the availability of free translation in necessary other languages.

c. CONTRACTOR shall make available forms, documents and brochures in the San Joaquin County threshold languages of English and Spanish to reflect the cultural needs of the community.

d. CONTRACTOR is responsible for providing culturally and linguistically appropriate services. Services are to be provided by professional and paraprofessional staff with similar cultural and linguistic backgrounds to the consumers being served.

Attachment 7: Contract Monitoring Tool – Annual Site Review Checklist – 6b/6e.

8. Review sample documentation for evidence of compliance with other contract requirements:
a. Employee HIPAA training and confidentiality statements;
b. Employee training including BHS Compliance Training, CANSA, cultural competency and limited English proficiency, and clinical documentation
c. Compliance Sanction Checks up to date (applicable to Medi-Cal providers)
d. Notice of Adverse Benefit Determination (NOABD) practices of agency (applicable to Medi-Cal providers)
e. Adoption of the Federal Office of Minority Health CLAS Standards; policy and practice examples
f. Timeliness standards
g. Presence of required postings and forms available for consumers; free interpretation services, HIPAA Rights, Mon-Discrimination notices, forms for suggestions and satisfaction surveys, Notice of Adverse Benefit Determination, Medi-Cal Beneficiary Brochure

MHSA Prevention and Early Intervention Component Program and Evaluation Report - DRAFT

San Joaquin County Behavioral Health Services

Fiscal Year 2019/20

Table of Contents

Introduction

In October 2015 the State of California Office of Administrative Law (OAL) approved new Prevention and Early Intervention (PEI) regulations.[1, 2] Under these regulations, San Joaquin County (SJCBHS) must submit an Annual Prevention and Early Intervention Program and Evaluation Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC).

For this report, SJCBHS's PEI Projects are classified into specific Program and Strategy categories per state regulation. Each of these Program and Strategy categories has a specific set of reporting requirements. The following table distributes SJCBHS's PEI Projects into these Program and Strategy categories:

Tab #	San Joaquin County PEI Projects	Program Category	Strategies			
			Access & Linkage to Treatment	Timely Access to Services for Underserved Populations	Non-Stigmatizing & Non-Discriminatory	Outreach for Increasing Recognition
1	Skill-Building for Parents and Guardians	Prevention	x	x	x	
2	Mentoring for Transitional Age Youth	Prevention	x	x	x	
3	Coping and Resilience Education Services (CARES)	Prevention	x	x	x	
4	Early Intervention to Treat Psychosis	Early Intervention	x	x	x	x
5	Early Mental Health Support Services for High Risk Youth at the Juvenile Justice Center	Prevention & Early Intervention	x	x	x	
6.a	Community Trainings - Outreach	Outreach for Increasing Recognition	x	x	x	
6.b	Community Trainings - Stigma	Stigma & Discrimination Reduction	x	x		x
7	Suicide Prevention Program	Suicide Prevention	x	x	x	
8	LEAD - Recovery Services for Nonviolent Offenders	Timely Services for Underserved Populations	x		x	
9	Whole Person Care	Access and Linkage to Treatment		x	x	

[1] *[1] (CCR, Title 9, 3200.245, 3200.246, 3510.010, 3560, 3560.010, 3560.020, 3700, 3701, 3705, 3706, 3710, 3717, 3720, 3725, 3726, 3730, 3735, 3740, 3745, 3750, 3755, 3755.010),*

[2] *[2] A copy of the regulations may be found at mhsoac.ca.gov/document/2016-03/pei-regulations*

This report includes a brief description of each SJCBHS Project along with the required information for each Program and Strategy as specified in Section 3560.010 of the CCR. In addition, this report includes interim evaluation findings for Fiscal Year 2019/20, which will be expanded upon in a Three-Year Program and Evaluation Report due December 31, 2022 per Section 3560.020 of the CCR. It is important to note that few significant qualitative findings or interpretations are included in this preliminary report.

COVID-19 Considerations

The coronavirus pandemic emerged in the third quarter of Fiscal Year 2019/20, and as a result, for some programs, activity levels decreased and participation dropped in relation to previous fiscal years. Additionally, we found that some of the social, emotional, and behavioral improvements demonstrated in previous years did not materialize; participant outcomes were not as strong. These findings echoed many anecdotal and research findings from across the country that describe the pandemic's broad toll on the public's physical and behavioral wellbeing. Ultimately, the evaluation team was quite heartened by the tenacity and flexibility of service providers, who, in the face of this public health crisis, maintained composure and continue serve the community. Throughout this year's report, footnotes are used to describe how participant counts or outcomes differed from those of the previous year.

Highlights from FY 2019/20

Under regulation, SJCBHS must conduct an evaluation of PEI programs every three years. In order to support data-driven decision-making, San Joaquin has chosen to do an interim evaluation every year. The following are highlights from Fiscal Year 2019/20. The report provides more detailed findings in each Project section.

Prevention Programs:

Skill-building for Parents and Guardians Program: Three community-based organizations offered 108 courses, served 1,644 individuals, and graduated 810 parents and guardians from evidence-based parenting classes during the fiscal year. Surveys conducted at the beginning and end of the courses revealed that 79% of participants had gained knowledge, skills, behaviors or improved attitudes about parenting.

Transitional Age Youth Program: Two community-based organizations provided evidence-based mentoring to 484 youth age 16-25 with emotional and behavioral health difficulties. Eighty-nine percent (89%) showed progress during their participation in the program and 61% exited having completed at least one of their self-identified goals.

Coping and Resilience Education Services (CARES) Program: BHS's Children and Youth Services (CYS) provided trauma screening and intensive evidence-based skill-building trainings to caregivers and children who had been exposed to trauma. The program served 180 children and 90 caregivers. Of parents who completed the program, 50% experienced a reduction in stress and 55% of children experienced a reduction in pediatric symptoms.[3]

Early Intervention Programs:

Early Intervention and Recovery Program (TEIR): Telecare provided an integrated set of promising practices intended to slow the progression of psychosis to 50 transitional age youth and their family members. Of the 16 participants discharged from services during the fiscal year, 12 (75%) graduated having completed the program's objectives. Of the

[3] Outcomes were poorer in FY 2019/20 than in the previous year, suggesting the pandemic's significant behavioral health impact on children and their families.

20 clients with matched pre/post CANSAs, 45% had an overall decrease in actionable items across all 4 core domains (i.e., outcomes improved) and 55% had a decrease or *no change* in actionable items (i.e., outcomes did not decline).[4]

Prevention and Early Intervention Programs:

Mental Health Services for High-Risk Youth at the Juvenile Justice Center: CYS provided voluntary early intervention and prevention services to detained youth, depending on their level of care need. Five hundred and eleven (511) youth were evaluated, 218 received a comprehensive psychosocial assessment and 98 received prevention or early intervention treatment. Of the those who received prevention or early intervention services during detention, 74% had an overall decrease in actionable CANSA concerns (i.e., outcomes improved) and 90% had a decrease or *no change* in actionable items (i.e., outcomes did not worsen).

Outreach for Increasing Early Recognition of Mental Illness & Stigma and Discrimination Reduction Programs

NAMI's Outreach for Increasing Recognition of Early Signs of Mental Illness program: San Joaquin County's chapter of National Alliance on Mental Illness delivered 15-hour Provider Education classes to 12 potential responders. **NAMI's Stigma and Discrimination Reduction Program** provided In Our Own Voices presentations, and Family to Family and Peer to Peer trainings to 418 participants. 72% showed positive change in attitudes, knowledge and/or behaviors related to mental illness and 81% showed positive change related to seeking mental health services.

Suicide Prevention

Suicide Prevention Program: The Child Abuse Prevention Council facilitated a Yellow Ribbon Suicide Prevention Campaign in 12 high-risk high schools within the county, reaching 6,406 individuals. The program trained 471 school personnel and 243 youth "gatekeepers", and provided more intensive SafeTalk training to 129 people throughout the county. On average, Eighty-nine percent (89%) of Yellow Ribbon Campaign

[4] Core domains include risk factors; behavioral/emotional needs; strengths; and life functioning. Each domain is comprised of multiple items. Actionable items are those items that score a 2 or 3. In early psychosis programs and other programs that intend to reduce symptoms *and* prevent symptoms from worsening, CANSA measurements include both "number who improve" *and* "number who improved or did not change."

recipients demonstrated an increase in ability to recognize signs, symptoms and risks of suicide, and knowledge about professional and peer resources available to help people at risk of suicide. CAPC also conducted 397 depressions screenings and provided depression support groups to 70 youth.

Access and Linkage to Treatment Strategy

All Prevention and Early Intervention Programs were required to implement an Access and Linkage to Treatment Strategy. The following table provides a breakdown of referrals to treatment, referrals to County MHPs in particular, and known linkages to treatment, as defined by having attended at least an intake assessment. In total, there were 575 referrals to treatment, of which 446 were to SJCBHS administered programs, and 81 known linkages to treatment from prevention and early intervention programs. [5]

Program	Treatment Referrals	Referrals to SJC MHP	Known Linkages
Skill building for Parents and Guardians	18	14	1
Mentoring for Transitional Age Youth	98	80	8
Coping and Resilience Education Services (CARES)	4	4	4
Early Interventions to Treat Psychosis (TEIR)	3	3	0
High-Risk Youth at Juvenile Justice Center	197	197	53
Outreach/Stigma and Discrimination Trainings	0	0	0
Suicide Prevention Program	231	126	9
LEAD - Recovery Services for Nonviolent Offenders	21	20	7
Whole Person Care	3	2	2
Totals	**575**	**446**	**81**

[5] In previous fiscal year, 2018/19, there were 450 referrals to treatment, of which 384 were to SJCBHS administered programs, and 108 known linkages to treatment from prevention and early intervention programs

Prevention Programs

Skill Building for Parents and Guardians Project

Project description:

Community-based organizations offer evidence-based parenting classes throughout San Joaquin County with the goal of reducing risk factors for mental illness and increasing protective factors associated with social connectedness, parent and family resilience, and knowledge of child development.

In FY 2019/20, the Skill Building for Parents and Guardian Project was delivered by three community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC) provided Parent Café groups
- Catholic Charities Diocese of Stockton provided Nurturing Parenting Program (NPP) groups
- Parents by Choice (PBC) provided Positive Parenting Program (Triple P) groups

Project Outputs

A total of 1,644 parents/guardians were served in FY 2019/20, of whom 810 (49%) graduated (i.e., completed the program).[6]

The following table shows the number of parents/guardians served by each program; the number who graduated from parenting programs; the number of groups and sessions delivered; the average group size; the dosage offered; and the dosage received.

[6] Participation dropped slightly following the onset of COVID-19 in the second half of the year. In FY 2019/19, a total of 1,854 parents/guardians were served.

Skill-Building Output FY 2019/20				
	CAPC-PC	CC-NPP	PBC - Triple P	Total
Unduplicated parent/guardian participants	791	305	548	**1644**
Number of unduplicated individuals who completed/graduated from the group/class during the reporting period?*	249	142	419	**810**
Percent who completed/graduated	31%	47%	76%	**49%**
Total number of groups delivered	42	21	45	**108**
Total number of sessions delivered	531	221	270	**1022**
Average number of participants per group (group size)	18.8	14.5	12.2	**15.2**
Average number of sessions delivered per group (dosage offered)	12.6	10.5	6.0	**9.5**
Average number of sessions attended per participant (dosage received)	4.7	5.4	5.2	**5.0**

*For CC-NPP defined as completing at least 7 of the 10 course topics; For PBC defined as attending 80% of Triple P classes and completing Assessment Tool and a Client Satisfaction Survey; for CAPC defined as attending 50% or more Parent Café sessions.

Participant Demographics [7]

Respondents identified as white (39%), another race (37%), Black (10%), more than one race (6%) Asian (5%); and American Indian (1%). Sixty-five percent (65%) were Hispanic/Latino. Eighty-seven percent (87%) of respondents were adults between age 26-59, 9% were older adults over age 59, and 3% were transitional age youth between 16-25 years old. Three percent (3%) were veterans. Fifty-nine percent (59%) of participants were female and 20% male-identified, 96% heterosexual, 2% lesbian or gay. Eighty-six percent (86%) reported no disability. Sixty-three percent (63%) of participants spoke Spanish as their primary language. Participants lived in Stockton (57%); Manteca (13%); Tracy (13%); Lodi (8%) and other (8%). Four percent (4%) identified as homeless.

Participant Outcomes

The following tables show the selected outcome measurement tools and the frequency of administration. The tables also show the number of participants who graduated, the number who showed improvement in various risk/protective factor domains, and the average number who showed improvement in each domain.

[7] Data on demographic groups with fewer than 10 members in any particular program are not made available to the public and are therefore not included in this report. More detailed demographic data are included in Tab 1 of the supplemental report to the State.

Outcomes: Child Abuse Prevention Council - Parent Cafés FY 2019/20		
Instrument: Protective Factors Survey Freq. of admin: First and last session		
Unduplicated individuals served	791	
Number of graduates	249	*31%*
Number of graduates w/ matched pre/post	249	*100%*
Number who showed:	Improvement	
Knowledge of parenting skills	244	*98%*
Access to support	217	*87%*
Parental resiliency	216	*87%*
Social connections	207	*83%*
Parent/child relationships	189	*76%*
Total participants who showed improvement*	**215**	*86%*

* Based on average number who showed improvement in each domain

Outcomes: Catholic Charities FY 2019/20		
Instrument: Adult Adolescent Parenting Inventory (AAPI) Freq. of admin: First and last session		
Unduplicated individuals served	305	
Number of graduates	142	*47%*
Number of graduates w/ matched pre/post	137	*96%*
Number who showed:	**Improvement**	
Inappropriate expectations	100	*73%*
Low level of empathy	120	*88%*
Belief in corporeal punishment	120	*88%*
Reverse family roles	81	*59%*
Restricts power and independence	95	*69%*
Total participants who showed improvement*	**103**	***75%***

* Based on average number who showed improvement in each domain

Outcomes: Parents by Choice - Triple P FY 2019/20		
Regular Triple P classes: Parenting Tasks Checklist (PTC) & Parenting Scale (PS) Parents of Teen classes: Conflict Behavior Questionnaire (CBQ) & Parenting Scale (PS) Family Transitions: Acrimony Scale & Depression Anxiety Stress Scale (DASS)		
Unduplicated individuals served	548	
Number of graduates	419	*76%*
Number of graduates w/ matched pre/post:	419	*100%*
Triple P Regular Graduates	222	
Triple P for Parents of Teens Graduates	84	
Family Transitions Graduates	113	
Number (regular participants) who showed:	**Improvement**	
Setting self-efficacy (PTC)	186	*84%*
Behavioral self-efficacy (PTC)	184	*83%*
Laxness and Overreactivity (PS)	173	*78%*
Total participants who showed improvement*	**181**	*82%*
Number (parents of teens) who showed:	**Improvement**	
Conflict behavior (CBQ)	56	*67%*
Laxness and Overreactivity (PS)	57	*68%*
Total participants who showed improvements*	**57**	*67%*
Number (Family Transitions) who showed:	**Improvement**	
Acrimony Scale	81	*72%*
DASS (Depression, Anxiety, Stress) Scale	86	*76%*
Total participants who showed overall improvements*	83.5	*74%*
Total participants for all programs who showed overall improvement*	**321**	***77%***

* Based on average number who showed improvement across each domain

Cost/Benefit Analysis

The following table shows several key indicators of performance for each provider and for the Skill Building Project as a whole, including costs of the project (represented by amounts invoiced); cost per participant; cost per graduate; and cost per individual who showed reduced risk factors and/or increased protective factors.

The programs cost $267 per individual served, $541 per graduate, and $686 per graduate who demonstrated improvement in parenting skills.[8]

[8] In previous Fiscal Year 2018-2019 program cost was $233 per individual served, $544 per graduate and $559 per graduate who demonstrated improvement. The cost per individual served and per graduate who demonstrated improved parenting skills may have increased as a result of conditions resulting from the coronavirus pandemic.

Skill-Building Expenditure/Benefit FY 2019/20				
	CAPC-PC	**CC-NPP**	**PBC-PPP**	**Total**
Program Expenditures	$155,359	$124,387	$158,703	$438,449
Unduplicated individuals served	791	305	548	1,644
Expenditure per individual served	*$196*	*$408*	*$290*	*$267*
Number who graduated	249	142	419	810
Expenditure per graduate	*$624*	*$876*	*$379*	*$541*
Number who showed improvement*	215	103	321	639
*Expenditure per individual who showed improvement**	*$723*	*$1,208*	*$494*	*$686*

* CAPC: Based on average number of individuals who showed improvement across all domains of the Protective Factors Survey; CC: Based on average number of individuals who showed improvement across all domains of the Adult Adolescent Parenting Inventory; PBC: Based on average number of individuals who showed improvement across all domains of the Parenting Tasks Checklist, the Parenting Scale, the Conflict Behavior Questionnaire, the Acrimony Scale, and/or the Anxiety Stress Scale.
Note: CAPC expenditures represent the amount invoiced by contractors.

Comparative Analysis

Child Abuse Prevention Council delivered the highest number of sessions to the highest number of participants. Less than one-third (31%) of participants graduated but this was in part because Child Abuse Prevention Council had the highest graduation expectation (50% of 15 sessions). For those who did graduate and complete a pre/post survey, more than 86% showed improvement in parenting skills, behaviors and/or attitudes, which was significantly higher than the two other programs. *Cost/Benefit:* CAPC had the lowest cost per individual served.

Catholic Charities served the fewest individuals, had the fewest graduates, and delivered the fewest groups and sessions. Of those who graduated, 75% showed improvement, a smaller percentage than the other two programs. *Cost/Benefit:* Catholic Charities had the highest cost per individual served, highest cost per graduate and highest cost per individual who showed improvement.

Parents by choice had the highest graduation rates (76%) and the highest number of graduates (419). Of those who completed the program, 77% showed improvements in parenting measures. *Cost/Benefit:* Costs per individual served were higher than CAPC's but the cost per graduate and the cost per graduate who showed improvement were much lower than both of the other programs.

Access and Linkage to Treatment Strategy

The following is a summary of data on referrals from the Skillbuilding Project. Detailed data on referrals, including demographic information, is provided in the attachment.

- The project as a whole referred 18 individuals to treatment. 14 of these were referred to San Joaquin County MHP programs. Catholic Charities referred the greatest number of individuals (9).

