San Joaquin County
Behavioral Health Services

Mental Health Services Act (MHSA)

Annual Update to the 2020-23
Three-Year Program and Expenditure Plan
FY 2022-23

Approved by:

San Joaquin County Board of Supervisors

June 21, 2022

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 / City Financial Officer**	
Name:	Tony Vartan	Name:	Jeffery Woltkamp
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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, _____ 6/1/2022
Mental Health Director Signature Date

I hereby certify that for the fiscal year ended June 30,2021 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, 2021. I further certify that for the fiscal year ended June 30, 2021, 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, _____ 6/1/22
County Auditor Controller Signature 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
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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 __6/21/22_____ .

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

6/1/2022
Date

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 _____.

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 2020 – June 2021):

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 2021 Introduction to MHSA Community Planning
    - MHSA Presentations and Updates on Community Convenings in January, February, April, May 2022 MHSA Community Planning Meetings and Public Hearing

5. Public Forums (Via Zoom Conference Call)
    - January 5, 2022 - BHS Consortium of Mental Health Providers
    - January 19, 2022 - BHS Behavioral Health Board
    - January 22, 2022 – General Town Hall Community Planning Session
    - January 26, 2022 – Co-hosted by El Concilio -Spanish
    - January 27, 2022 - General Town Hall Community Planning Session

Targeted Discussions:

6. Consumer Focus Groups (Via Zoom Conference Call)
    - January 6, 2022 - Co-hosted by the Wellness Center
    - January 13, 2022 - Co-hosted by the Martin Gipson Socialization Center

Consumer and Stakeholder Surveys:

7. 2021-22 MHSA Consumer and Stakeholder Surveys

Assessment of Mental Health Needs

County Demographics and County's Underserved/Unserved Populations

San Joaquin County, located in California's Central Valley, is a vibrant community with just over 775,000 individuals, with a diverse population. English is spoken by more than half of all residents, though nearly 180,000 residents are estimated to speak Spanish as their first language. Tagalog, Chinese, Khmer, and Vietnamese are also spoken by large components of the population. 41% of the county population is predominantly centrally situated in Stockton, the largest city in the county. Cities like Lodi, Tracy, and Manteca make up an additional 32% of the county population, while the remaining smaller cities of Ripon, Lathrop, and Escalon make up 7% of the county population. Unincorporated areas of San Joaquin County make up 20% of the remaining balance. San Joaquin County's gender ratio is 99 men to 100 women (99:100) or .99, equal to the California State average of 99:100.

San Joaquin County age distribution shows that the 20-54 age group makes up the largest percentage in the county with the 0-19 age group following behind.

Age Distribution	Percent of Population
0-19	30.6%
20-54	46.6%
55-64	11
65 and over	11.9%

*Source: San Joaquin Council of Governments

San Joaquin County stakeholders have identified underserved/unserved populations as individuals that are historically part of a vulnerable racial, ethnic and/or cultural group. In addition, underserved/unserved populations also include immigrants, refugees, uninsured adults, LGBTQIA+ individuals, Limited English Proficient individuals, and rural residents of north and south county.

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 2020-21 demonstrates the program participation compared to the county population.

Mental Health Services Provided in 2020-21

Services Provided by Age	Number of Clients*	Percent of Clients
Children	2,603	15%
Transitional Age Youth	2,970	17%
Adults	9,793	56%
Older Adults	2,000	12%
Total	**17,366**	**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	258,051	33%	5,917	34%
Latino	316,124	41%	4,793	28%
African American	57,495	7%	2,885	17%
Asian	109,599	14%	1,393	8%
Multi-Race/Other	26,605	4%	1,825	10%
Native American	3,646	.5%	478	3%
Pacific Islander	3,830	.5%	75	0.4%
Total	**775,350**	**100%**	**17,366**	**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). 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 6%.

Services Provided by City	County Population by City**	Percent of County Population	Clients Served*	Percent of Clients
Stockton	319,188	41%	11,386	66%
Lodi	68,751	9%	1,457	8%
Tracy	98,601	12%	1,167	7%
Manteca	87,319	11%	1,287	7%
Lathrop	28,503	4%	324	2%
Ripon	16,292	2%	137	1%
Escalon	7,501	1%	112	1%
Balance of County	155,691	20%	1,449	8%
Total	**783,534**	**100%**	**17,366**	**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.

Stakeholder Involvement:

BHS recognizes the meaningful relationship and involvement of stakeholders in the MHSA process and related behavioral health system. A partnership with constituents and stakeholders is achieved through various committees throughout the BHS system to enhance mental health policy, programming planning and implementation, monitoring, quality improvement, evaluation, and budget allocations. Stakeholders are involved in committees and boards such as: Behavioral Health Board, MHSA Consortium, Quality Assessment & Performance Improvement (QAPI) Council (including Grievance Subcommittee and QAPI Chairs), Consumer Advisory Committee, Cultural Competency Committee and SUD Monthly Providers Committee.