- Of the 18 referred individuals, only one individual (7%) engaged in treatment, defined as attending at least an intake assessment. The average duration of untreated mental illness was 6 months. The average interval between referral and treatment was 34 days.

Timely Access to Services for Underserved Populations Strategy

San Joaquin County has identified the following underserved populations[9]: A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking. The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file.

- Eighteen (18) Hispanics/Latinos were referred to mental health treatment or a different PEI program. Of those, there was one known linkage to treatment. At this time, it was not possible to track linkages to other PEI programs, so ostensibly, a larger number of individuals could have received the services to which they were referred. The average interval between referral and participation was 34 days.

- Seventeen (17) non-English language speakers were referred to mental health treatment or a different PEI program. Of those, there was one known linkages to treatment. The average interval between referral and participation was 34 days.

- Three (3) transitional age youth (TAYs) were referred to mental health treatment or a different PEI program. Of those, there were no known linkages to treatment.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the Skill Building Project encourage access to services and follow through:

[9] These include populations that have been, unserved, underserved or historically inappropriately served.

- All PEI provider organizations are trained in referral to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

- Participants in Catholic Charities' NPP Program (predominantly Latino/Hispanic) are encouraged to seek support during training sessions in which sensitive parenting topics are discussed. Since the beginning of the COVID pandemic, referrals are offered via phone call.

- CAPC's Parent Café staff inform the community about the resources that are available for them and their children. On the first day of a Parent Cafe group, staff inform the parents that it is a safe place and to reach out to program staff for support. They let participants know that it's normal to need help at some point, and that trauma can happen to anyone. Staff also assess their group participants to look for signs of depression or anything else that may indicate a need for intervention. Lastly, when connecting families to resources, staff will follow-up by meeting with them to ensure service delivery is going well and to see if there is anything else that they need. Since the onset of the coronavirus pandemic, staff have been sharing resources that participants and their families may benefit during the shelter-in-place period. Staff are calling and signing up families for food banks (e.g., Bread of Life) and sending them information about essential jobs that are hiring. Many parents have been laid off due to COVID-19 and are worried about how they will make ends meet. Resources have also been shared with participants about financial assistance opportunities.

- Parents by Choice staff members emphasize referrals to SJCBHS and other providers and services in the community. They have been referring more participants to the CARES program and following up with them, and they hosted the CARES team at a staff meeting for a presentation.

Mentoring for Transitional Age Youth Project

Project description:

Community-based organizations provide intensive mentoring and support to transitional-age youth (16-25) with emotional and behavioral difficulties who do not meet the criteria for specialty mental health care. The project targets very high-risk youth to reduce the possibility of youth developing serious and persistent mental illnesses which are associated with adverse childhood experiences, severe trauma or ongoing stress, family or domestic violence, and/or self-harm or suicidal thoughts.

In FY 2019/20, the Mentoring for Transitional Age Youth (TAY Mentoring) Project was delivered by two community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC)
- Women's Center Youth and Family Services of San Joaquin County (Women's Center, or WCYFS)

Both providers used the evidence-supported Transition to Independence (TIP) service model.

Project Outputs

In FY 2019/20, the TAY Mentoring Project served a total of 484 individuals.[10] The following table shows the number of youths directly served and the number of individual service sessions delivered by each provider. The table also includes TIP model fidelity scores. The Organizational Survey fidelity scores, rated by program managers, are a composite of 9 items related to staffing, services, supervision and other system-level items, and the TIP Practice Probes are a composite of the scores of three interview questions posed to program staff related to their knowledge and practices.[11]

[10] In spite of COVID-19, the TAY mentoring program served more participants than the previous year. In FY 2018/19 the program served 330 individuals.

[11] WCYFS did not report fidelity scores in FY 19/20.

TAY Mentoring Outputs: FY 2019/20			
	CAPC	WCYFS	All TAY Mentoring
Unduplicated individuals served	286	198	484
Number of individuals who graduated (exited having completed at least one)	193	101	294
Percent who graduated	67%	51%	61%
Number of sessions delivered	1926	1655	3581
Average number of sessions delivered per individual	6.7	8.4	7.4
Organizational Survey fidelity scores (average)	92%	n/a	92%
TIP Practice Probes fidelity scores (average)	95%	n/a	95%

Participant Demographics[12]

Race and ethnicity data are reliable for only one of the programs.[13] Of the 198 newly enrolled participants with reliable data, 57% identified as Hispanic/Latino. Twenty-one percent (21%) were Black/African American, 17% white, and 16% multi-racial. Of the 314 reporting on the other demographic categories, all were between ages 16-25; 53% were assigned female at birth and 47% male. Seventy percent (70%) reported no disability. Eleven percent (11%) spoke Spanish as their primary language. Seventy-nine percent (79%) identified as heterosexual and 12% as bisexual. Seventy eight percent (78%) of participants lived in Stockton, 8% in Tracy and 6% in Manteca.

Participant Outcomes

Graduation from this program was defined as participants having completed at least one of their program goals. According to staff, 61% graduated or completed their goals in the program.

The program used two other methods to measure outcomes. The TIP Tracker and the CANSA. The TIP Tracker rated each participant at discharge on progress towards or the completion of their self-identified goals in up to 8 categories. The following table shows the number of participants who had goals in each of the 8 categories and the number and percent who showed improvement in meeting these goals. The bottom row shows a weighted average for the percent of participants who showed improvement towards meeting goals across all 8 categories. Across both programs, 89% made progress towards meeting their self-identified goals.

[12] Information for demographic groups with fewer than 10 members in any particular program is not made available to the public and is therefore not included in this report. More detailed demographic data are included in Tab 1 of the supplemental report to the State.

[13] Data included from CAPC's program only.

	CAPC TIP			WCYFS TAY			Total TAY		
Participant-identified goals FY 2019/20	# with goals in this category	# who showed improve-ment	*% who showed improvement*	# with goals in this category	# who showed improve-ment	*% who showed improve-ment*	# with goals in this category	# who showed improve-ment	*% who showed improve-ment*
Education	116	108	*93%*	77	53	*69%*	193	161	*83%*
Employment and career	140	133	*95%*	82	69	*84%*	222	202	*91%*
Living situation	21	21	*100%*	51	40	*78%*	72	61	*85%*
Social support and connections	83	77	*93%*	26	23	*88%*	109	100	*92%*
Emotional and wellbeing	64	61	*95%*	42	37	*88%*	106	98	*117%*
Physical health	18	16	*89%*	7	6	*86%*	25	22	*31%*
Financial	33	28	*85%*	77	75	*97%*	110	103	*94%*
Parenting	11	10	*91%*	12	9	*75%*	23	19	*83%*
Average	**61**	**57**	***93%***	**47**	**39**	***83%***	**108**	**96**	***89%***

The third method of measuring outcomes involved a modified 15-item CANSA tool administered at intake and discharge. The 15 items that were selected best represent the risk and protective factors that program managers felt could be addressed through the TIP model. The following table shows overall improvements and declines for both programs and for the project as a whole. In all, 65% of clients showed an overall improvement in CANSA scores. More detailed CANSA scores will be available in subsequent years' reports.

TAY CANSA Outcomes FY 2019/20						
	CAPC		WC		Total	
Number of matched CANSA scores	253		129		382	
Individuals showing improvement (lower score) in total score	176	69.6%	73	56.6%	249	65.2%
Individuals showing Improvement or no change in total score	234	92.5%	118	91.5%	352	92.1%
Individuals showing decline (higher) total score	19	7.5%	11	8.5%	30	7.9%

Cost/Benefit Analysis

The following table shows several key indicators of performance for each CBO provider and for the TAY Mentoring Project as a whole, including costs of the project (represented by amount invoiced), cost per participant, and cost per graduate (individual who met at least one of their goals). The total cost per individual was $1,501 and the total cost per individual who completed at least one goal was $2,472. CAPC showed overall better improvements on client-identified goals, as measured with the TIP Tracker, and higher CANSA score improvements.

TAY Mentoring Expenditure/Benefit FY 2019/20			
	CAPC TIP	WCYFS TAY	**Total**
Program Expenditures	$400,206	$326,454	**$726,660**
Unduplicated individuals served	286	198	**484**
Expenditures per individual served	*$1,399*	*$1,649*	***$1,501***
Number of participants exiting program	253	146	**399**
Number who graduated (exited having completed at least one goal)	193	101	**294**
Expenditures per graduate	*$2,074*	*$3,232*	***$2,472***

Note: WCYFS TAY expenditures represent the amount invoiced by contractors.

Comparative Analysis

The Child Abuse Prevention Council program served 44% more participants than the Women's Center TAY mentoring program (286 versus 116). The higher number resulted in a lower cost per individual. In addition, Child Abuse Prevention Council had a greater number of graduates having completed at least one goal compared to the Women's Center, resulting in a significant cost differential of $1,158 per individual.

Access and Linkage to Treatment Strategy

The following is a summary of data on referrals from the TAY Mentoring Project. Detailed data on referrals, including demographic information, is provided in the attachment. Demographic groups with fewer than 10 individuals are not made available to the public and are thus not included in this report. More detailed data on access and linkage to treatment is included in the supplemental file.

- The project as a whole referred 98 individuals to treatment, 80 of whom were referred to county MHP programs.

- Of the 80 county-referred individuals, 8 (10%) were known to have engaged in treatment, defined as attending at least an intake assessment. The average duration of untreated mental illness was just over 7 months. The average interval between referral and treatment was 76 days.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file.

- Ninety-seven (97) transition age youth were referred to mental health treatment or a different PEI program. Of those, there were 8 known linkages to treatment.

- Thirty-nine (39) Hispanics/Latinos were referred to mental health treatment or a different PEI program. Of those, there were two (2) known linkages to treatment. At this time, it was not possible to track linkages to other PEI programs, so ostensibly, more could have received the services to which they were referred.

- Twenty-three (23) African American/Black individuals were referred to mental health treatment or a different PEI program. Of those, there were three (3) known linkages to treatment.

- Twenty-five (25) LGBTQ individuals were referred to mental health treatment or a different PEI program. Of those, there were two (2) known linkages to treatment.

- Five (5) homeless youth were referred to mental health treatment or a different PEI program. Of those, there were no known linkages to treatment. The average interval between referral and participation was 21 days.

- Six (6) individuals for whom English was not their primary language were referred to mental health treatment or a different PEI program. Of those, there was one known linkage to treatment. The average interval between referral and participation was 3 days.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the TAY Mentoring Project encourages access to services and follow through:

- All PEI provider organizations are trained in referral to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

- Child Abuse Prevention Council's TAY Mentoring program provides community resources to youth, and informs participants of their options. Through the assessment process staff identify case management/resource needs. TAY

coaches regularly check in with clients to ensure they have followed through on tasks and provide referrals. Staff started an event calendar to enhance youth involvement and awareness of the program. They implemented the peer mentor portion of the program which utilizes a peer-to-peer strategy to encourage participation in services.

- The Women's Center TAY Mentoring program has a once-a-week case management meeting to provide a supportive environment for staff to share their caseload and get feedback and assistance with challenging youth situations. Client referrals are distributed by the TAY Manager, and contact is attempted and documented at least three times before facilitators put aside a referral. The Women's Center TAY program monitors all referrals at case management meetings through Apricot (case management software). Staff focus on developing a high retention program by providing leadership opportunities, fostering a sense of community, and offering more engaging opportunities such as: Building Self Esteem, Game Time, Problem Solving, Job Readiness, etc. Follow up on all referrals and appointments with potential clients is initiated within 24 hours. The intake process is clearly outlined in program guidelines. All referrals are followed up by the TAY Specialist. Specialists stay in contact with organizations and individuals who refer youth to the program. The Peer Mentor Coordinator is focused on contacting potential referral resources and building relationships within the community at large.

Coping and Resilience Education Services (CARES) Project

Project description:

CARES serves children and youth (ages 6-17) who are CPS-involved, exposed to trauma, or referred by Child Welfare, but who do not meet medical necessity for specialty mental health services. The program serves family members and other caregivers/resource families as well. Children and youth are screened for trauma-related symptoms and receive a 12-session evidence-based intervention to address previous traumas and sustain them though difficult situations using the Child/Youth version of the Reach, Achieve, and Excel through Empowerment Strategies curriculum (CRAXES/YRAXES). Resource families, parents, and other caregivers receive trauma-informed training using the PRAXES curriculum. Staff provide one-on-one and group support.

In addition, in coordination with the County's Human Services Agency, project staff attend Child Family Team (CFT) meetings with children and family members who are not ready to be connected to behavioral health services. The project also provides trainings to resource families, teachers, and group home providers on the causes and effects of trauma and on caring for children who have experienced trauma.

Project Outputs

In FY 2019/20, CARES served a total of 270 individuals—180 children and 90 parents/caregivers.[14] The following table shows the number of individuals who attended an outreach event related to CARES, number referred from external programs, number who participated in and then completed the children and youth (CRAXES/YRAXES) and parents/caregiver curriculums (PRAXES); and number of trauma trainings delivered to resource families.

[14] The number of youth served did not appear to vary significantly as a result of COVID-19. In FY 2018/19, CARES served 295 individuals—179 youth and 116 caregivers.

CARES Output FY 2019/20	
Number of individuals who attended an outreach event	282
Number of children/youth referred to program	355
Number of children served in the program	180
Number of caregivers served in the program	90
Unduplicated number of participants	**270**
Number of adults who completed PRAXES curriculum	8
Number of children who completed CRAXES/YRAXES curriculum	53
Total number of individuals who completed (graduated) from program	**61**
Number of trauma informed trainings delivered to resource families, teachers and group home providers	12

Participant Demographics[15]

Forty-five percent (45%) of participants identified as white; 17% African American/Black; 22% other; and 6% more than one race. Sixty-Seven percent (67%) identified as Hispanic/Latino. Children ages 15 and under comprised 63% of the participants and adults age 16-25 were 29%. Of those who responded, 63% identified as female and 37% as male; 93% as heterosexual. Eighty-seven percent (87%) claimed no disability. Nineteen percent (19%) spoke Spanish as a primary language. Eighty-one (81%) percent lived in Stockton, 5% in Lodi and 5% in Tracy, 4% in Manteca and 4% in other areas of the county. Four percent (4%) identified as homeless.

Participant Outcomes

The CARES program used the Parental Stress Index at intake and discharge. The index has four sub-domains: Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC) Fifty percent (50%) of the 8 matched pre- and post-tests demonstrated a reduction in stress across each of the 4 domains.[16]

[15] Information for demographic groups with fewer than 10 members in any particular program is not made available to the public and is therefore not included in this report. More detailed demographic data are included in Tab 1 of the supplemental report to the State.

[16] Parental stress outcomes varied dramatically from previous year, potentially as a result of COVID-19. In FY 2018/19 84% of parents demonstrated a reduction of stress. It must be noted, however, that FY 2019/20's sample size was very small and significance testing was not performed.

CARES Parental Stress Index Outcomes FY 2019/20*						
Number of matched pre and post tests	8					
Parental Stress Index	DR	PD	P-CDI	DC	Total Stress	% showing reduced stress
Number of individuals showing reduction in stress (lower score post test)	6	6	3	6	4	50%
Average Pre Score	17.1	28.7	30.9	34.6	93.5	
Average Post Score	15.3	24.0	26.9	28.9	79.8	
Average difference	2.1	5.6	-0.3	5.3	10.6	
Standard Deviation of Difference	2.1	7.0	5.6	5.9	13.3	

*Includes only those parents who opened and closed in FY19/20 and who had matched pre and post test results

CARES used the Pediatric Symptom Checklist to measure youth risk. Of the 91 youth who received matched pre- and post-screenings, 50 (55%) showed a reduction in symptoms.[17]

CARES Pediatric Symptom Checklist Outcomes FY 2019/20		
Number of matched pre and post tests	91	
PSC-35 score		% showing reduced symptoms
Number of individuals showing reduction in symptoms (lower score post test)	50	55%
Average Pre Score	24.9	
Average Post Score	11.8	
Average Difference	12	
Standard Deviation of Difference	10	

Cost/Benefit Analysis

The following table shows the program costs, and average cost per individual served, and the estimated cost for children and caregivers who demonstrated a reduction in pediatric symptoms or parental stress.

[17] Pediatric outcomes were significantly poorer in Fiscal Year 2019/20 compared to the previous year, possibly as a result of COVID-19. In FY 2018/19, 85% of youth demonstrated a reduction in overall symptoms.

CARES Expenditure/Benefit FY 2019/20	
Program Expenditures*	$1,263,673
Unduplicated individuals served (180 children and 90 caregivers)	270
Expenditure per individual served	*$4,680*
Number who showed improvement**	144
Cost per individual who showed improvement	*$8,776*

** Expenditures include coordination with HSA, attendance at CFT meetings, and trauma-informed trainings for resource families, etc.*

*** Extrapolated from existing sample showing 50% of adults improved on the stress index and 55% of children demonstrated improvements on the PSC-35*

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the CARES Project. Detailed data on referrals, including demographic information, is provided in the attachment.

- Four (4) individuals were referred to mental health treatment, all to county MHP programs.

- One individual (25%) was known to have engaged in treatment, defined as attending at least an intake assessment. The duration of untreated mental illness and the interval between referral and treatment were both unknown.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of data on referrals to treatment and PEI programs for underserved populations[18]. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file.

- Two (2) Hispanic/Latino participants were referred to mental health treatment or a different PEI program. Of those, there was one (1) known linkage to treatment. The average number of days between referral and participation for these two individuals was 104 days.

[18] Demographic categories with fewer than 10 represented program participants are not made available to the public and are therefore not included in this report

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the CARES program, in particular, encourage access to services and follow through:

- All PEI provider organizations are trained in referral to crisis services, outpatient mental health treatment, and PEI programs, and how to document referrals per State regulations.

- Each referral is screened by team members, during which the CANSA assessment tool is used to gather the most accurate and current information regarding a candidate's level of functioning in six distinct areas. Because the CARES staff office is located near the mental health clinic, the team often assists with ensuring direct and timely linkage to these services.

- During this fiscal year, CARES project staff set up booths at various community events to share program information with the public as well as to offer assistance with completion of referrals with individuals and/or families.

- The program continues to reach out through email and/or telephone to community agencies, shelters, and school staff. Staff monitor each referral assigned to them and maintain weekly contacts by phone to ensure the program meets ongoing quality of care expectations

Early Intervention Programs

Early Intervention to Treat Psychosis (TEIR) Project[19]

Project description:

The Telecare Early Intervention and Recovery Services (TEIR) program provides an integrated set of promising practices intended to slow the progression of psychosis. The project follows the evidence-based Portland Identification and Early Referral (PIER) model and provides an integrated set of promising practices designed to slow the progression of psychosis early in its onset. The project goal is to identify and provide treatment to individuals who have experienced their first psychotic episode in the past two years or who are showing prodromal symptoms of psychosis in order to prevent disability and the onset of the acute stage of illness.

Project Outputs

Fifty (50) unduplicated individuals received TEIR intervention services in the first three quarters of FY 2019/20. No data were reported for the fourth quarter. The following table shows the number of psychosis screenings, the number of screenings that resulted in program eligibility, and the number of individuals and family members who participated in the program.

TEIR Output FY 2019/20	
Number of early psychosis outreach presentations delivered	14
Number of individuals participating in presentations	58
Number of early psychosis screenings completed	21
Number of screenings that resulted in program eligibility	12
Total unduplicated count of individuals receiving early intervention*	50
Average number of individuals receiving services per quarter*	39
Number of family members who participated in program*	13

*Includes individuals rolled over from previous Fiscal Year

Participant Demographics

All participants were transitional age youth. Thirty percent (30%) of participants identified as white; 26% as other; 20% as African American/Black; 11% as multiracial; 6%

[19] No data were reported for 4th quarter. Data reported are for the first three quarters of FY 2019-200.

as Asian and 7% declined to answer. Of those who responded to ethnicity questions, 37% were Hispanic/Latino. Six percent (6%) spoke Spanish as a primary language. Fifty four percent (54%) identified as female; 41% as male and 6% as transgender. No sexual orientation data were collected.

Information for demographic groups with fewer than 10 members in any particular program is not made available to the public and is therefore not included in this report. More detailed demographic data are included in Tab 1 of the supplemental report to the State.

Participant Outcomes

During the reporting period, 16 participants discharged from services. Of those, 12 completed program objectives; one did not complete program objectives and did not transition to a lower level of care; one was discharged to a higher level of care; one moved out of the county; and one was lost to services.

SIPS/SOPS Outcomes

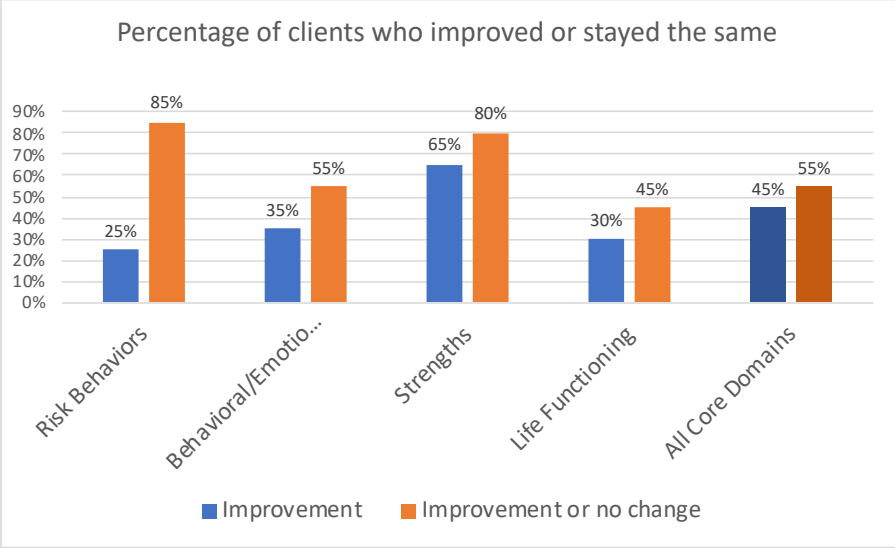
No data reported in fiscal year

Milestone Assessment Outcomes

No data reported in fiscal year

CANSA Outcomes

TEIR participants were assessed using the CANSA at intake, 6-month intervals, and at discharge from the program. Outcomes were tracked by matching client scores from their last CANSA to their earliest recorded CANSA. The interval between matched CANSAs may be different for each participant, depending on how long they have been in the program. The chart below shows the percentage of clients who had a decrease in actionable items (i.e., scores of 2 or 3) in each of four core CANSA domains.[20] Forty-five percent (45%) of clients had an overall decrease in actionable items across all 4 core domains and 55% had a decrease or no change in actionable items.

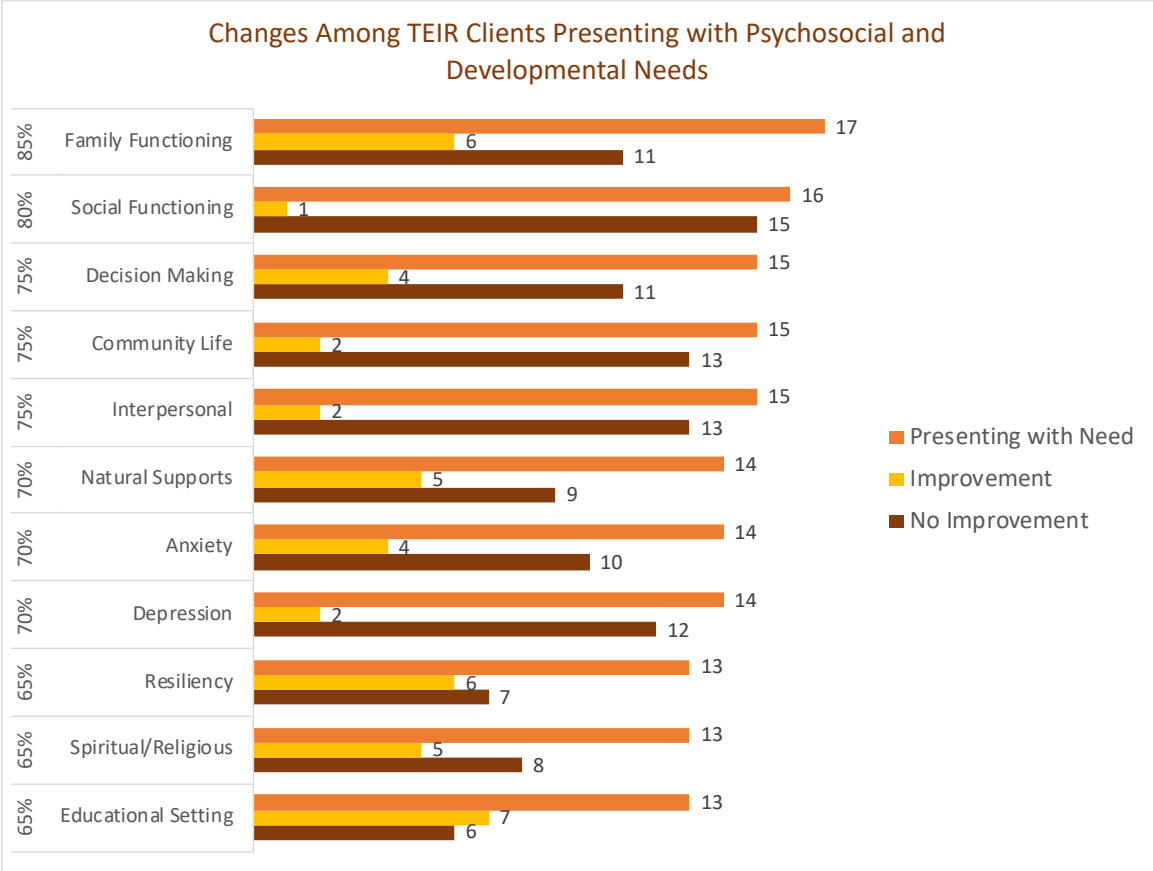


The next chart show the 11 CANSA items that scored the highest (i.e., had the highest proportion of actionable items at intake). For example, 85% of clients presented with family functioning needs. Of these, 6 out of 20 clients (30%) improved and 11 clients (70%) did not improve (i.e., scored lower or the same) in their most recent CANSA assessment. These tables are included to show the areas of greatest concern among the client population and to show the degree to which they improved or declined during treatment.[21] While the majority of clients did not improve during their program tenure, they were most likely to show improvements in Educational Settings (level of support individual receives from the school/training program) and Resiliency (ability to identify and use internal strengths in managing their lives). Clients are least likely to show

[20] Core domains include risk factors; behavioral/emotional needs; strengths; and life functioning. Each domain is comprised of multiple items.

[21] Additional items are available on Tab 4 of supplemental materials and upon request to MHSA coordinator.

improvement in Social Functioning, Community Life (connections to people, place, or institutions in the community), Interpersonal (social and relationship skills) and Depression.



Note on interpreting data:
The tables above demonstrate changes in participant needs and strengths over a period of time. The report makes no effort to demonstrate causality, nor does it compare this program to other early intervention programs, and it does not compare outcomes for participants versus a control group. The information can be used to:

1) identify the types of challenges, issues and strengths experienced by program participants to answer the question: are we serving the intended population?
2) Identify the types of challenges and needs that the program is likely to help participants manage
3) Identify the areas in which the program can improve, or in which the wider system of care can provide additional resources
4) Establish a baseline for future assessments or to compare like programs.

Cost/Benefit Analysis

The following table shows the cost per individual served for the TEIR program. Due to the long-term nature of this project, the cost per individual demonstrating improvement will be provided in the three-year evaluation report only.

TEIR Expenditure/Benefit FY 2019/20	
Program Expenditures	$737,352
Unduplicated individuals receiving early intervention	50
Expenditure per individual receiving early intervention	*$14,747*

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the TEIR Project. Detailed data on referrals, including demographic information, is provided in the attachment.

- Three (3) individuals were referred to mental health treatment, all of whom were referred to county MHP programs. None of these three individuals were known to have engaged in treatment.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of data on referrals to treatment and PEI programs for underserved populations[22]. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file.

- Several met the criteria for underserved populations but due to the small sample size, no further information on demographic categories is available to the public.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the TEIR Project encourage access to services and follow through:

- All PEI provider organizations are trained in referral to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

[22] Demographic categories with fewer than 10 represented program participants are not made available to the public and are therefore not included in this report

- Timeliness and access to services are prioritized. Three staff-members and a Referral Coordinator are responsible for receiving and contacting referral sources to ensure that referrals are not missed. To ensure that referrals are not missed, this individual is the point of contact for all referral agencies and the staff team.

Combined Prevention and Early Intervention Projects

Juvenile Justice (JJC) Project

Project description:

The Juvenile Justice Project was delivered by San Joaquin County Behavioral Health Children and Youth Services (CYS). CYS provides behavioral health evaluations and transition services for youth detained at San Joaquin County's Juvenile Justice Center (JJC). Upon detention, JJC administers a MAYSI-II screening. CYS evaluates youth with high- and medium-risk MAYSI-II scores within 24 hours and youth with low-risk scores within 5 days. Regardless of MAYSI-II score, if youth agree to participate in CYS services they receive a comprehensive behavioral health assessment. Youth determined to be SMI/SED receive early intervention-oriented mental health services whereas those who are not SMI/SED receive prevention-oriented services. If youth are detained for 60 days or longer, they receive a followup CANSA assessment, which is used to measure outcomes related to mental status, risk and protective factors.

Project Outputs:

In FY 2019/20 CYS conducted 511 evaluations of youth entering the juvenile detention facility. Of those, 218 were detained long enough and agreed to a comprehensive psychosocial assessment. Of the 144 who were identified as severely emotionally disturbed, 77 (52%) ended up participating in early intervention services. Of the 47 who were not SED, 21 (45%) participated in services. In total, 98 youth received at least one prevention or early intervention service.[23]

[23] In FY 2018/19, 603 youth received a MAYSI-2 evaluation of which 44% received a comprehensive assessment, which was similar to the proportion assessed in FY 19/20. Of those who were eligible, 58% received early intervention and 35% received prevention, which was also similar to this year's findings. A total of 140 individuals received prevention or early intervention services in FY 18/19, compared to 98 this fiscal year. The decrease was apparently due to the decline in detentions, assessments, and eligible youth resulting from COVID conditions in the detention center, and not due to a reduction in PEI program offerings.

JJC Output FY 2019/20			
	#	%	
Number of youth received an MAYSI-2 evaluation (i.e., youth opened to BHS)	511		
Number who received a comprehensive psychosocial assessment (i.e., number who were in detention long enough, and who voluntarily agreed to an assessment)	218	43%	% of evaluated youth
Number with SMI/SED who were eligible for early intervention	144	66%	% of youth who were evaluated and qualified for early intervention
Number without SMI/SED who were eligible for preventions services	47	22%	% of youth who were evaluated and qualified for prevention
Number with SMI/SED who received at least one services (Early Intervention) post assessment	77	53%	% of youth who were eligible for early intervention who received early intervention services
Number w/out SMI/SED who received at least one services (prevention) post assessment	21	45%	% of youth who were eligible for prevention who received prevention services
Total receiving PEI services	98	51%	% of eligibles who received at least one service

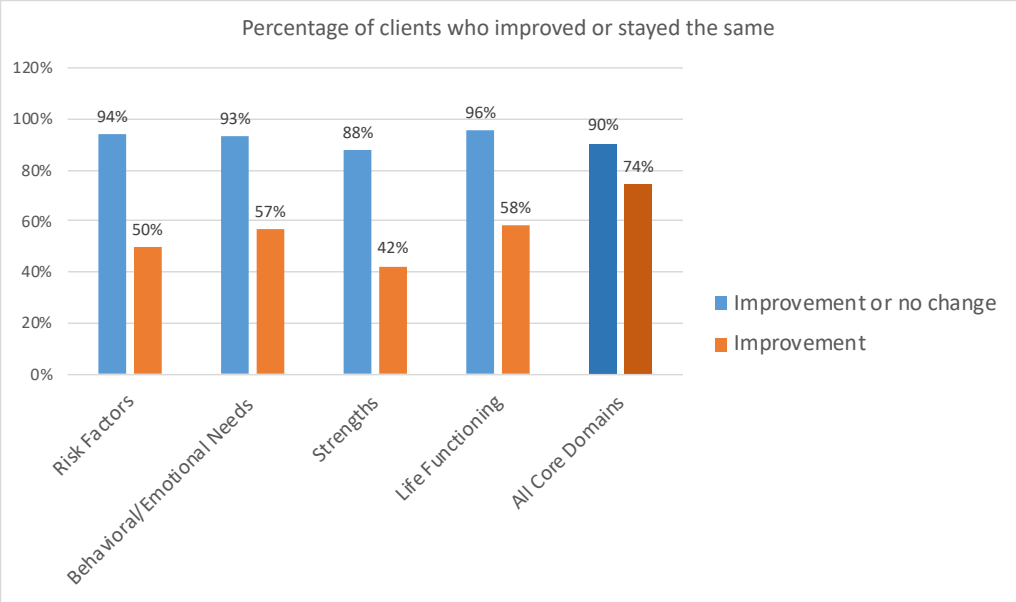
Participant Demographics

Demographic data were collected for 197 detained youth. However, many demographic fields remained empty, so the following summary is based on the number of individuals responding in each of the categories. Thirty-seven percent (37%) of those who responded were African American/Black, 23% white; 4% Native American; 3% Native Hawaiian/Pacific Islander; 3% Asian. The remainder identified as other or multi-race. Of those who responded to the ethnicity question, 74% were Hispanic/Latino. Sixty percent of the youth were over the age of 16; 79% male, 17% female and 1% transgender. Ninety one percent (91% identified as heterosexual, 5% as bisexual, 2% as gay/lesbian and 3% as questioning, queer or another orientation. Six percent (6%) spoke Spanish as primary language and 2% spoke another language.

Information for demographic groups with fewer than 10 members in any particular program is not made available to the public and is therefore not included in this report. More detailed demographic data are included in Tab 1 of the supplemental report to the State.

Participant Outcomes

A CANSA assessment was completed at intake and at 60-day intervals during participants' detention period. There were 113 matched intake and followup assessments.[24] The following chart shows the percentage of clients who had a decrease in actionable items (i.e., scores of 2 or 3) in each of four core CANSA domains[25]. Seventy three percent (74%) of clients had an overall decrease in actionable items across all 4 core domains and 90% had a decrease or no change in actionable items.

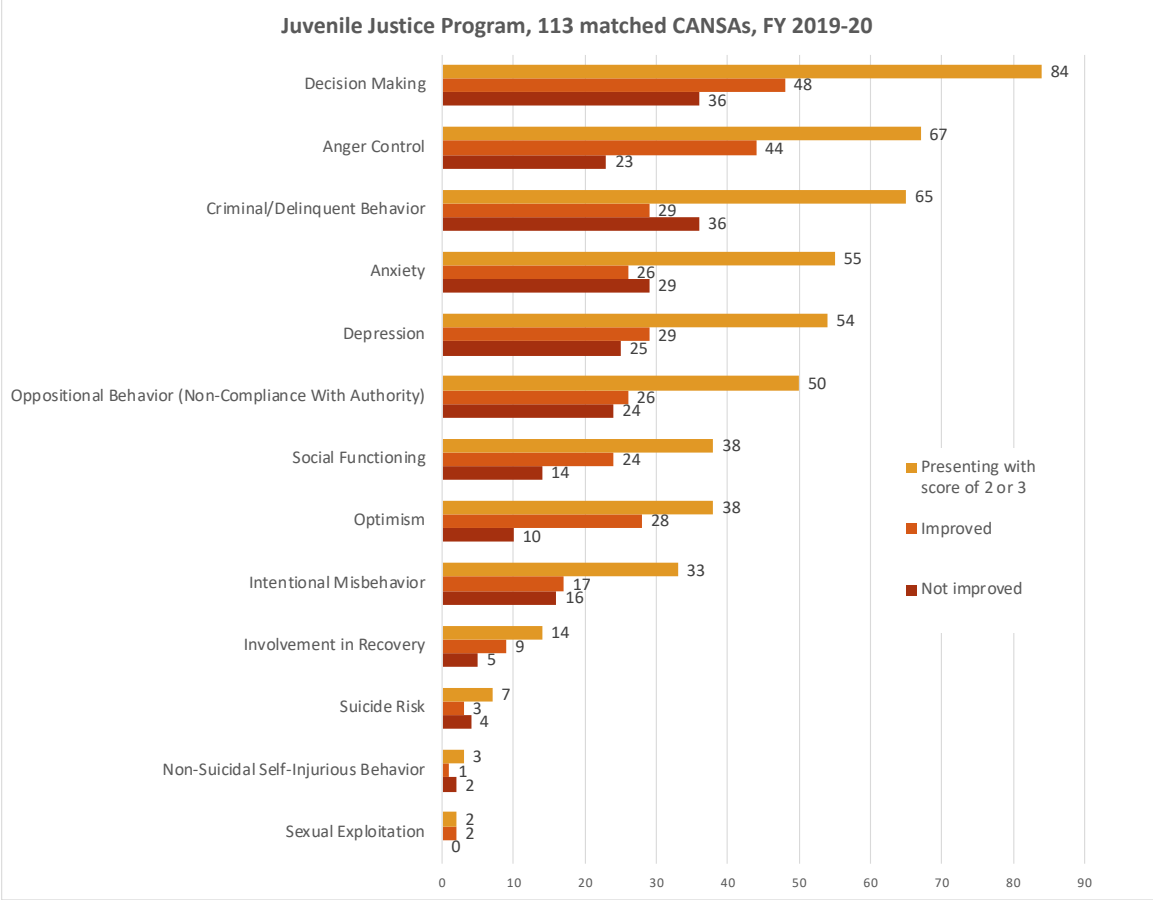


The chart below shows the number of clients with scores of 2 or 3 (high-risk/high-need scores) on 13 selected behavioral health factors which were determined ahead of time to be most likely to improve as a result of mental health services during detention. The analysis found that youth were most likely to present with poor decisionmaking, anger control, and delinquency issues. Nearly half presented with anxiety and depression. Between intake and the most recent assessment, clients were likely to demonstrate improvement in decisionmaking and anger control, but less likely to show improvements in delinquency, anxiety, depression, intentional misbehavior, or oppositional behavior. Social functioning and a sense of optimism increased among youth who presented with concerns in these areas. Few youth (7) presented as suicidal;

[24] The analysis matches the most recent assessment completed during the fiscal year with the earliest assessment, regardless of when and within which program it was completed. The interval between presenting and followup assessment may vary.