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 2021-22:

Behavioral Health Board Agenda Items

At the December 2021 Behavioral Health Board meeting, the MHSA Coordinator announced that the MHSA Plan's community program planning process would begin in January 2022. He shared the methodology and timeline for the annual planning process, which informed the Plan's 2022-23 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 seven community discussion groups convened in January 2022, two of which specifically targeted adult consumers and family members. 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 a training and overview of the MHSA, a summary of its five components, and the intent and purpose of the different components including:

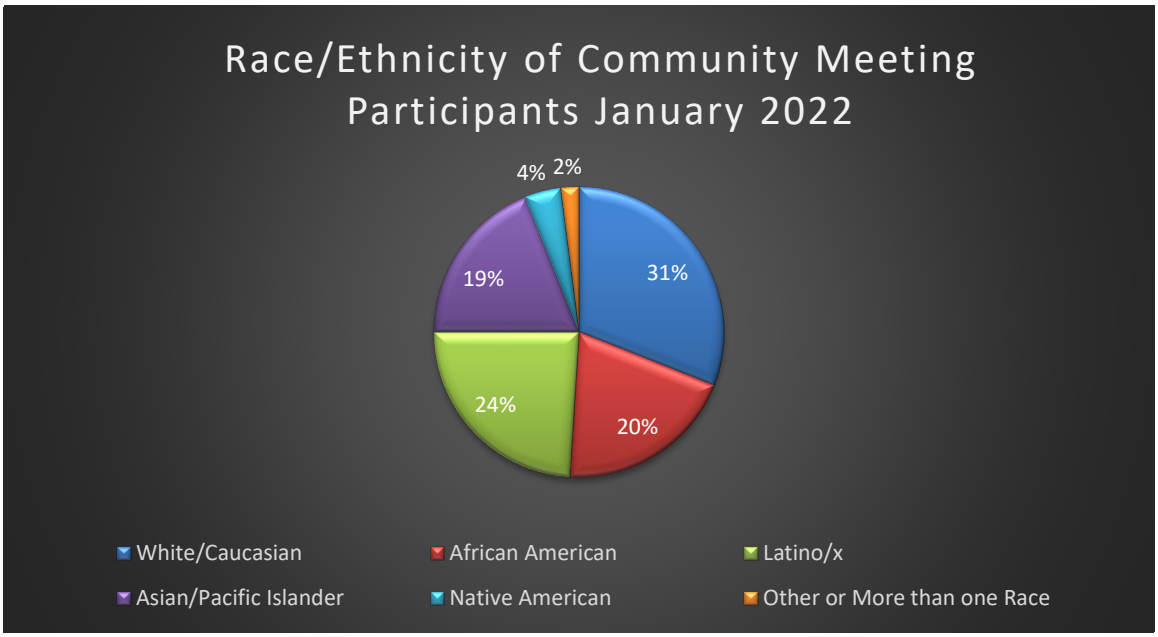
- Funding priorities
- Populations of need
- Regulations guiding the use of MHSA funding

Stakeholder participation was tracked through 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 117 individuals, 71% 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, 22% 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:

- Consumer Advocates/Family Members
- Substance use disorder treatment providers
- Community-based organizations
- Children and family services
- Law Enforcement
- Veteran's 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 Latino/x participants were underrepresented.



Survey Input and Stakeholder Feedback

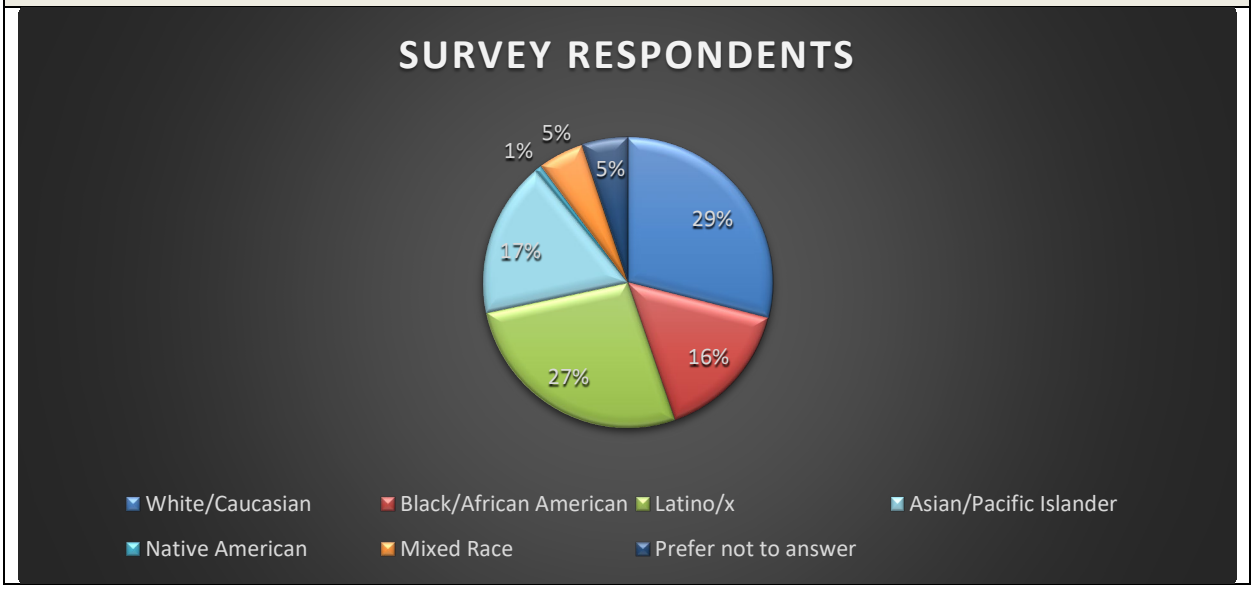
In late February of 2022, BHS distributed electronic and paper surveys to consumers, family members, and stakeholders to learn more about the perspectives, needs, and lives of clients served through mental health programs. Surveys were completed online and in person with multiple-choice answers and responses were tallied through Survey Monkey reports. There were 423 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 85% of respondents reporting that they would recommend BHS services to others. According to respondents, BHS Informational materials such as flyers, brochures and website need to be updated. A large majority of respondents reported that the BHS Lobby and reception areas are friendly and welcoming from a cultural and linguistic perspective. 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.

Survey respondents were diverse and identified as: White/Caucasian (29%), Latino/x (27%), African American (16%), Asian/Pacific Islander (17%), Native American (1%), and Mixed Race 5%

Self-Reported Race and Ethnicity of Stakeholder Respondents
MHSA 2021-22 Consumer and Stakeholder Surveys



Self-Reported Age/Gender of Stakeholder Respondents

Age Range	Percent
Under 18	13%
18-25	10%
26-59	63%
60 and over	11%
Prefer not to say	3%

Gender	Percent
Male	40%
Female	55%
Transgender	1%
Non-Binary	1%
Prefer not to say	2%

The 423 respondents surveyed represent the broad diversity of stakeholders in the community and consumers served by BHS. 72% of respondents identify as someone who is receiving, or who needs, mental health treatment services. Less than half of respondents have children, with 49% describing themselves as parents. Consistent with the general population, 9% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQ). Nearly a third of respondents identified with having a physical or developmental disability. Few are military veterans, with 7% reporting that they have served in the US Armed Forces. 17% of consumers reported experiencing homelessness more than four times or being homeless for at least a year; and 32% 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 prevention and earlier interventions, and education for children and families.

- Greater focus on 0-5 Population with focus on prevention.
- Need program to work with LGBTQ children and youth
- Needs to address generational and cultural gap between parents and children around mental health diagnosis.
- 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 Prevention within PEI programs for Children and Youth.
- Provide Youth Mental Health First Aid Training for the community and schools.
- Provide Family Services for African American, Asian/Pacific Islander and Latino Community to educate parents on signs and symptoms of mental illness and stigma reduction with an emphasis on cultural consideration
- Explore programming at local Community Centers with focus on Mental Wellness for children and families

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 ensure that TAY programming includes enhancing life skills and suicide prevention education.
- TAY Workforce development and training opportunities, specifically for Peer Support Specialist within the TAY Community.
- TAY focused temporary crisis housing and permanent housing to prevent homelessness

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.
- Develop programming with Community Based Organizations to enhance Access and linkage efforts with focus on vulnerable communities that represent the TAY Population.
- Explore a TAY Skill building program to enhance social skills, coping skills and development of self-advocacy, resiliency, hope, and empowerment.
- Expand existing Mentoring for Transitional Aged Youth program with focus on trauma informed care practice and exploring the use of culturally rooted healing practices for 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, trauma services for the African American community, and lack of services for rural areas of north and south San Joaquin County.