[25] Core domains include risk factors; behavioral/emotional needs; strengths; and life functioning. Each domain is comprised of multiple items. Actionable items are those items that score a 2 or 3.

however, less than half of those showed improvement during detention. Two youth had a history of sexual exploitation, but were no longer high-risk upon reassessment.



Cost/Benefit Analysis

The following table shows the cost per individual assessed and cost per individual who received at least one prevention or early intervention service following assessment.[26]

JJC Expenditure/Benefit Analysis FY 2019/20	
Program Expenditures	$1,253,451
Number of individuals assessed	218
Expenditure per individual assessed	$5,750
Number of individuals who received at least one PEI service	98
Expenditure per individual who received at least one PEI service	*$12,790*

Access and Linkage to Treatment Strategy

The following is a summary of data on referrals from the JJC Project. Detailed data on referrals, including demographic information, is provided in the attachment.

- The project as a whole referred 197 individuals to treatment upon discharge from the Juvenile Justice Center, all of whom were referred to county MHP programs.

- Of the 197 referred to county MHP programs, 53 (27%) engaged in treatment. The average duration of untreated mental illness was 18 months. The average interval between referral and treatment was 165 days.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of data on referrals to treatment and PEI programs for underserved populations[27]. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file.

- One hundred eighteen (118) Transitional Age Youth were referred to mental health treatment or a different PEI program. Of those, there were 17 (14%) known linkages to treatment. At this time, it was not possible to track linkages to other PEI programs, so ostensibly, a larger number could have received the services to which they were referred. The average interval between referral and participation was 121 days.

- Eighty-three (83) Hispanics/Latinos were referred to mental health treatment or a different PEI program. Of those, there were 21 (25%) known linkages to treatment. The average interval between referral and participation was 174 days.

- Fifty-five (55) African Americans/Black individuals were referred to mental health treatment or a different PEI program. Of those, there were 16 (29%) known linkages to treatment. The average interval between referral and participation was 171 days.

[27] Demographic categories with fewer than 10 represented program participants are not made available to the public and are therefore not included in this report.

- Eighteen (18) LGBTQ individuals were referred to mental health treatment or a different PEI program. Of those, there were 7 (39%) known linkages to treatment. The average interval between referral and participation was 107 days.

Encouraging Access to Services and Follow Through

The following are ways in which the Juvenile Justice project encourages access to services and follow through:

- All PEI provider organizations are trained in referral to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

- Before transferring a chart to a program, there is a "supervisor-to-supervisor" conversation to facilitate the chart transfer. This prevents delays to services for youth coming out of JJC.

- CYS works closely with the TAY Mentoring Program; staff come out to JJC to engage the youth into their program prior to discharge. CYS makes frequent referrals to that program.

Outreach for Increasing Recognition of Early Signs of Mental Illness Program: Community Trainings

Project description:

Outreach for Increasing Recognition of Early Signs of Mental Illness was delivered by National Alliance on Mental Illness San Joaquin (NAMI). NAMI Provider Education introduces mental health professionals to the unique perspectives of people with mental health conditions and their families. Participants develop enhanced empathy for the daily challenges of people with mental health conditions and recognize the value of including them in all aspects of the treatment process.

NAMI Provider Education is a free, 15-hour program of in-service training taught by a team consisting of an adult with a mental health condition, a family member and a mental health professional who is also a family member or has a mental health condition themselves.

Program Outputs

NAMI delivered one on-line Provider Education class to 12 participants from the Disability Resource Agency for Independent Living (DRAI).[28] Classes were taught by a team consisting of an adult with mental illness, a family member, and a mental health professional. Nine (9) individuals graduated.

Program Demographics

Of the potential responders 56% identified as White, 22% as African American/Black, and 22% as Hispanic/Latino. Two thirds (67%) of participants were adults age 26-59, 22% were older adults and 11% transitional age youth. Twenty-two percent (22%) were veterans. Two thirds (67%) identified as female and one-third as male; 100% as heterosexual.

Information for demographic groups with fewer than 10 members in any particular program is not made available to the public and is therefore not included in this report. More detailed demographic data are included in Tab 1 of the supplemental report to the State.

[28] Thirty (30) individuals were trained in FY 18/19. The reduction in participation in the current fiscal year may were likely due to COVID-19 conditions during the second half of the year

Cost/Benefit Analysis

The following table shows the amount invoiced by the provider for both the *Outreach for Early Recognition Program* and the *Stigma and Discrimination Reduction (SDR) Program* combined; and the total number of individuals who received training in each of the two programs. The average cost per individual trained in either Outreach or SDR programming was $34.

NAMI Expenditure Benefit Analysis for Stigma & Discrimination and Outreach Programs FY 2019/20	
Total Expenditures for SDR and Outreach Programming combined	$14,790
Total individuals trained in Stigma and Discrimination Reduction programming (IOOV, F2F, P2P) (See tab 6b)	418
Total individuals trained in Outreach for Early Recognition	12
Total number of individuals trained	430
Expenditure per individual trained	*$34*

Note: These expenditures represent the amount invoiced by contractor.

Access and Linkage to Treatment Strategy

The program reported no referrals to a higher level of mental health treatment.

Timely Access to Services for Underserved Populations Strategy

The program reported no referrals to treatment or another PEI program.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the Outreach program, in particular, encourages access to services and follow through:

- All PEI provider organizations are trained in referral to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

- The only follow-ups are with those individuals who reach out directly at the time of the presentation or by contacting NAMI after the fact. In both cases, follow-up calls are made to assist access to resources. The website, general membership meetings, and newsletters often result in inquiries for services and/or resources. This allows NAMI additional opportunities to provide support.

Stigma and Discrimination Reduction Program: Community Trainings

In FY 2019/20, stigma and discrimination workshops and trainings were delivered throughout the County by National Alliance on Mental Illness San Joaquin (NAMI).

Project Outputs:

A total of 418 individuals were reached through the Stigma and Discrimination Reduction Project in FY 2019/20.[29] The following table shows the type and number of each training/workshop offered and the number of individuals reached.

NAMI Stigma Reduction Output FY 2019/20			
		Number of trainings/ workshops	Number of individuals reached
In Our Own Voice (IOOV)	60-90 minute presentations by two trained speakers describing personal experiences living with mental health challenges and achieving recovery	23	366
Family to Family	12-session educational program for family members of adults living with mental illness taught by trained teachers who are also family members.	1	18
Peer to Peer (P2P)	10-session class to help adults living with mental illness challenges achieve and maintain wellness taught by Peer Mentors living in recovery	3	34
TOTAL		27	418

Participant Outcomes

Following each presentation or series of classes, NAMI facilitators distributed evaluation surveys with a set of retrospective Likert Scale items asking participants to rate the degree to which they agreed with certain statements. During the first half of the year, programs distributed a survey developed by NAMI. There were 285 responses. Responses were distributed into two reporting categories identified by State regulations, namely, number of participants who showed positive change in attitudes, knowledge and/or behavior related to *mental illness*; and number who showed positive change in attitudes, knowledge and/or behavior related to *seeking mental health services.* Our analysis demonstrated 72% showed positive change in statements related

[29] NAMI Stigma and Discrimination Reduction Programming reached 694 individuals in FY 2018/19. The reduction in participation in the current fiscal year may were likely due to COVID-19.

to mental illness and 81% showed positive change in statements related to seeking mental health services.

During the second half of the year, NAMI used a survey developed by the statewide MOQA project, and synthesized the outcomes into 4 domains. Due to COVID, there were fewer participants in the latter half of the year. For this survey 93% of participants showed positive change in attitudes, knowledge and/or behavior related to *mental illness*; and 90% showed positive change in attitudes, knowledge and/or behavior related to *seeking mental health services.*

MOQA Survey Outcomes			
As a direct result of this program, I am MORE willing to…		# who "agreed" or "strongly agreed"	%
	Number of Survey Responses by Domain	42	
1	Help seeking and Support	39	93%
2	Differing and Blame	38	90%
3	Social Distancing	38	90%
4	Recovery Beliefs	38	90%

Note: This table summarizes the 12 survey questions and groups them into four domains

Outreach for Increasing Recognition of Early Signs of Mental Illness Strategy

Six instructors (i.e., potential responders) conducted presentations/classes in the following settings and with the following types of participants. Responder demographics are not included due to the small sample size. Most of the outreach occurred in behavioral health settings, with several provided in shelters. Target populations were principally consumers and family members, and veterans/active military.

NAMI Stigma Reduction Output FY 2019/20	
Settings in which potential responders were engaged	**Total**
Schools/Universities	1
Shelters	4
Law enforcement agencies	1
Behavioral healthcare provider offices	17
Residential Substance Abuse Treatment Center	1
Churches or Faith-based organizations	1
Other	2
Total	27
Classes/Presentations targeted the following types of participants	**Total**
General Public	1
Other Social Service Providers	2
Active Military or Veteran	3
Legal/Court/Law Enforcement	1
Consumers and/or family members	19
College and university students	1
Total Participants	27

Access and Linkage to Treatment Strategy

The program reported no referrals to a higher level of mental health treatment or to other PEI programs.

Timely Access to Services for Underserved Populations Strategy

The program reported no referrals to treatment or another PEI program

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and NAMI's stigma and discrimination program, in particular, encourages access to services and follow through:

> See the above section—Outreach for Increasing Recognition of Early Signs of Mental Illness—for a combined description of ways in which NAMI encourages access to services and follow-through.

Suicide Prevention Program[30]

Project description:

In FY 2019/2020, the Suicide Prevention Program was delivered in 12 San Joaquin County high schools by Child Abuse Prevention Council of San Joaquin County (CAPC). The program involved the evidence-based Yellow Ribbon (YR) Suicide Education Campaign and ancillary Be a Link Adult Gatekeeper and Ask 4 Help Youth Gatekeeper Trainings. In addition, Child Abuse Prevention Council provided SafeTALK workshops to youth over age 15 to assist in the recognition of individuals with suicidal thoughts and to connect them to mental health resources. The Suicide Prevention Project also included depression screenings, referrals, and school-based depression support groups.

Output Summary

In FY 2019/20, the Suicide Prevention Project reached a 6,406 participants.[31] The following table is a detailed breakdown of the number of individuals reached by various program components:

CAPC Suicide Prevention Output FY 2019/20	
Total reached (duplicated count)	6,406
Yellow Ribbon Campaign Messaging	5,094
Be a Link ® Adult Gatekeeper Training	473
Ask 4 Help ® Youth Gatekeeper Training	243
SafeTalk Training	129
Depression Screening	397
CAST Support Group Participants	29
Break Free from Depression Support Group Participants	41

Participant Demographics

Demographic information was collected for 6,392 participants. Nineteen percent (19%) identified as mixed race, 19% white; 14% Asian, 6% African American/Black; 2% Native Hawaiian/Pacific Islander; and 1% American Indian.[32] Thirty-seven percent (37%) identified as an Hispanic/Latino. Of all participants children under the age of 15 comprised 55%, transitional age youth were 26%, and 6% were adults over age 18.

[30] Much of the data in this report, most notably that which is represented in grey fields, were compiled by the MOQA project. For more information see https://www.cibhs.org/measurements-outcomes-and-quality-assessment-moqa

[31] The Suicide Prevention Program reached 9828 individuals in FY 2018/19. The reduction in participation was due to school closures and other COVID-19-related conditions.

[32] Participants who declined to answer individual questions are included in total.

Forty-seven percent of participants identified as female, 39% as male and 2% were transgender or questioning. Seventy percent (70%) identified as heterosexual, 6% as bisexual, 2% gay or lesbian, and 3% a different orientation or questioning. Fifteen percent (15%) of participants spoke Spanish and 10% spoke another language as a primary language.

Information for demographic groups with fewer than 10 members in any particular program is not made available to the public and is therefore not included in this report. More detailed demographic data are included in Tab 1 of the supplemental report to the State.

Participant Outcomes

Yellow Ribbon Campaign Messaging		
On behalf of San Joaquin County Behavioral Health Services (BHS), Child Abuse Prevention Council of San Joaquin County (CAPC) implements the evidence-based Yellow Ribbon Campaign in 12+ high schools throughout San Joaquin County. As part of the campaign, student gatekeepers provide classroom presentations and distribute Ask for Help cards. The campaign aims to increase public awareness of suicide prevention, decrease suicide risk and promote help-seeking behaviors.		
Number of Recipients		
5094		
Number of MOQA Surveys Collected (% of Participants)		
4875 (96%)		
Outcomes	**N**	**% Agreeing/ Strongly Agreeing**
better able to recognize the signs, symptoms and risks of suicide?	4193	86%
more knowledgeable about the professional and peer resources that are available to help people who are at risk of suicide?	4085	84%

Be a Link Adult Gatekeeper Training		
As part of the Yellow Ribbon Campaign, 144 school personnel from the 12 participating high schools participated in "Be a Link" Adult Gatekeeper Trainings.		
Number of Participants		
473		
Number of MOQA Surveys Collected (% of Participants)		
284 (60%)		
Outcomes	**N**	**% Agreeing/ Strongly Agreeing**
better able to recognize the signs, symptoms and risks of suicide?	251	88%
More knowledgeable about the professional and peer resources that are available to help people who are at risk of suicide	256	90%

SafeTalk		
SafeTALK was offered in high schools and other locations throughout San Joaquin County. SafeTALK is a 3-hour training program that teaches participants to recognize and engage persons who might be having thoughts of suicide and to connect them with community resources trained in suicide intervention. SafeTALK helps bridge the gap between short suicide awareness sessions and longer suicide intervention skills training.		
Number of Participants		
129		
Number of MOQA Surveys Collected (% of Participants)		
123 (95%)		
Outcomes	**N**	**% Agreeing/ Strongly Agreeing**
better able to recognize the signs, symptoms and risks of suicide?	120	98%
more knowledgeable about the professional and peer resources that are available to help people who are at risk of suicide?	121	98%
More knowledgeable about how to intervene?	118	96%

Cost Benefit Analysis

The following table shows the cost per individual reached by the Suicide Prevention program as well as the cost per individual who demonstrated improvement.

CAPC - Suicide Prevention Cost/Benefit FY 2019/20	
Program Expenditures*	$518,299
Total Reached**	6406
*Expenditure per individual served****	*$79*
Percent who showed improvement/positive change*	89%
*Expenditure per individual who showed improvement/positive change*****	*$89*

* Expenditures represent the amount invoice by contractor

***Some individuals may have been counted more than once due to participation in multipe programs*

*** Based on 98% of total budget. 2% of total individuals served were given depression screenings with no measurable outcomes.

**** Based on average number of individuals who showed improvements in multiple surveys

Access and Linkage to Treatment Strategy

The following is a summary of data on referrals from the Suicide Prevention Project. Detailed data on referrals, including demographic information, is provided in the attachment.

- In addition to referrals to depression groups, the Child Abuse Prevention Council reported having made 231 referrals to treatment programs, 126 of which were to County MHP programs.

- Of the 126 referrals to county MHP programs, 9 individuals (7%) engaged in treatment. The average number of days between referral and treatment was 88, and the average duration of untreated mental illness was 10 months.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of data on referrals to treatment and PEI programs for underserved populations[33]. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file.

[33] Demographic categories with fewer than 10 represented program participants are not made available to the public and are therefore not included in this report.

- One hundred twenty-nine (129) Hispanics/Latinos were referred to mental health treatment or a different PEI program. Of those, there were only two (2%) known linkages to treatment. At this time, it was not possible to track linkages to other PEI programs, so ostensibly, a larger number could have received the services to which they were referred. The average interval between referral and participation was 63 days.

- Twenty-eight (28) Asians were referred to mental health treatment or a different PEI program. Of those, there were no known linkages to treatment.

- Twenty-five (25) African American/Black individuals were referred to mental health treatment or a different PEI program. Of those, there was one (4%) known linkage to treatment. The average interval between referral and participation was 107 days.

- One hundred seventy (170) transitional age youths were referred to mental health treatment or a different PEI program. Of those, there were 3 (2%) known linkages to treatment. The average interval between referral and participation was 84 days.

- Sixty-six (66) participants whose primary language was not English were referred to mental health treatment or a different PEI program. Of those, there were 5 (8%) known linkages to treatment. The average interval between referral and participation was 85 days.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the Suicide Prevention Program encourages access to services and follow through:

- All PEI provider organizations are trained in referral to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

- The Suicide Prevention Program provides updated lists of contact information for additional services throughout the year, both to school staff and to the students they serve. Mental Health Specialists attend staff meetings and school events in order to partner with schools to increase knowledge of school staff about resources, and to ensure that MHS are connecting students to their

school's resources. Depending on the severity of the symptoms that a student presents with, staff will follow up with them within the week, and at 30-60-90 days in order to ensure connection to services or groups depending on need.

- The Suicide Prevention Program is working with CAPC's marketing team to develop a Facebook page. They are also in communication with counselors at school sites; emailing referrals; and reaching out to students through FaceTime, phone calls, school's social media accounts; and Zoom. The suicide prevention program has increased the rate at which staff make contact with students to weekly or twice a month to ensure newly developed issues can be addressed quickly.

Timely Service for Underserved Populations Program: Recovery Services for Nonviolent Offenders (LEAD)

Project description:

BHS works with San Joaquin County Courts, District Attorney, and local law enforcement agencies to provide targeted outreach and engagement, screening and assessment, and linkage to appropriate services and supports. Brief interventions are offered to individuals identified with emerging mental health concerns such as PTSD or associated disorders. A significant portion of the target population is assumed to be homeless and/or have co-occurring disorders.

The goal of the project is to engage individuals with behavioral health concerns that are repeat non-serious, nonviolent offenders and provide recovery and rehabilitation services to increase functioning in order to reduce negative outcomes associated with untreated mental health concerns such as arrest, incarceration, homelessness, and prolonged suffering.

Project Outputs:

In FY 2019/2020, LEAD served a total of 53 individuals, 23 of whom were admitted in the previous fiscal year and 30 in this fiscal year. On average, individuals received 885 minutes (14.7 hours) of service.

LEAD Output FY 2019/20	
Total individuals served (including rollovers from previous fiscal year)	53
Individuals admitted during fiscal year	30
Total Minutes of service	46,894
Average minutes per individual	885
Average hours per individual	15

Program Demographics

Demographic information was available for 30 LEAD program participants. They identified as white (27%), Black/African American (20%), more than one race (10%), and Native Hawaiian or other Pacific Islander (3%), with forty percent (40%) declining to answer. Thirteen percent (13%) identified their ethnicity as Mexican or Mexican American. All participants listed English as their primary language. Nearly half of the participants (47%) were between age 26-59, 10% were between the ages of 16-25, 13% were 60 years or older, and 30% declined to answer. Forty-seven percent (47%) currently identify as male and 23% female, with 30% unreported. Forty-seven percent

(47%) of participants identified as heterosexual and 3% as bisexual or questioning, with 50% declining to answer. Ten percent were veterans.

Information for demographic groups with fewer than 10 members in any particular program is not made available to the public and is therefore not included in this report. More detailed demographic data are included in Tab 1 of the supplemental report to the State.

Cost/Benefit Analysis

The following table shows costs of the project, the cost per individual referred to treatment, and cost per individual who engaged in treatment.

LEAD Expenditure/Benefit FY 2019/20	
Program Expenditures	$183,396
Unduplicated individuals served	53
Expenditure per individual served	*$3,460*

Access and Linkage to Treatment Strategy

The following is a summary of data on referrals from the LEAD Project. Detailed data on referrals, including demographic information, is provided in the attachment.

- LEAD reported 21 referrals to treatment, 20 of which were to county mental health providers. Seven individuals (35%) were known to have engaged in treatment. The average number of days between referral and treatment was 35, and there was no data on the duration of untreated mental illness.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of data on referrals to treatment and PEI programs for underserved populations[34]. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file.

- Eighteen (18) homeless individuals were referred to mental health treatment or a different PEI program. Of those, there were 5 (28%) known linkages to treatment. The average interval between referral and participation was 40 days.

[34] Demographic categories with fewer than 10 represented program participants are not made available to the public and are therefore not included in this report.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS encourages access to services and follow through:

- All PEI provider organizations are trained in referral to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

- The Whole Person Care and LEAD projects provides intensive case management, navigation and warm handoffs to all referral destinations. Case management involves helping clients schedule or reschedule appointments and transportation as needed. Case managers build trust and rapport in order to convey the importance and benefits of services. The program addresses a wide array of psycho-social stressors, including food, clothing, and shelter, since Maslow's Hierarchy of Needs suggest they these concerns may inhibit clients' ability to engage in services. Clients in crisis are immediately linked to services.

Access and Linkage to Services Program: Whole Person Care

Project description:

This project provides match funding for San Joaquin County's Whole Person Care Pilot Project, approved by DHCS in 2016. The purpose of San Joaquin County's Whole Person Care pilot project is to test interventions and create a care management infrastructure to better support individuals who are at high risk of untreated mental illness and are high utilizers of health care services. Program services target adult Medi-Cal beneficiaries who over-utilize emergency department services, have a mental health and/or substance use disorder, or are homeless or at risk for homelessness upon discharge from an institutionalized setting.

Project Outputs:

In FY 2019/20, Whole Person Care served a total of 108 individuals, including 51clients who entered into service during the previous fiscal year. The following table shows the total number of new admissions, total participant count and average minutes of service provided to each individual during FY 2019/20.

WPC Output FY 2019/20	
Total individuals served (including rollovers from previous fiscal year)	108
Individuals admitted during fiscal year	51
Total Minutes of service	52,471
Average minutes per individual	486
Average hours per individual	8

Cost/Benefit Analysis

The following table shows costs of the project and cost per individual served.

WPC Expenditure/Benefit FY 2019/20	
Program Expenditures	$378,550
Unduplicated individuals served	51
Expenditure per individual served	*$7,423*

Program Demographics

Demographic information was available for 23 program participants. Fifty-two percent 952%) identified as white; 17% as African American/Black and 13% as another race, and 17% identified as Hispanic/Latino. The majority, 87% were adults age 26-59 and 13% were transitional age youth. All spoke English as their primary language. The majority

were male (78%) and 22% female at birth. Current gender identity and sexual orientation were not reliably reported.

Access and Linkage to Treatment Strategy

Three (3) individuals were referred to treatment, all of whom were referred to county MHP treatment. Two (2) of these individuals engaged in treatment in a county MHP program. The average interval between referral and treatment was 11 days. The average duration of untreated mental illness was 60 months.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of data on referrals to treatment and PEI programs for underserved populations[35]. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file.

- One (1) individual from an underserved population was referred to mental health treatment or a different PEI program, and this individual had a linkage to treatment. The interval between referral and participation was 6 days.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS encourages access to services and follow through:

- All PEI provider organizations are trained in referral to crisis services, outpatient mental health treatment and PEI programs; and how to document referrals per State regulations.

- The Whole Person Care and LEAD projects provides intensive case management, navigation and warm handoffs to all referral destinations. Case management involves helping clients schedule or reschedule appointments and transportation as needed. Case managers build trust and rapport in order to convey the importance and benefits of services. The program addresses a wide array of psycho-social stressors, including food, clothing, and shelter, since Maslow's Hierarchy of Needs suggest they these concerns may inhibit clients' ability to engage in services. Clients in crisis are immediately linked to services.

[35] Demographic categories with fewer than 10 represented program participants are not made available to the public and are therefore not included in this report.

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Behavioral Health Services
A Division of Health Care Services Agency

Tony Vartan, MSW, LCSW, BHS Director

San Joaquin County mhsa

Transforming Mental Health Services

Community Planning Meetings
Mental Health Services Act (MHSA)

The Mental Health Services Act (MHSA), intended to transform public mental health care for children, youth, adults and seniors. MHSA provides funding allocations for community mental health services in five program areas:

- Community Services and Supports (CSS)
- Prevention and Early Intervention (PEI)
- Workforce Education and Training (WET)
- Capital Facilities and Technological Needs (CF/TN)
- Innovation (INN)

Please join us at one of the following consumer and family member focused community meetings to discuss the needs and opportunities to strengthen mental health services in San Joaquin County. These meetings will include an update on how MHSA funds are currently being used, as well as a chance to share your opinion and recommendations on how to enhance programs and services. Your feedback is needed to inform next year's 2021-22 MHSA Annual Update to the Three Year 2020-23 Program and Expenditure Plan.

We are counting on your voice to help guide us!

Wellness Center **Wednesday, January 13, 2021** **10 AM – 12 PM**	**Gipson Center** **Thursday, January 14, 2021** **10 AM – 12 PM**
Join Zoom Meeting https://caltelehealth.zoom.us/j/96715016315?pwd=eDFNQTVQdXFXbjBETmpvRC9OUWo0UT09 Phone: 1 669 900 6833 Meeting ID: 967 1501 6315 Passcode: 107504	

Meeting accessibility is important. Please contact us at 209-468-8750 to discuss accessibility questions. All meetings are held in accessible locations. Translation assistance is available upon request. Families are welcome.

Please post this notice in a public location and distribute via your mailing lists. Thank you for passing this invitation along.

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Behavioral Health Services
A Division of Health Care Services Agency
Tony Vartan, MSW, LCSW, BHS Director

San Joaquin County mhsa

Transforming Mental Health Services

Community Planning Meetings – Via ZOOM Call
Mental Health Services Act (MHSA)

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BHS Consortium	**BHS Behavioral Health Board**	**General Session**	**General Session**	**El Concilio – SPANISH Session**
Wednesday, Jan 13 **3 PM – 5 PM**	**Wednesday, Jan 20** **5 PM – 7 PM**	**Thursday, Jan 21** **4 PM – 6 PM**	**Tuesday, Jan 26** **10 AM – 12 PM**	**Thursday, Jan 28** **4 PM – 6PM**
Join Zoom Meeting https://caltelehealth.zoom.us/j/96715016315?pwd=eDFNQTVQdXFXbjBETmpvRC9OUWo0UT09 Phone: 1 669 900 6833 Meeting ID: 967 1501 6315 Passcode: 107504				

Please post this notice in a public location and distribute via your mailing lists. Thank you for passing this invitation along.

SAN JOAQUIN COUNTY

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Welcome to 2020-21 MHSA Community Planning

- Please sign in by providing name and email address in ZOOM Chat Box
- Please complete Survey Monkey Demographics (link in the chat box)
- Meeting will be recorded for Transcribing Purposes

1

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San Joaquin County Behavioral Health Services
Mental Health Services Act – Overview and Planning

Community Program Planning for Fiscal Year 2021-2022

2

Part 1: Overview of BHS

WELCOME AND INTRODUCTIONS
BHS MISSION, VISION, AND VALUES

Mission and Vision

Mission Statement

- The mission of San Joaquin County Behavioral Health Services is to partner with the community to provide integrated, culturally and linguistically competent mental health and substance abuse services to meet the prevention, intervention, treatment, and recovery needs of San Joaquin County residents.

Vision Statement

- The vision of San Joaquin County Behavioral Health Services is to collaborate as a resilient team exploring changes, sharing ideas, striving to empower consumers, families, volunteers and care providers toward building hope, addressing disparities, and fostering wellness and recovery through individual strength-based treatment.

Core Values

SERVICE:

We are dedicated to serving our community through the promotion of behavioral health and wellness.

RESPECT:

We value diverse experiences, beliefs, and backgrounds and strive in our interactions to keep everyone's dignity intact.

RECOVERY:

We share a belief that all individuals can find a path towards health and well-being.

INTEGRITY:

Our values guide us as individuals and as an organization to be responsive and trustworthy.

Providing our clients with the same quality of care that we all would want our families to receive.

Part 2: Mental Health Services Act

OVERVIEW OF MHSA
COMMUNITY INVESTMENT
NEW MHSA PROGRAMS

Mental Health Services Act (MHSA)

Purpose of MHSA Funding

- Expand and enhance mental health services for individuals with serious mental illness.
- Provide prevention and early intervention services for those at risk of developing a mental illness.
- Promote innovative solutions that will advance the field of mental health.
- Strengthen the personnel, technology, and facilities through which services are offered.

Common Acronyms

(MHSA) Mental Health Services Act, Prop. 63

(CSS) Community Services and Supports
(PEI) Prevention and Early Intervention
(INN) Innovation
(WET) Workforce Education and Technology
(CFTN) Capital Facilities and Technology

MHSA Core Principles

- **Client/family driven**
- **Cultural competence**
- **Community collaboration**
- **Service integration**
- **Focus on recovery, wellness, and resilience**
- **Serving the unserved and underserved**

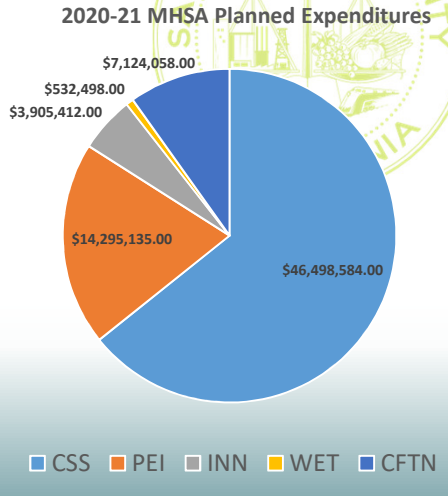
COVID-19 Pandemic – Fiscal Forecast

- **Delayed Impact: The economic downturn in Calendar Year 2020 will be felt in FY 2022-23 and beyond for MHSA Funding**
- **Loss of Funding: Main Source of funding (MHSA) are drawn from millionaire's tax.**
  - MHSA projected to decrease significantly over the next 1-5 years
- **Annual Stakeholder Planning continues in a fiscally responsible and cautious effort as to maximize planning and expenditures of MHSA funds annually.**

MHSA Programming in San Joaquin County

Program Areas

- **Community Services and Supports**
- **Prevention and Early Intervention**
- **Innovative Programs**
- **Workforce Education and Training**
- **Capital Facilities and Technology Needs**



New and Expanded MHSA Programs

2020 New and Expanded Programs

- School Based Interventions for Children and Youth (PEI)
- Two Intensive Adult Care FSP's (CSS)
- Two Intensive Justice Response FSP's (CSS)
- Peer Navigation (CSS)

Program Operations have Begun

2021 New and Expanded Programs

- FSP High-Risk Transition Team (CSS)
- Community Trauma Services for Adults (PEI)
- Information and Education Campaign (PEI)
- Suicide Prevention in the Community (PEI)

MHSA planning benefits from community stakeholder input

- Consumers, family members, and providers
- Review programs and make recommendations
- Input for improvements outlined in Annual Update
- Plan reviewed (30 days) & public hearing at Behavioral Health Board

Part 4: Planning Discussion

GROUP BRAINSTORM
- WHAT WORKS?
- WHAT NEEDS IMPROVEMENT?

SMALL GROUP DISCUSSION

PRIORITIZATION

Community Program Planning

Purpose: *To assess the mental health needs of the entire community, including those that are currently served, and those that are unserved, underserved, or inappropriately served.*

Feedback Requested:

1) What is working?
2) What needs improvement?
3) Identify key needs and concerns by age groups.
4) Prioritize needs or concerns.

Definitions:

Gap or Need – Services do not exist, or does not exist for a specific population.

Issue or Concern – Services exist, but there is an issue or concern to be addressed.

Instructions for Discussions

1. Group Brainstorm:

- **Think about the following questions**
  - What is working?
  - What needs improvement?
- **Share your ideas in the large group discussion.**

2. Small Group Discussion: (If Applicable)

- **Introduce yourselves to the others at your table.**
- **Talk about the issues raised,**
  - Identify key needs and concerns by age group.
  - Identify type of issue or concern
  - Identify population with the greatest needs

3. Report-outs and Prioritization

- **Group spokesperson reviews needs or concerns discussed**
- **Common themes and priorities are identified**

Planning Activities for this Annual Update

- **Community Planning Meetings**
- **Consumer Discussion Groups**
- **Stakeholder Surveys**
- **Key Informant Interviews**
- **MHSA Consortium**
- **Behavioral Health Board**
- **Draft Plan for 30-day Public Review (March or April)**
- **Public Hearing (April or May)**
- **Presentation to the Board of Supervisors (May or June)**

Collecting your Feedback!

- **Please make sure to:**
  - Sign-in to the meeting via the chat .
  - Complete the linked demographic form (SurveyMonkey).
  - Complete the confidential stakeholder feedback form (SurveyMonkey).
  - Consider sending additional feedback, suggestions or ideas to:

Mail:

MHSA Comments
c/o MHSA Coordinator
1212 N. California St.
Stockton CA 95202

E-mail:

mhsacomments@sjcbhs.org

Angelo Balmaceda
MHSA Coordinator
abalmaceda@sjcbhs.org

SAN JOAQUIN COUNTY
Behavioral Health Services

Comment Form MHSA Planning 2020-2021

1. How would you rate the Planning Session?

- ◯ Exceptional
- ◯ Good
- ◯ Okay
- ◯ Needs improvement

2. Which part(s) of this meeting worked well?

3. How would you improve this meeting?

4. How can BHS improve implementation of the MHSA?

5. Is there a specific region or demographic that the MHSA should prioritize and if so, what is your recommendation?

SAN JOAQUIN COUNTY
Behavioral Health Services

Forma de Comentarios

Plantificación de San Joaquin 2020/21

* 1. ¿ En general, qué tan bien ha cumplido con sus expectativas esta junta? (Por favor marque uno)

- ◯ Muy Bien
- ◯ Bien
- ◯ Un Poco
- ◯ Para Nada

2. ¿Qué parte de esta junta funcionó bien?

3. ¿Cómo mejoraría usted esta junta?

4. ¿Cómo puede Servicios de Salud del Compartamiento (BHS) mejorar la implementación de la Ley de Servicios de Salud Mental (MHSA)?

5. ¿Existe alguna región o grupo demográfico específica que la Ley de Servicios de Salud Metal (MHSA) debe priorizar y, en caso afirmativo, cuál es su recomendacíon?

SAN JOAQUIN COUNTY
Behavioral Health Services

Planificación MHSA 2020-2021 - Demografía

En acuerdo con las directrices del estado de California, debemos reportar información demográfica de participantes del plan. Esta información se mantendrá confidencial y se usará con fines informativos. Usted puede negarse a responder estas preguntas.

* 1. ¿A qué reunión asististe?