- Individuals with mental illnesses, and co-occurring disorders that are homeless lack wrap around services and specialized housing case management.
- Housing options continue to be scarce for adults. Homeless individuals need more outreach/engagement and clear pathway to housing options with intensive treatment for MH and SUD Challenges.
- MH and SUD Services in rural parts of north and south San Joaquin County (Linden, Escalon, Ripon, Woodbridge, Lockeford) are lacking.
- Need for Outreach and Engagement programming for African American, Asian/Pacific Islander, and Latino Communities, specifically Mental Health First Aid (MHFA) Training and Stigma Reduction for faith-based organizations and leaders in communities of color.

Recommendations to Strengthen Services for Adults

- BHS should continue to strengthen the housing continuum for people with serious mental illnesses.
- BHS should explore avenues in programming to incorporate non-traditional forms of healing and culturally rooted community defined practices.
- 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 and provide MHFA training to the community.
- BHS should explore expansion of Wellness Centers to provide peer support services in rural areas of the County.
- Expand Trauma Services for Adults to the African American Community
- Explore strengthening vocational training as part of an individual's long term recovery success, enhance job skills and job placement in existing employment programming.

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 are included in those that are homeless and living alone.

Recommendations to Strengthen Services for Older Adults:

- BHS Older Adult Services should provide meaningful alternatives such as a “day program” for daily living that combats depression and isolation including more socialization activities and more activities that prevent memory deterioration or loss of cognitive functioning.
- Explore a PEI program specific to Older Adults to 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 support services program 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.
- Broaden suicide prevention efforts to target the older 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.

Before the Board of Supervisors

County of San Joaquin, State of California

B-22-330

APPROVAL OF THE 2022-2023 ANNUAL UPDATE TO THE 2020-2023 MENTAL HEALTH SERVICES ACT THREE YEAR PROGRAM AND EXPENDITURE PLAN, FOR AN AMOUNT OF $107,304,308, AND RELATED BUDGET ADJUSTMENT (4/5THS VOTE REQUIRED)

THIS BOARD OF SUPERVISORS DOES HEREBY:

1. Approve the 2022-2023 Annual Update to the 2020-2023 Mental Health Services Act Three Year Program and Expenditure Plan, for the period of July 1, 2022 to June 30, 2023, for an amount of $107,304,308; and
2. Approve an increase in appropriations and estimated revenues of $17,353,882 to the 2022-2023 Mental Health Services budget #4040500000 (4/5ths vote required).

I HEREBY CERTIFY that the above order was passed and adopted on June 21, 2022 by the following vote of the Board of Supervisors, to wit:

MOTION: Rickman/Miller/5

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

NOES: **None**

ABSENT: **None**

ABSTAIN: **None**

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

By: Rachél DeBord

III. Public Review of 2022-23 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 April 18, 2022 until May 18, 2022.

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 May 18, 2022, in conjunction with a regularly scheduled Behavioral Health Board Meeting

Public Hearing began with a brief presentation of the Annual Update, its purpose and the community planning process used to inform the Annual Update. The presentation also included highlights of significant changes (new and expanded programming) created through the plan. The presentation concluded with the timeline for the next community program planning process for the upcoming Three Year Program and Expenditure Plan.

A copy of the public presentation is included in the Appendix.

The San Joaquin County Board of Supervisors accepted the 2022-23 MHSA Three Year Program and Expenditure Plan on____6/21/22_____.

Public Comments:

Overall, there was strong support at the public hearing for the new and expanded programming and additional updates in this Annual Update. Comments included the following suggestions and observations:

- Appreciation for new programming for prevention services for 0-5 aged Children and Youth (PEI project number two: Comment – There has been a gap in the 0-5 prevention services
- Comment: Wanted to make a statement that we need to be resilient with the funding, looming recession.
- Question: Age 0-5 and 0-13 increase in requests for services will we be able to staff their new programs during this shortage? Response: We have a few contractors that we work with that have expressed interest in providing these types of services, this new program will be put out for RFP. The PEI Program School Based Interventions is currently working with children 5-13.
- Question: Do you have the names of the agencies? Delta College has some services for these age groups. Response: This will be an RFP process, once the plan is approved, we will put out bids for this project, not a sole source.

Comments and feedback shared during the 30-day public comment period are an important part of the community planning process. Planning is ongoing and many of the comments received during this period will be incorporated into ongoing implementation activities and will help guide future planning efforts. Changes made to the Annual Update during the 30-day Public Review period and reflected in the Final Draft of the May 27, 2022, include:

- Minor edits to address typos, formatting, pagination, etc.
- Minor wordsmithing to clarify intent
- Feedback received regarding data on page 10, corrected data to reflect date range for clients served
- Feedback received regarding need for services for youth under 13, specifically those that identify in the LGBTQ community. Added to the Key Issues for Children and Youth section on page 14
- A budget adjustment to CFTN Project 4 for increased contract cost for Electronic Health Records project in partnership with CalMHSA.