- ◯ Miércoles 13 de enero, 10 a.m. - 12 p.m. 2021 (Wellness Center)
- ◯ Miércoles 13 de enero, 3 p.m. - 5 p.m. 2021 (BHS Consortium)
- ◯ Jueves 14 de enero, 10 a.m. - 12 p.m. 2021 (Gipson Center)
- ◯ Miércoles 20 de enero, 5 p.m. - 7 p.m. 2021 (BHS Behavioral Health Board)
- ◯ Jueves 21 de enero, 4 p.m. - 6 p.m. 2021 (Sesión General)
- ◯ Jueves 26 de enero, 10 a.m. - 12 p.m. 2021 (Sesión General)
- ◯ Jueves 28 de enero, 4 p.m. - 6 p.m. 2021 (El Concilio - Sesión de español)

* 2. Indique su rango de edad

- ☐ Menor de 18
- ☐ 18-25
- ☐ 26-59
- ☐ 60 o mayor

* 3. Indique su género

- ◯ Mujer
- ◯ Hombre
- ◯ No binario
- ◯ Transgénero
- ◯ Otro (por favor especifique)

4. ¿Cuál es su orientación sexual?

- ◯ Heterosexual
- ◯ LGBTQI
- ◯ Prefiero no contestar
- ◯ Otro (por favor especifique)

* 5. Indique el idioma principal que se habla en su hogar

- ◯ Ingles
- ◯ Español
- ◯ Otro (por favor especifique)

* 6. Indique su raza o etnia

- ◯ Indígena Americano/Indio Americano/Primeras Naciones (incluyendo Hawaiano y Nativo)
- ◯ Negro / Afro-Americano
- ◯ Hispano / Latinx
- ◯ Sudeste Asiático
- ◯ Aiatico o Isleno del Pacifico
- ◯ Blanco / Caucasico
- ◯ Raza Mezclada u Otro

* 7. Afiliación de consumidor (si aplica)

- ☐ Cliente de salud mental / consumidor
- ☐ Familiar de un consumidor de salud mental
- ☐ Ninguna de las anteriores

* 8. Afiliación de intereses (marque todas las que aplican)

- [ ] Proveedor de servicios de salud mental comunitarios / sin fines lucrativos
- [ ] Organización comunitaria (no un proveedor de servicios de salud mental)
- [ ] Defensor
- [ ] Proveedor de servicios para niños y familias
- [ ] Proveedor de educación K-12
- [ ] Orden publico
- [ ] Servicios para Veteranos
- [ ] Servicios para personas mayores
- [ ] Proveedor de Hospital / cuidado de salud
- [ ] Proveedor de vivienda/servicios de vivienda
- [ ] Proveedor del condado del departamento de salud mental o de servicios de abuso de sustancias
- [ ] Otro (por favor especifique)

SAN JOAQUIN COUNTY
Behavioral Health Services

2020 - 2021 MHSA Consumer Survey

BHS works hard to provide culturally appropriate and responsive services regardless of age, gender identity, sexual orientation, language, disability status, race, or ethnicity. In order to track the effectiveness of our efforts, please answer questions 1-18. Answering demographic questions 19-30 are optional. All surveys are confidential and anonymous.

1. Do you identify as someone who is receiving, or who needs, mental health treatment services?

- ◯ Yes
- ◯ No
- ◯ Not sure

2. How would you rate the location where our services are provided?

Needs Improvement	Fair	Good	Very Good	Excellent
★	★	★	★	★

3. How would you rate the information available in flyers, pamphlets, or on our website that describes our services?

Needs Improvement	Fair	Good	Very Good	Excellent
★	★	★	★	★

4. How would you rate the length of time it takes to get an appointment?

Needs Improvement	Fair	Good	Very Good	Excellent
★	★	★	★	★

5. How would you rate the types of individual or group interventions that are offered?

Needs Improvement	Fair	Good	Very Good	Excellent
★	★	★	★	★

6. How would you rate the thoroughness of the services that are provided?

Needs Improvement	Fair	Good	Very Good	Excellent
★	★	★	★	★

7. Would you recommend our services to people who need help for a mental health or substance use concern?

- ◯ Yes
- ◯ No
- ◯ Not Sure

8. What services or supports need the most improvement and what should BHS do to make them better?

9. From a cultural and linguistic perspective, are the BHS lobby and reception areas friendly and welcoming?

Yes, very much so	Yes, somewhat	No, not really	I don't know
☆	☆	☆	☆

10. Are BHS staff members courteous and professional?

Yes, very much so	Yes, somewhat	No, not really	I don't know
☆	☆	☆	☆

11. Are BHS staff members respectful of your cultural heritage?

Yes, very much so	Yes, somewhat	No, not really	I don't know
☆	☆	☆	☆

12. Do BHS staff members explain things in a way that you like and understand?

Yes, very much so	Yes, somewhat	No, not really	I don't know
☆	☆	☆	☆

13. Are BHS programs helpful for many different types of people?

Yes, very much so	Yes, somewhat	No, not really	I don't know
☆	☆	☆	☆

14. Have you or a family member ever used BHS interpretation services?

- ◯ Yes
- ◯ No
- ◯ Not sure

15. If you've used BHS interpretation services, how would you describe the quality of the interpretation services?

Needs improvement	Fair	Good	Very good	Excellent
★	★	★	★	★

16. What is the MOST important factor that contributes to wellness and recovery?

17. What is the SECOND most important factor that contributes to wellness and recovery?

18. What is the THIRD most important factor that contributes to wellness and recovery?

* 19. Please indicate the language that is most frequently spoken in your home (please choose only one).

- ◯ English
- ◯ Spanish
- ◯ Mon-Khmer, Cambodian
- ◯ Vietnamese
- ◯ Other (please specify)
- ◯ Tagalog
- ◯ Lao, Laotian
- ◯ Hmong-Mien
- ◯ Prefer not the say

20. What is your race?

- ◯ White or Caucasian
- ◯ Black or African American
- ◯ Hispanic or Latino
- ◯ Asian or Asian American
- ◯ Mixed race (please specify)
- ◯ American Indian or Alaska Native
- ◯ Native Hawaiian or other Pacific Islander
- ◯ Prefer not to answer

21. Are you currently homeless or at risk of homelessness?

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

22. In the past three years, have you been homeless for more than a year or have you experienced homelessness for more than four times?

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

23. Have you ever been arrested or detained by the police?

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

24. Please indicate your age

- ◯ Under 18
- ◯ 18-25
- ◯ 26-59
- ◯ 60 and older
- ◯ Prefer not to say

25. Are you a parent or are you about to be a parent?

- ◯ Yes
- ◯ No
- ◯ Not sure
- ◯ Prefer not to say

26. Please indicate your gender

- ◯ Female
- ◯ Male
- ◯ Non-Binary
- ◯ Transgender
- ◯ Prefer not to say

27. Do you self-identify as someone with a physical or developmental disability?

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

28. Are you a U.S. Military Veteran of the Army, Navy, Marines, Air Force, or Coast Guard?

- ◯ Yes
- ◯ No
- ◯ Prefer not to say

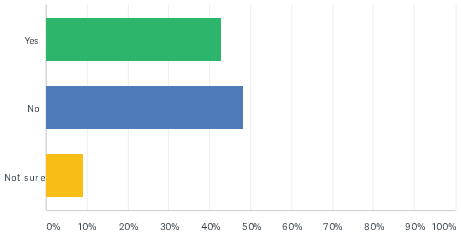
29. What is your sexual orientation?

- ◯ Heterosexual / Straight
- ◯ Lesbian
- ◯ Gay
- ◯ Bisexual
- ◯ Transgender
- ◯ Queer
- ◯ Questioning
- ◯ Prefer not to say

30. Is there anything else you want to share about what is needed to better support your wellness and recovery?

Q1 Do you identify as someone who is receiving, or who needs, mental health treatment services?

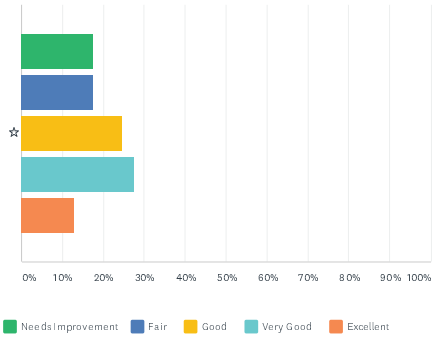
Answered: 112 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	42.86%	48
No	48.21%	54
Not sure	8.93%	10
TOTAL		112

Q2 How would you rate the location where our services are provided?

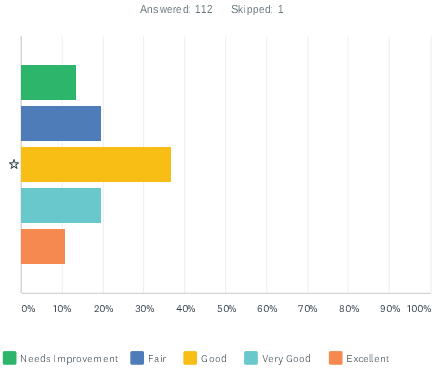
Answered: 109 Skipped: 4



	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	17.43% 19	17.43% 19	24.77% 27	27.52% 30	12.84% 14	109	3.01

Q3 How would you rate the information available in flyers, pamphlets, or on our website that describes our services?

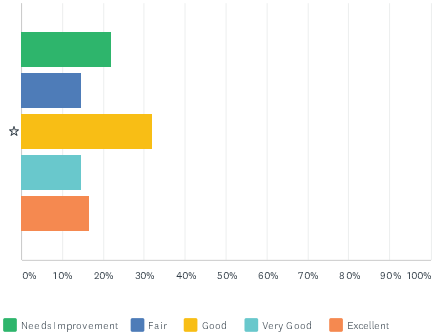
Answered: 112 Skipped: 1



	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	13.39% 15	19.64% 22	36.61% 41	19.64% 22	10.71% 12	112	2.95

Q4 How would you rate the length of time it takes to get an appointment?

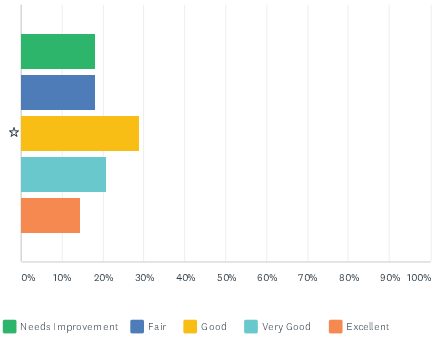
Answered: 109 Skipped: 4



	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	22.02% 24	14.68% 16	32.11% 35	14.68% 16	16.51% 18	109	2.89

Q5 How would you rate the types of individual or group interventions that are offered?

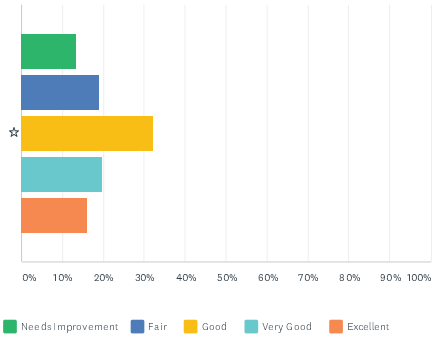
Answered: 111 Skipped: 2



	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	18.02% 20	18.02% 20	28.83% 32	20.72% 23	14.41% 16	111	2.95

Q6 How would you rate the thoroughness of the services that are provided?

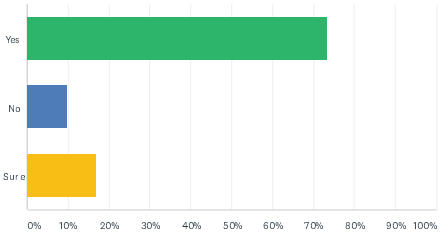
Answered: 112 Skipped: 1



	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	13.39% 15	18.75% 21	32.14% 36	19.64% 22	16.07% 18	112	3.06

Q7 Would you recommend our services to people who need help for a mental health or substance use concern?

Answered: 112 Skipped: 1



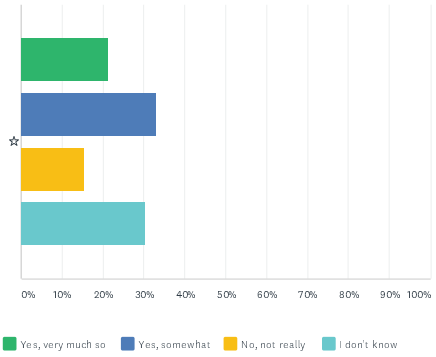
ANSWER CHOICES	RESPONSES	
Yes	73.21%	82
No	9.82%	11
Not Sure	16.96%	19
TOTAL		112

Q8 What services or supports need the most improvement and what should BHS do to make them better?

Answered: 89 Skipped: 24

Q9 From a cultural and linguistic perspective, are the BHS lobby and reception areas friendly and welcoming?

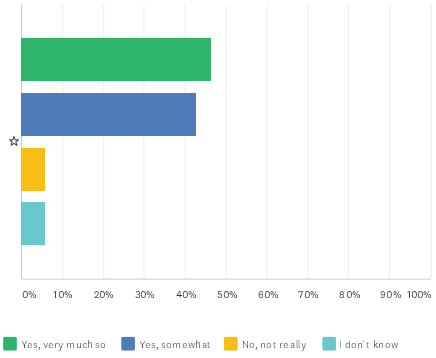
Answered: 112 Skipped: 1



	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	21.43% 24	33.04% 37	15.18% 17	30.36% 34	112	2.54

Q10 Are BHS staff members courteous and professional?

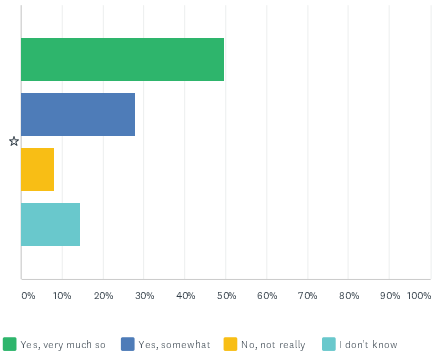
Answered: 108 Skipped: 5



	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	46.30% 50	42.59% 46	5.56% 6	5.56% 6	108	1.70

Q11 Are BHS staff members respectful of your cultural heritage?

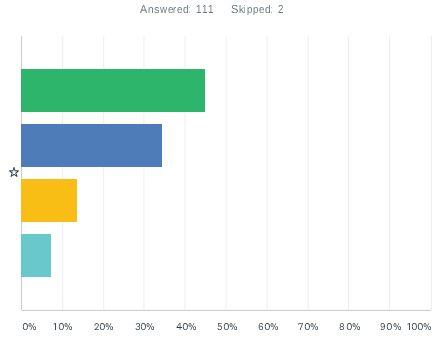
Answered: 111 Skipped: 2



	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	49.55% 55	27.93% 31	8.11% 9	14.41% 16	111	1.87

Q12 Do BHS staff members explain things in a way that you like and understand?

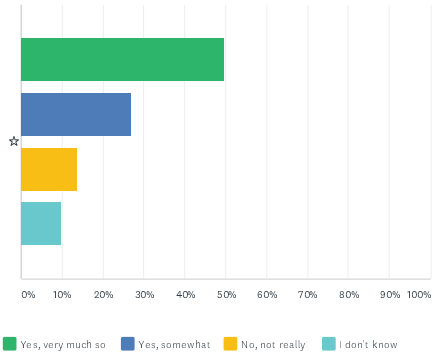
Answered: 111 Skipped: 2



	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	45.05% 50	34.23% 38	13.51% 15	7.21% 8	111	1.83

Q13 Are BHS programs helpful for many different types of people?

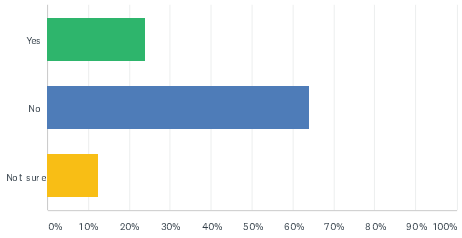
Answered: 111 Skipped: 2



	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DONT KNOW	TOTAL	WEIGHTED AVERAGE
☆	49.55% 55	27.03% 30	13.51% 15	9.91% 11	111	1.84

Q14 Have you or a family member ever used BHS interpretation services?

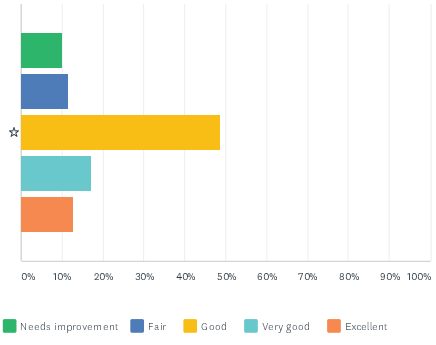
Answered: 113 Skipped: 0



ANSWER CHOICES	RESPONSES	
Yes	23.89%	27
No	63.72%	72
Not sure	12.39%	14
TOTAL		113

Q15 If you've used BHS interpretation services, how would you describe the quality of the interpretation services?

Answered: 70 Skipped: 43



	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	10.00% 7	11.43% 8	48.57% 34	17.14% 12	12.86% 9	70	3.11

Q16 What is the MOST important factor that contributes to wellness and recovery?

Answered: 96 Skipped: 17

Q17 What is the SECOND most important factor that contributes to wellness and recovery?

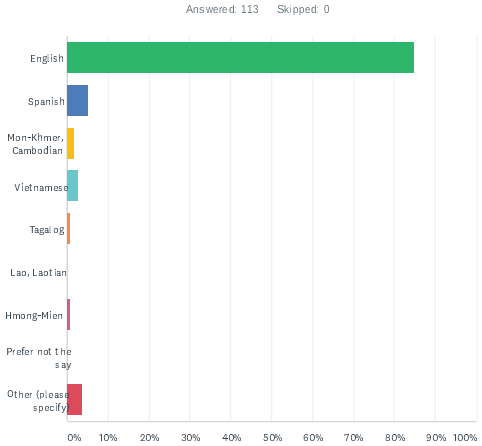
Answered: 93 Skipped: 20

Q18 What is the THIRD most important factor that contributes to wellness and recovery?

Answered: 89 Skipped: 24

Q19 Please indicate the language that is most frequently spoken in your home (please choose only one).

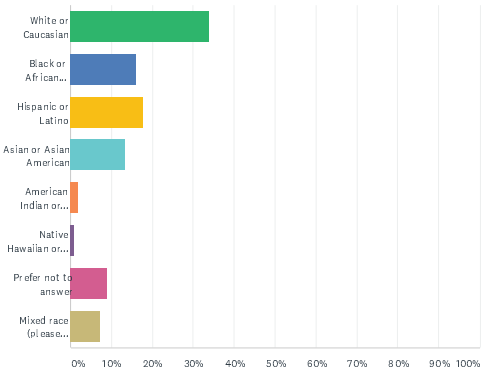
Answered: 113 Skipped: 0



ANSWER CHOICES	RESPONSES	
English	84.96%	96
Spanish	5.31%	6
Mon-Khmer, Cambodian	1.77%	2
Vietnamese	2.65%	3
Tagalog	0.88%	1
Lao, Laotian	0.00%	0
Hmong-Mien	0.88%	1
Prefer not the say	0.00%	0
Other (please specify)	3.54%	4
TOTAL		113

Q20 What is your race?

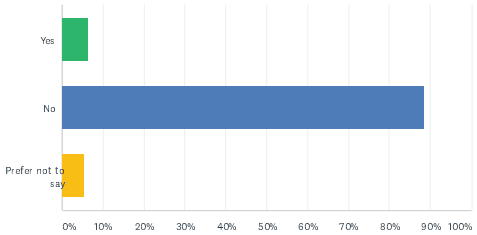
Answered: 112 Skipped: 1



ANSWER CHOICES	RESPONSES	
White or Caucasian	33.93%	38
Black or African American	16.07%	18
Hispanic or Latino	17.86%	20
Asian or Asian American	13.39%	15
American Indian or Alaska Native	1.79%	2
Native Hawaiian or other Pacific Islander	0.89%	1
Prefer not to answer	8.93%	10
Mixed race (please specify)	7.14%	8
TOTAL		112

Q21 Are you currently homeless or at risk of homelessness?

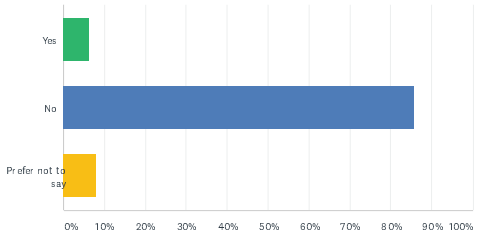
Answered: 112 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	6.25%	7
No	88.39%	99
Prefer not to say	5.36%	6
TOTAL		112

Q22 In the past three years, have you been homeless for more than a year or have you experienced homelessness for more than four times?

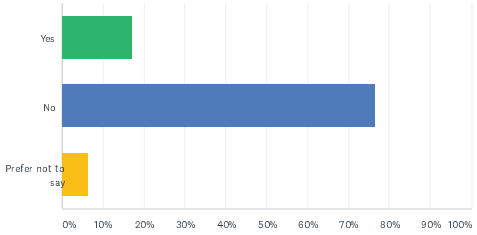
Answered: 112 Skipped: 1



ANSWER CHOICES	RESPONSES	
Yes	6.25%	7
No	85.71%	96
Prefer not to say	8.04%	9
TOTAL		112

Q23 Have you ever been arrested or detained by the police?

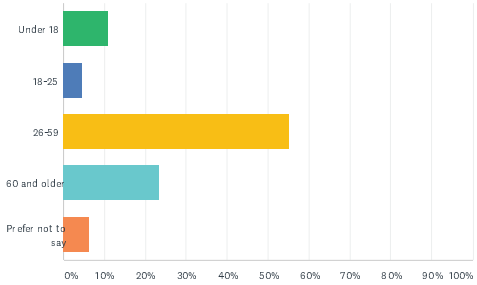
Answered: 111 Skipped: 2



ANSWER CHOICES	RESPONSES	
Yes	17.12%	19
No	76.58%	85
Prefer not to say	6.31%	7
TOTAL		111

Q24 Please indicate your age

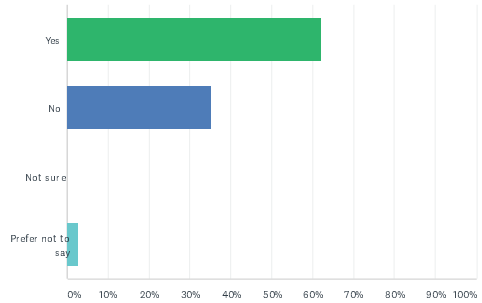
Answered: 111 Skipped: 2



ANSWER CHOICES	RESPONSES	
Under 18	10.81%	12
18-25	4.50%	5
26-59	54.95%	61
60 and older	23.42%	26
Prefer not to say	6.31%	7
TOTAL		111

Q25 Are you a parent or are you about to be a parent?

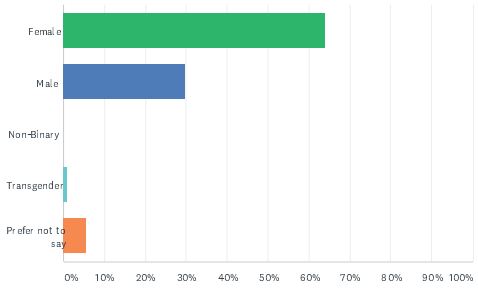
Answered: 111 Skipped: 2



ANSWER CHOICES	RESPONSES	
Yes	62.16%	69
No	35.14%	39
Not sure	0.00%	0
Prefer not to say	2.70%	3
TOTAL		111

Q26 Please indicate your gender

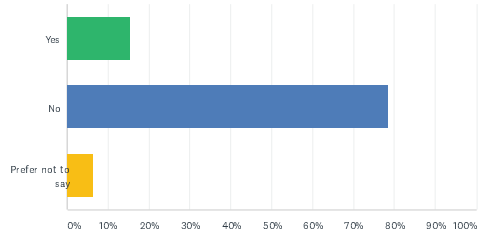
Answered: 111 Skipped: 2



ANSWER CHOICES	RESPONSES	
Female	63.96%	71
Male	29.73%	33
Non-Binary	0.00%	0
Transgender	0.90%	1
Prefer not to say	5.41%	6
TOTAL		111

Q27 Do you self-identify as someone with a physical or developmental disability?

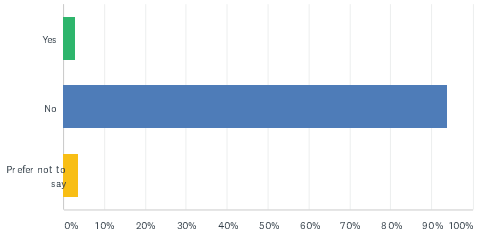
Answered: 111 Skipped: 2



ANSWER CHOICES	RESPONSES	
Yes	15.32%	17
No	78.38%	87
Prefer not to say	6.31%	7
TOTAL		111

Q28 Are you a U.S. Military Veteran of the Army, Navy, Marines, Air Force, or Coast Guard?

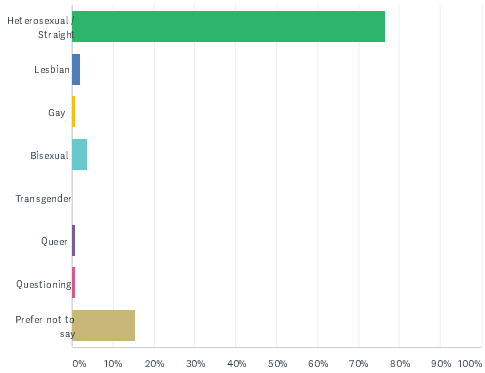
Answered: 111 Skipped: 2



ANSWER CHOICES	RESPONSES	
Yes	2.70%	3
No	93.69%	104
Prefer not to say	3.60%	4
TOTAL		111

Q29 What is your sexual orientation?

Answered: 111 Skipped: 2



ANSWER CHOICES	RESPONSES	
Heterosexual / Straight	76.58%	85
Lesbian	1.80%	2
Gay	0.90%	1
Bisexual	3.60%	4
Transgender	0.00%	0
Queer	0.90%	1
Questioning	0.90%	1
Prefer not to say	15.32%	17
TOTAL		111

Q30 Is there anything else you want to share about what is needed to better support your wellness and recovery?

Answered: 61 Skipped: 52

SAN JOAQUIN COUNTY
Behavioral Health Services

Encuesta del Consumidor de MHSA 2020-2021

BHS trabaja duro para proporcionar servicios culturalmente apropiados y que responden a las necesidades, independientemente de la edad, identidad de género, orientación sexual, idioma, estado de discapacidad, raza u origen étnico. Para realizar un seguimiento de la eficacia de nuestros esfuerzos, por favor responda a las preguntas 1-18. Responder a las preguntas demográficas 19-30 es opcional. Todas las encuestas son confidenciales y anónimas.

1. ¿Se identifica como alguien quien esté recibiendo, o quien necesite, servicios de tratamiento de salud mental?

- ◯ Sí
- ◯ No
- ◯ No estoy seguro(a)

2. ¿Cómo calificaría la ubicación de donde proveemos nuestros servicios?

Necesita mejorar	Razonable	Bien	Muy Bien	Excelente
★	★	★	★	★

3. ¿Cómo calificaría la información disponible en folletos, o en nuestro sitio web que describe nuestros servicios?

Necesita mejorar	Razonable	Bien	Muy Bien	Excelente
★	★	★	★	★

4. ¿Cómo calificaría la duración para recibir una cita?

Necesita mejorar	Razonable	Bien	Muy Bien	Excelente
★	★	★	★	★

5. ¿Cómo calificaría los tipos de intervención en grupo o individual que son ofrecidos?

Necesita mejorar	Razonable	Bien	Muy Bien	Excelente
★	★	★	★	★

6. ¿Cómo calificaría la rigurosidad de los servicios proporcionados?

Necesita mejorar	Razonable	Bien	Muy Bien	Excelente
★	★	★	★	★

7. ¿Recomendaría nuestros servicios a gente que necesite ayuda por una preocupación relacionada a la salud mental o consumo de sustancias?

- ◯ Sí
- ◯ No
- ◯ No estoy seguro(a)

8. ¿Qué servicios o apoyos necesitan el mayor mejoramiento y qué puede hacer BHS para mejorarlos?

9. Por favor déjenos saber si piensa que los servicios del programa BHS están satisfaciendo las necesidades culturales y lingüísticas de la comunidad.

¿Las áreas de la recepción son amigables y cálidas?

Sí, mucho	Sí, un poco	No, no tanto	No sé
☆	☆	☆	☆

10. ¿Los empleados de BHS son amables y profesionales?

Sí, mucho	Sí, un poco	No, no tanto	No sé
☆	☆	☆	☆

11. ¿Los empleados de BHS son respetuosos de su patrimonio cultural?

Sí, mucho	Sí, un poco	No, no tanto	No sé
☆	☆	☆	☆

12. ¿Los empleados de BHS explican las cosas de una manera que le gusta y endiente?

Sí, mucho	Sí, un poco	No, no tanto	No sé
☆	☆	☆	☆

13. ¿Los programas de BHS son útiles para muchos tipos de gente?

Sí, mucho	Sí, un poco	No, no tanto	No sé
☆	☆	☆	☆

14. ¿Usted o algún familiar ha usado los servicios de interpretación de BHS?

- ◯ Sí
- ◯ No
- ◯ No estoy seguro(s)

15. Si ha usados los servicios de interpretación de BHS, ¿cómo describiría la calidad de los servicios de interpretación?

Necesita mejorar	Razonable	Bien	Muy bien	Excelente
★	★	★	★	★

16. ¿Cuál es el factor MÁS importante que contribuye al bienestar y recuperación?

17. ¿Cuál es el SEGUNDO factor más importante que contribuye al bienestar y recuperación?

18. ¿Cuál es el TERCER factor más importante que contribuye al bienestar y recuperación?

* 19. Por favor indique el idioma que se habla con más frecuencia en su hogar (por favor elija solo uno):

- ◯ Inglés
- ◯ Español
- ◯ Mon-Khmer, Camboyano
- ◯ Vietnamita
- ◯ Otro:
- ◯ Tagalog
- ◯ Lao, Laosiano
- ◯ Hmong-Mien
- ◯ Prefiero no decir

20. ¿Cuál es su raza?

- ◯ Afroamericano / Negro
- ◯ Hispanic or Latino
- ◯ Asiático Americano
- ◯ Nativo Americano / Primeras Naciones (incluyendo Hawaiano o Natal de Alaska)
- ◯ Otro, me identifico como
- ◯ Native Hawaiian or other Pacific Islander
- ◯ Caucásico / Blanco
- ◯ Prefiero no decir

21. ¿Actualmente está desamparado o en riesgo de estar desamparado?

- ◯ Sí
- ◯ No
- ◯ Prefiero no decir

22. ¿En los últimos tres años ha estado desamparado por más de un año o ha experimentado estar desamparado más de cuatro veces?

- ◯ Sí
- ◯ No
- ◯ Prefiero no decir

23. ¿Ha sido arrestado(a) o detenido(a) por la policía?

- ◯ Sí
- ◯ No
- ◯ Prefiero no decir

24. Por favor indique su edad:

- ◯ Menor de 18 años
- ◯ 18-25
- ◯ 26-59
- ◯ 60 o mayor
- ◯ Prefiero no deci

25. ¿Es padre o a punto de ser padre?

- ◯ Sí
- ◯ No
- ◯ No estoy seguro(a)
- ◯ Prefiero no decir

26. Por favor indique su género

- Mujer
- Hombre
- No Binario
- Transgénero
- Prefiero no decir

27. ¿Usted se identifica como alguien con una discapacidad física o del desarrollo?

- Sí
- No
- Prefiero no decir

28. Si es un adulto, ¿es un Veterano Militar Estadunidense, Naval, Marina, Fuerza Aérea o Guardacostas?

- Sí
- No
- Prefiero no decir

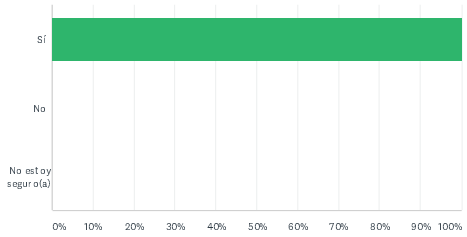
29. ¿Usted se identifica como Lesbiana, Gay, Bisexual, Transgénero, u Homosexual/Cuestionándose (LGBTQ)?

- Sí
- No
- Prefiero no decir

30. ¿Hay alguna otra cosa que quisiera compartir sobre qué se necesitaría para apoyar de mejor manera su bienestar y recuperación?

Q1 ¿Se identifica como alguien quien esté recibiendo, o quien necesite, servicios de tratamiento de salud mental?

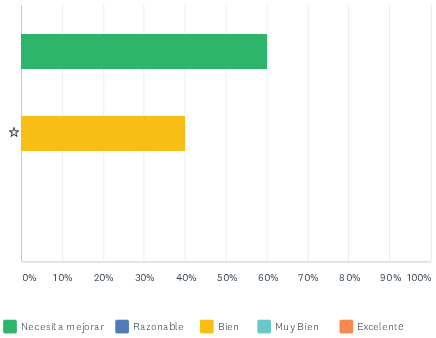
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	100.00%	5
No	0.00%	0
No estoy seguro(a)	0.00%	0
TOTAL		5

Q2 ¿Cómo calificaría la ubicación de donde proveemos nuestros servicios?

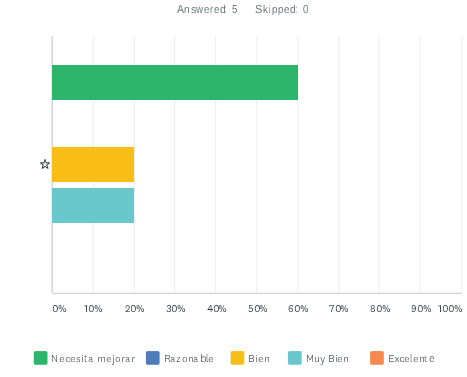
Answered: 5 Skipped: 0



	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	60.00% 3	0.00% 0	40.00% 2	0.00% 0	0.00% 0	5	1.80

Q3 ¿Cómo calificaría la información disponible en folletos, o en nuestro sitio web que describe nuestros servicios?

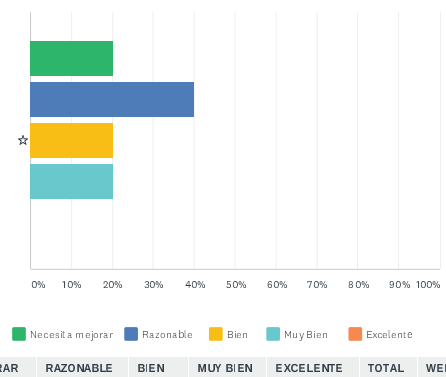
Answered: 5 Skipped: 0



	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	60.00% 3	0.00% 0	20.00% 1	20.00% 1	0.00% 0	5	2.00

Q4 ¿Cómo calificaría la duración para recibir una cita?

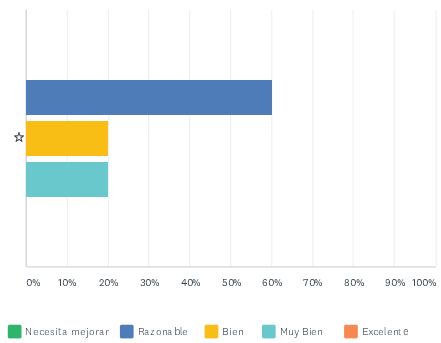
Answered: 5 Skipped: 0



	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	20.00% 1	40.00% 2	20.00% 1	20.00% 1	0.00% 0	5	2.40

Q5 ¿Cómo calificaría los tipos de intervención en grupo o individual que son ofrecidos?

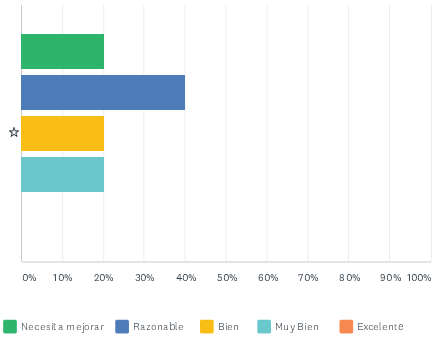
Answered: 5 Skipped: 0



	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	0.00% 0	60.00% 3	20.00% 1	20.00% 1	0.00% 0	5	2.60

Q6 ¿Cómo calificaría la rigurosidad de los servicios proporcionados?

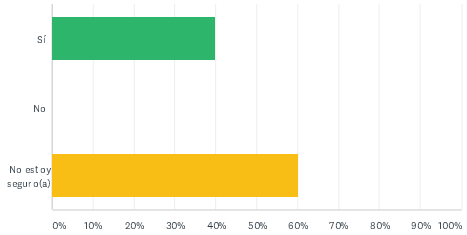
Answered: 5 Skipped: 0



	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	20.00% 1	40.00% 2	20.00% 1	20.00% 1	0.00% 0	5	2.40

Q7 ¿Recomendaría nuestros servicios a gente que necesite ayuda por una preocupación relacionada a la salud mental o consumo de sustancias?