IV. MHSA Component Funding for FY 2022-23

MHSA Component Worksheets describe the total planned expenditures for Fiscal Years 2022-23

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 2022/23 Mental Health Services Act Annual Update
Funding Summary

County: San Joaquin County

Date: 4/1/2022

	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 2022/23 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	33,275,942	11,883,806	6,941,951	1,150,291	17,065,434	
2. Estimated New FY 2022/23 Funding	43,355,000	10,839,800	2,852,300			
3. Transfer in FY 2022/23	(4,047,638)			500,000	3,547,638	0
4. Access Local Prudent Reserve in FY 2022/23						
5. Estimated Available Funding for FY 2022/23	72,583,304	22,723,606	9,794,251	1,650,291	20,613,072	
B. Estimated FY 2022/23 MHSA Expenditures	71,576,386	17,662,878	6,236,472	577,953	11,250,619	
G. Estimated FY 2022/23 Unspent Fund Balance	1,006,918	5,060,728	3,557,779	1,072,338	9,362,453	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2021	6,939,866
2. Contributions to the Local Prudent Reserve in FY 2021/22	0
3. Distributions from the Local Prudent Reserve in FY 2021/22	0
4. Estimated Local Prudent Reserve Balance on June 30, 2022	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 2022/23 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: San Joaquin Date: 4/1/2022

	Fiscal Year 2022/23					
	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	10,832,452	7,499,028	3,316,974			16,450
2. Transitional Age Youth FSP	1,294,527	959,501	320,426			14,600
3. Adult FSP	11,381,973	6,930,924	4,211,399			239,650
4. Older Adult FSP	1,830,680	1,475,155	333,375			22,150
5. Community Corrections FSP	2,187,632	1,894,461	263,231			29,940
6. InSPIRE FSP	800,327	690,539	105,588			4,200
7. Intensive Adult FSP	2,550,000	1,953,752	589,248			7,000
8. Intensive Justice Response FSP	2,440,000	1,339,672	1,024,328			76,000
9. Housing Empowerment Services FSP	2,109,038	2,109,038				
10. High-Risk Transition Team	741,600	741,600				
11. Adult Residential Treatment Services	4,700,000	4,700,000				
Non-FSP Programs						
12. Mental Health Outreach and Engagement	639,007	639,007				
13. Mobile Crisis Support Team	1,630,563	1,226,437	60,000			344,126
14. Peer Navigation	300,000	300,000				
15. Wellness Center	1,053,667	1,053,667				
16. Project Based Housing	15,500,000	15,500,000				
17. Employment Recovery Services	377,012	377,012				
18. Community Behavioral intervention Services	900,000	666,462	216,438			17,100
19. Housing Coordination Services	6,170,127	6,032,770	128,757			8,600
20. Crisis Services Expansion	8,281,716	5,530,257	2,555,909			195,550
21. System Development Expansion	3,450,160	3,450,160	0			
CSS Administration	6,506,944	6,506,944				
Total CSS Program Estimated Expenditures	85,677,425	71,576,386	13,125,673	0	0	975,366
FSP Programs as Percent of Total	51.1%					

FY 2022/23 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: San Joaquin Date: 4/1/2022

	Fiscal Year 2022/23					
	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	926,502	926,502				
2. Prevention for Children 0-5	1,200,000	1,200,000				
3. Mentoring for Transitional Age Youth	806,467	806,467				
4. Coping and Resiliency Education Services	1,322,547	1,322,547				
5. School-Based Prevention Services	2,578,235	2,578,235				
Early Intervention Programs for Children and Youth						
6. Early Interventions to Treat Psychosis	1,532,989	934,609	566,780			31,600
Early intervention Programs for Adults and Older Adults						
7. Community Trauma Services for Adults	2,700,000	2,700,000				
8. Recovery Services for Nonviolent Offenders	528,981	528,981				
Access and Linkage to Treatment Program						
9. Whole Person Care	922,525	922,525				
Outreach for Increasing Recognition of the Early Signs of Mental Illness						
10. Increasing Recognition of Mental Illnesses	42,616	42,616				
Stigma and Discrimination Reduction Program						
11. Information and Education Campaign	1,756,521	1,756,521				
Suicide Prevention Program						
12. Suicide Prevention with Schools	800,000	800,000				
13. Suicide Prevention and Education in the Community	633,696	633,696				
PEI Administration	2,362,662	2,272,905	85,017			4,740
PEI Assigned Funds						
Funds assigned to CalMHSA	237,274	237,274				
Total PEI Program Estimated Expenditures	18,351,015	17,662,878	651,797	0	0	36,340

FY 2022/23 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: San Joaquin Date: 4/1/2022

	Fiscal Year 2022/23					
	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	1,830,759	1,830,759				
2. Progressive Housing	915,380	915,380				
3. Home to Stay and Future INN Projects	2,923,381	2,923,381				
	0					
	0					
	0					
INN Administration	566,952	566,952				
Total INN Program Estimated Expenditures	6,236,472	6,236,472	0	0	0	0

FY 2022/23 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: San Joaquin Date: 4/1/2022

	Fiscal Year 2022/23					
	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	266,811	266,811				
2. Internship and Financial Assistance	258,601	258,601				
	0					
	0					
	0					
WET Administration	52,541	52,541				
Total WET Program Estimated Expenditures	577,953	577,953	0	0	0	0

FY 2022/23 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: San Joaquin Date: 4/1/2022

	Fiscal Year 2022/23					
	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	10,700,000	5,269,814				5,430,186
2. Facility Renovations	0					
3. Facility Repair and Upgrades	2,800,000	2,800,000				
	0					
CFTN Programs - Technological Needs Projects						
4. Technology Equipment and Software	1,713,333	1,713,333				
	0					
CFTN Administration	1,467,472	1,467,472				
Total CFTN Program Estimated Expenditures	16,680,805	11,250,619	0	0	0	0

V. 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) Dynamic Problem List (formally* Client Treatment Plan): For youth in treatment in a FSP, a dynamic problem list 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 client's 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

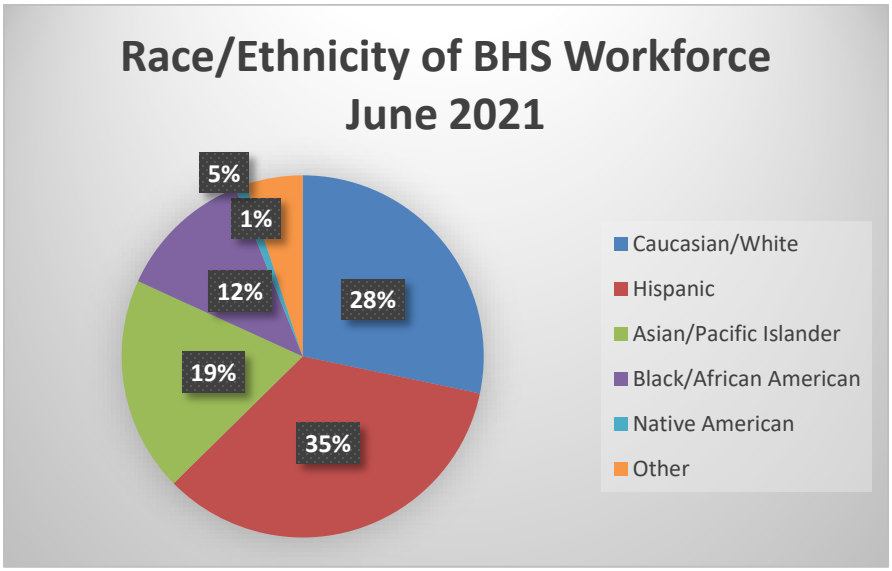
General System Development

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 17,000 individuals with serious mental illness (a 17:1 ratio of clients to partners and staff). BHS employs the largest proportion of the workforce (N=737) or 74% 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 34% of the workforce, compared to 41% 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 1,900 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 20-21
Full Service Partnership Programs	
1. Children and Youth FSP (5 Teams)	792
2. Transitional Age Youth (TAY) FSP (1 Team)	62
3. Adult FSP (7 Teams)	547
4. Older Adult FSP (1 Team)	62
5. Community Corrections FSP (1 Team)	234
6. InSPIRE FSP (1 Team)	23
7. Intensive Adult FSP (2 Teams)	117
8. Intensive Justice Response FSP (2 Teams)	113
9. High Risk Transition Team FSP (1 Team; Services began in Spring 2021)	15
TOTAL CLIENTS ENROLLED IN FSP PROGRAMS	**1,965**

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.

Documentation of Achievement in performance outcomes:

The number of youth served by BHS in an FSP program have increased by 200% since Fiscal Year 2018/2019. We are showing a steady increase in the number of youth being served in FSP's from 19% in March of 2021 to 21% in February of 2022. We provide Intensive Home Based Services (IHBS) in our FSP programs and we have seen a 231% increase in the number of youth who have received IHBS from Fiscal Year 2018/2019 to the current year. The number of foster youth served in FSP's has also increased. There has been a 67% increase since Fiscal Year 2018/2019 to the current year. This data demonstrates that SJC BHS is providing intensive services to youth who need it.