Answered: 5 Skipped: 0



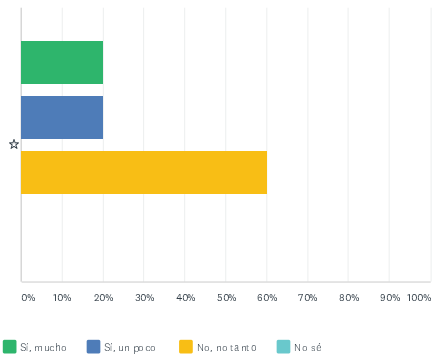
ANSWER CHOICES	RESPONSES	
Sí	40.00%	2
No	0.00%	0
No estoy seguro(a)	60.00%	3
TOTAL		5

Q8 ¿Qué servicios o apoyos necesitan el mayor mejoramiento y qué puede hacer BHS para mejorarlos?

Answered: 4 Skipped: 1

Q9 Por favor déjenos saber si piensa que los servicios del programa BHS están satisfaciendo las necesidades culturales y lingüísticas de la comunidad.¿Las áreas de la recepción son amigables y cálidas?

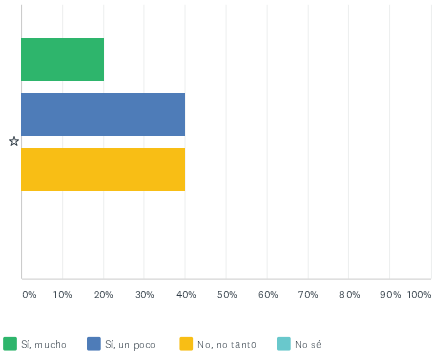
Answered: 5 Skipped: 0



	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	20.00% 1	20.00% 1	60.00% 3	0.00% 0	5	2.40

Q10 ¿Los empleados de BHS son amables y profesionales?

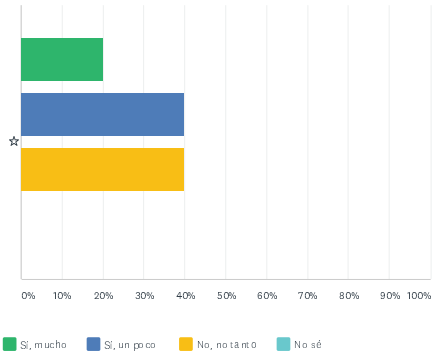
Answered: 5 Skipped: 0



	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	20.00% 1	40.00% 2	40.00% 2	0.00% 0	5	2.20

Q11 ¿Los empleados de BHS son respetuosos de su patrimonio cultural?

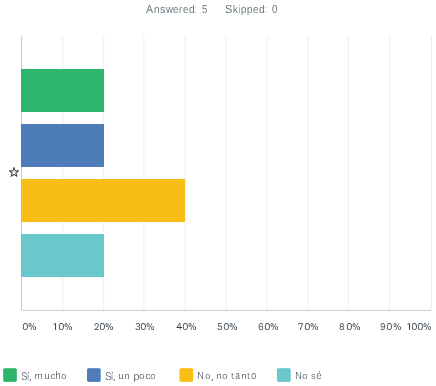
Answered: 5 Skipped: 0



	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	20.00% 1	40.00% 2	40.00% 2	0.00% 0	5	2.20

Q12 ¿Los empleados de BHS explican las cosas de una manera que le gusta y endiente?

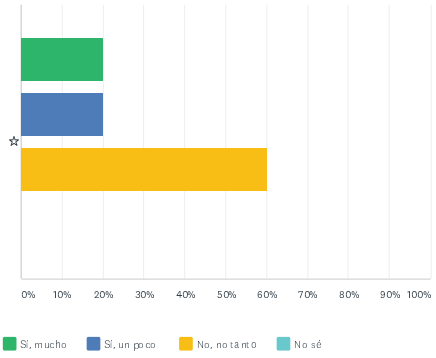
Answered: 5 Skipped: 0



	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	20.00% 1	20.00% 1	40.00% 2	20.00% 1	5	2.60

Q13 ¿Los programas de BHS son útiles para muchos tipos de gente?

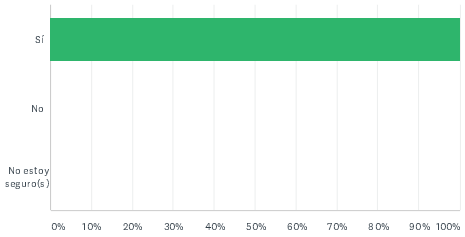
Answered: 5 Skipped: 0



	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	20.00% 1	20.00% 1	60.00% 3	0.00% 0	5	2.40

Q14 ¿Usted o algún familiar ha usado los servicios de interpretación de BHS?

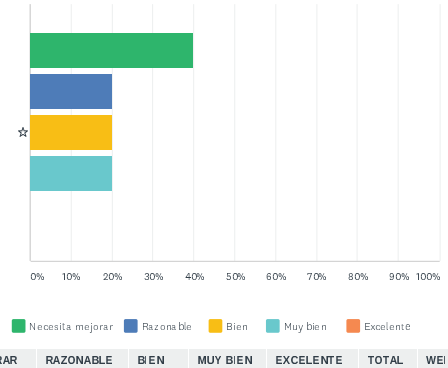
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	100.00%	5
No	0.00%	0
No estoy seguro(s)	0.00%	0
TOTAL		5

Q15 Si ha usados los servicios de interpretación de BHS, ¿cómo describiría la calidad de los servicios de interpretación?

Answered: 5 Skipped: 0



	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	40.00% 2	20.00% 1	20.00% 1	20.00% 1	0.00% 0	5	2.20

Q16 ¿Cuál es el factor MÁS importante que contribuye al bienestar y recuperación?

Answered: 5 Skipped: 0

Q17 ¿Cuál es el SEGUNDO factor más importante que contribuye al bienestar y recuperación?

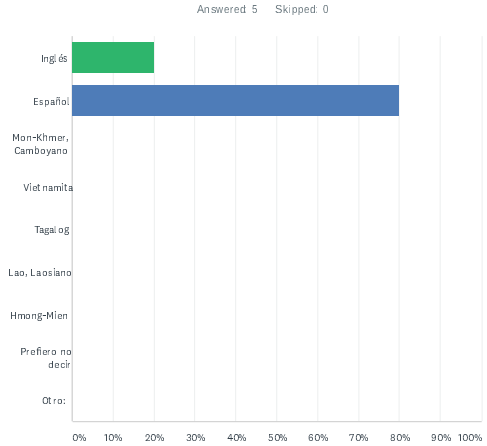
Answered: 5 Skipped: 0

Q18 ¿Cuál es el TERCER factor más importante que contribuye al bienestar y recuperación?

Answered: 5 Skipped: 0

Q19 Por favor indique el idioma que se habla con más frecuencia en su hogar (por favor elija solo uno):

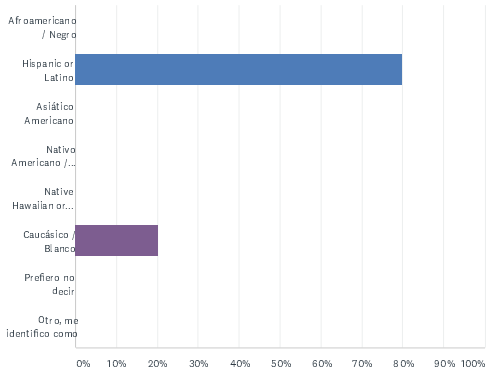
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Inglés	20.00%	1
Español	80.00%	4
Mon-Khmer, Camboyano	0.00%	0
Vietnamita	0.00%	0
Tagalog	0.00%	0
Lao, Laosiano	0.00%	0
Hmong-Mien	0.00%	0
Prefiero no decir	0.00%	0
Otro:	0.00%	0
TOTAL		5

Q20 ¿Cuál es su raza?

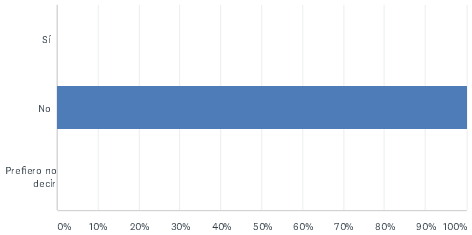
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Afroamericano / Negro	0.00%	0
Hispanic or Latino	80.00%	4
Asiático Americano	0.00%	0
Nativo Americano / Primeras Naciones (incluyendo Hawaiano o Natal de Alaska)	0.00%	0
Native Hawaiian or other Pacific Islander	0.00%	0
Caucásico / Blanco	20.00%	1
Prefiero no decir	0.00%	0
Otro, me identifico como	0.00%	0
TOTAL		5

Q21 ¿Actualmente está desamparado o en riesgo de estar desamparado?

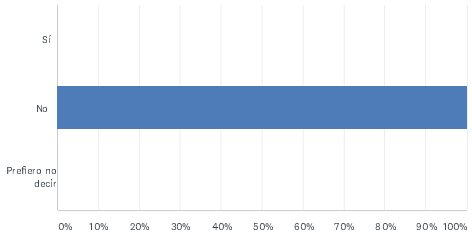
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	0.00%	0
No	100.00%	5
Prefiero no decir	0.00%	0
TOTAL		5

Q22 ¿En los últimos tres años ha estado desamparado por más de un año o ha experimentado estar desamparado más de cuatro veces?

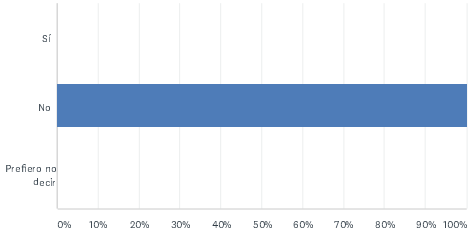
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	0.00%	0
No	100.00%	5
Prefiero no decir	0.00%	0
TOTAL		5

Q23 ¿Ha sido arrestado(a) o detenido(a) por la policía?

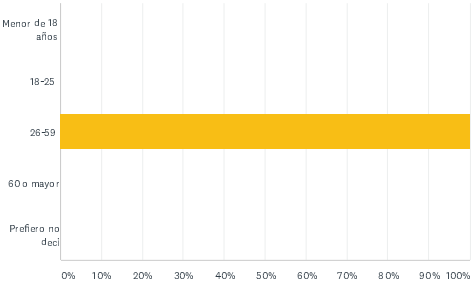
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	0.00%	0
No	100.00%	5
Prefiero no decir	0.00%	0
TOTAL		5

Q24 Por favor indique su edad:

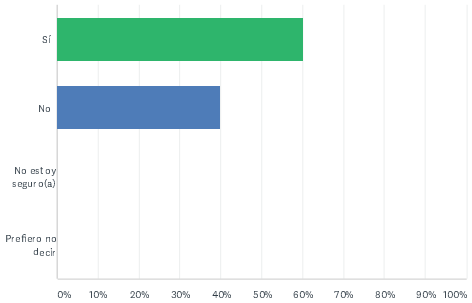
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Menor de 18 años	0.00%	0
18-25	0.00%	0
26-59	100.00%	5
60 o mayor	0.00%	0
Prefiero no deci	0.00%	0
TOTAL		5

Q25 ¿Es padre o a punto de ser padre?

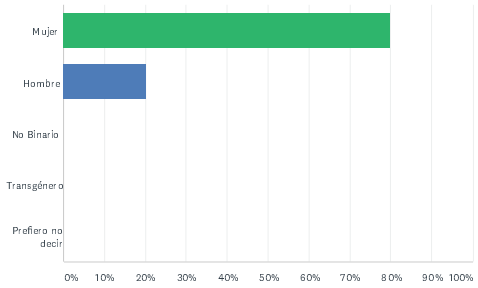
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	60.00%	3
No	40.00%	2
No estoy seguro(a)	0.00%	0
Prefiero no decir	0.00%	0
TOTAL		5

Q26 Por favor indique su género

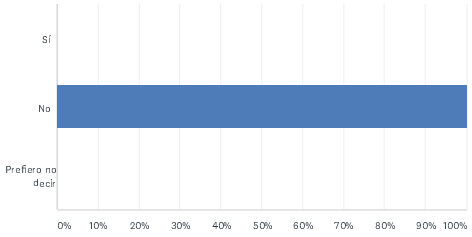
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Mujer	80.00%	4
Hombre	20.00%	1
No Binario	0.00%	0
Transgénero	0.00%	0
Prefiero no decir	0.00%	0
TOTAL		5

Q27 ¿Usted se identifica como alguien con una discapacidad física o del desarrollo?

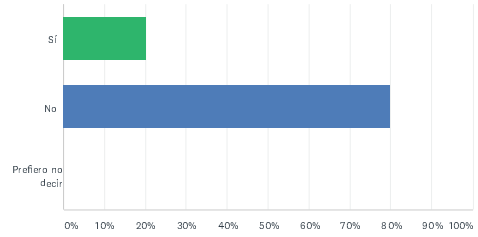
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	0.00%	0
No	100.00%	5
Prefiero no decir	0.00%	0
TOTAL		5

Q28 Si es un adulto, ¿es un Veterano Militar Estadunidense, Naval, Marina, Fuerza Aérea o Guardacostas?

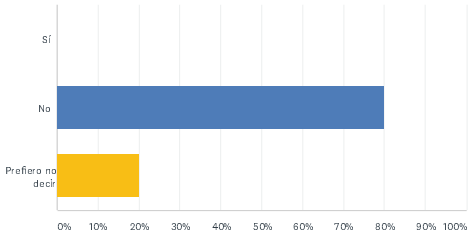
Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	20.00%	1
No	80.00%	4
Prefiero no decir	0.00%	0
TOTAL		5

Q29 ¿Usted se identifica como Lesbiana, Gay, Bisexual, Transgénero, u Homosexual/Cuestionándose (LGBTQ)?

Answered: 5 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	0.00%	0
No	80.00%	4
Prefiero no decir	20.00%	1
TOTAL		5

Q30 ¿Hay alguna otra cosa que quisiera compartir sobre qué se necesitaría para apoyar de mejor manera su bienestar y recuperación?

Answered: 4 Skipped: 1

SAN JOAQUIN COUNTY

Greatness grows here.

Public Hearing

Mental Health Services Act Program Expenditure Plan

2021-22 MHSA Annual Update to the 2020-23 Three Year Plan

Posted for Public Review May 17, 2021

Preface Statement

The 2021-22 Annual Update to the 2020-23 Three-Year Mental Health Services Act (MHSA) Plan, developed by San Joaquin County Behavioral Health Services (BHS) in Spring 2021, presents a continuation of most MHSA projects included in the 2020-23 with other program edits being kept to a minimum. The Plan is intended to take a conservative approach to programming and limits changes from the prior year's Plan due to the uncertainty of the economy in the midst of the COVID-19 crisis.

BHS conducted a community planning effort that encompassed community participation, identification of some gaps in services and many valuable ideas for new projects. Page 8 of the Plan provides more information about the process and outcomes. BHS thanks everyone that participated in the community planning process and thanks them for their commitment to improving and enhancing mental health services in our County.

Preface Statement

Local MHSA revenues are based upon personal income tax receipts collected by the State. The current COVID-19 pandemic has impacted many aspects of this nation, particularly the economy. However, it is too early in the current situation to quantify how significantly MHSA funding will be impacted. In an effort to responsibly and cautiously move forward with budgetary planning, BHS has recommended the outlined approach included in this Plan due to the revenue uncertainty in the coming fiscal years. Once MHSA revenue impacts can be identified, BHS may elect to revise this plan and the projects included in it.

Mental Health Services Act (MHSA)

Purpose of Funding

- Expand and enhance mental health services for individuals with serious mental illness.
- Provide prevention and early intervention services for those at risk of developing a mental illness.
- Promote innovative solutions that will advance the field of mental health.
- Strengthen the personnel, technology, and facilities through which services are offered.

MHSA Programming in San Joaquin County

Program Areas

- **Community Services and Supports (CSS)**
- **Prevention and Early Intervention (PEI)**
- **Innovative Programs (INN)**
- **Workforce Education and Training (WET)**
- **Capital Facilities and Technology Needs (CFTN)**

Community Services & Supports

- **Full Service Partnership Programs**
- **Outreach and Engagement**
- **System Development**

Prevention and Early Interventions

- **Prevention**
  - Children, Youth, and Families
- **Early Intervention**
  - Children and Youth
  - Adults and Older Adults
- **Reducing Stigma & Discrimination**
- **Increasing Recognition of Mental Illnesses**
- **Suicide Prevention**
  - Schools
  - Community-wide

Planning Methodology

- **Public Meetings** (Jan 2021)
- **Behavioral Health Board** (Jan-Feb 2021)
- **Consumer Discussion Groups** (Jan 2021)
- **MHSA Consortium Meeting** (Feb 2021)
- **Consumer Online Surveys** (March 2021)
  - 117 Respondents

Community Program Planning

Purpose: *To assess the mental health needs of the entire community, including those that are currently served, and those that are unserved, underserved, or inappropriately served.*

Feedback Requested:

1) What is working?
2) What needs improvement?
3) Identify key needs and concerns by age groups.
4) Prioritize needs or concerns.

Definitions:

Gap or Need – Services do not exist, or does not exist for a specific population.

Issue or Concern – Services exist, but there is an issue or concern to be addressed.

Stakeholder Participants

- **Consumer Advocates**
- **Substance use disorder treatment providers**
- **Community-based organizations**
- **Children and Family Services**
- **Law Enforcement**
- **Veterans Services**
- **Senior Services**
- **Housing Providers**
- **Healthcare Providers**
- **County Mental Health Staff**
- **Consumers and Family Members**

Next Steps

- **Complete minor staff edits**
  - Typos, formatting etc.
- **Incorporate feedback from 30-day Public Review and the Public Hearing**
- **Submit to Board of Supervisors for Review**
  - July 13, 2021 (*Anticipated)*

Questions / Comments

Audience comments will be documented by staff and included in the summary of these proceedings.

Audience members are also invited to write down and submit any feedback or comments.

- Please submit to Isabel Espinosa at the end of this meeting

THANK YOU!

Send Further Comments to:

mhsacomments@sjcbhs.org