Challenges or barriers:

One challenge experienced in the CYS FSP is high staff turnover rates including the manager of the program. One of the CYS FSP programs had three different managers in a span of one year. The Board of Supervisors recently approved a raise for employees that will help with retention. Exit Interviews have been implemented to help the department head find ways to encourage staff retention. In addition, the team has experienced staff shortages due to medical and educational leaves. Cross training staff in other programs has been implemented so program coverage can be in place when leaves of absences are needed. Another challenge is staff misunderstanding of the FSP program which results in inappropriate referrals. A project improvement plan (PIP) has begun that focuses on the CYS FSP. This PIP is in progress now.

CSS Funding: $7,499,028

Clients Served within the Children and Youth FSP Program

Client Demographics

Children and Youth FSP Program 2020-2021 N=792		
	Number	**Percent**
Total by Age Group Served		
▪ Children and Youth	519	66%
▪ Transitional Age Youth	273	34%
Gender Identity		
▪ Female	417	53%
▪ Male	375	47%
Race/Ethnicity		
▪ African American	161	20%
▪ Asian / Pacific Islander	11	1%
▪ Hispanic/Latino	179	23%
▪ Native American	2	0 %
▪ White/Caucasian	156	20%
▪ Other / Not-Identified	284	36%
Linguistic Group		
▪ English	756	95%
▪ Spanish	10	1%
▪ Asian/Pacific Islander	3	1%
▪ Arabic or Farsi	0	0%
▪ Other non-English	23	3%

Cost per Client

Number Served	**Total Expenditures**
792	$6,781,780
Average Annual Cost	**Average Monthly Cost**
$7,139	$595

Client Projections

Clients Served/Projected				
2020-21	**2021-22**	**2022-23**	**2023-24**	**Age Group**
792	1020	1090	1200	Combined
519	673	719	792	Children & Youth
273	347	371	408	TAY

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.

Documentation of Achievement in performance outcomes:

TAY FSP program currently serves 53 clients. The team has also served 37 TAY FSP clients under 21 during this time. We also assessed and served 15 presumptive transfers and 9 Pathways to Well-being clients. TAY FSP began to link TAY clients after their release from the hospital during the Post PHF Clinic to TAY and TBS services. Linking clients at Post Hospitalization will assist in lowering rehospitalizations and increasing client follow up with beginning outpatient services.

Challenges or barriers:

One challenge for the TAY FSP Team was staff vacancies in the program as well as staff on medical leave. We also had a change of leadership in the program including the manager position. In addition, due to COVID there were more staff absences. To mitigate some of these challenges, recently, the board of supervisors approved a salary raise to employees that will help with retention.

Project Components:

There is one FSP team working with Transitional Age Youth.

CSS Funding: $959,501

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

Client Demographics

Transitional Age Youth FSP Program 2020-2021 N=62		
	Number	**Percent**
Total by Age Group Served		
▪ Adult	16	26%
▪ Transitional Age Youth	46	74%
Gender Identity		
▪ Female	26	42%
▪ Male	36	58%
Race/Ethnicity		
▪ African American	16	26%
▪ Asian / Pacific Islander	3	5%
▪ Hispanic/Latino	24	39%
▪ Other	5	8%
▪ White/Caucasian	14	22%
Linguistic Group		
▪ English	70	87%
▪ Spanish	4	6%
▪ Other, Asian		%
▪ Arabic or Farsi	0	0%
▪ Other non-English	4	6%

Cost per Client

Number Served	**Total Expenditures**
62	$568,031
Average Annual Cost	**Average Monthly Cost**
$9,162	$763

Client Projections

Clients Served/Projected				
2020-21	**2021-22**	**2022-23**	**2023-24**	**Age Group**
62	82	102	122	Combined
16	21	27	32	Adult
46	61	75	90	TAY

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
   Southeast 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.

Documentation of Achievement in performance outcomes:

Since fiscal year 18/19, Adults served by FSP has increased by 1%.
Our current clinical project improvement plan (PIP) began in fiscal year 20/21 and has been focused on services provided after crisis and hospitalization to prevent re-hospitalization. In fiscal year 18/19, 17% of clients were re-hospitalized in 30 days. Fiscal year 20/21 that has reduced to 13%.

Challenges or barriers:

High staff turnover rates and continued staff vacancies. Staff vacancies have included Managers, Clinicians, Case Managers and Peer Support staff. The Board of Supervisors recently approved a raise for employees that will help with retention. COVID 19 pandemic also posed barriers in terms of staff being out for illness or caring for family members resulting in staff absences at various times. Modifying service delivery to include safety precautions for COVID 19 created some challenges for clients to access care as well as for staff providing services. Another challenge has been program staff misinterpretation of the FSP program, which resulted in inappropriate referrals as well as utilizing appropriate treatment modalities to engage clients into treatment. There has been ongoing training with staff on FSP guidelines and treatment interventions to best assist our population. Ongoing interviews are being conducted to fill positions in the program. Adult system of Care has also initiated cross-trainings among its diverse staff to minimize shocks to the systems that results in shortages, and these has gone a long way to maintain the level of services required by clients.

CSS Funding: $6,930,924

Clients Served within the Adult FSP Program

Client Demographics

Adult FSP Program 2020-2021 N=547		
	Number	**Percent**
Total by Age Group Served		
▪ Transitional Age Youth	29	6%
▪ Adults	462	84%
▪ Older Adults	55	10%
Gender Identity		
▪ Female	239	44%
▪ Male	308	56%
Race/Ethnicity		
▪ African American	127	23%
▪ Asian / Pacific Islander	59	11%
▪ Hispanic/Latino	91	17%
▪ Native American	32	6%
▪ White/Caucasian	215	39%
▪ Other / Not-Identified	20	4%
Linguistic Group		
▪ English	465	85%
▪ Spanish	29	5%
▪ Asian/Pacific Islander	14	3%
▪ Arabic or Farsi	0	0%
▪ Other non-English	38	7%

Cost per Client

Number Served	**Total Expenditures**
547	$4,480,337
Average Annual Cost	**Average Monthly Cost**
$8,172	$681

Client Projections

Clients Served/Projected				
2020-21	**2021-22**	**2022-23**	**2023-24**	**Age Group**
547	587	627	667	Combined
29	35	38	40	TAY
462	493	527	560	Adults
55	59	63	67	Older Adults

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.

Documentation of Achievement in performance outcomes:

Since 7/1/20, 19 consumers were closed to FSP, 4 successfully transitioned to SD. (3 moved out of area, 4 went to SNF, 5 died, 3 referred to Intensive FSP Contracts). Recently, we have begun referring our more stable Core and SD consumers to Welbe Health/PACE, but they must have stable housing and stable mental health (FSP is not eligible).

Challenges or barriers:

This team has not had a consistent full time manager for 2 years. Continued staff vacancies, high turnover and cross training has resulted in less staff to provide services to this program. Caseloads

are high and new referrals and Team transfers from other clinics come weekly. Housing for this population is lacking. Many of the local B&C homes have closed. While we have had an increase in Enhanced RCFE's (Residential Care Facility for the Elderly), client medial needs coupled with mental health needs creates barriers to placement. The transition from Skilled Nursing Facilities to B&C homes proves difficult. Assisted Living waivers take 2 years or more to acquire and are limited. Misinformation about Insurance health plans is a big issue for older adults. They are easily misled about switching insurance that may help with medical or dental issues but removes them from behavioral health coverage with BHS.

CSS Funding: $1,475,155

Clients Served within the Older Adult FSP Program

Client Demographics

Older Adult FSP Program 2020-2021 N=62		
	Number	**Percent**
Total by Age Group Served		
▪ Older Adults	62	100%
Gender Identity		
▪ Female	39	63%
▪ Male	23	37%
Race/Ethnicity		
▪ African American	20	32%
▪ Asian / Pacific Islander	2	3%
▪ Hispanic/Latino	10	16%
▪ Native American	1	2%
▪ White/Caucasian	28	45%
▪ Other / Not-Identified	1	2%
Linguistic Group		
▪ English	48	77%
▪ Spanish	10	16%
▪ Arabic or Farsi	0	0%
▪ Other non-English	4	6%

Cost per Client

Number Served	**Total Expenditures**
62	$539,110
Average Annual Cost	**Average Monthly Cost**
$8,695	$725

Client Projections

Clients Served/Projected				
2020-21	**2021-22**	**2022-23**	**2023-24**	**Age Group**
62	82	102	122	Older Adults

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

Documentation of Achievement in performance outcomes: for CSS and INN programs/services:

The number of clients served by BHS in an FSP program have increased since Fiscal Year 2018/2019. We are showing a steady increase in the number of adults being served in the Forensic FSP from 212 in 2018/2019 to 229 year to date in 2022. We are providing more intensive triage services at the first appointment, as well as follow up case management services in the field. The average number of direct service hours has increased from 1.1 in 2018/2019 to 4.0 year to date in 2022. This data demonstrates that the Forensic FSP program is providing more intensive services to the community.

Challenges or barriers:

One challenge experienced in the Forensic FSP was the change in leadership over the program along with the shift back to traditional services from the extreme COVID health and safety guidelines implemented. The Forensic FSP program experienced a vacant manager position since the beginning of COVID and was covered by another manager with programs of their own to manage. Although there was a Forensic Supervisor, changes were difficult to implement without the oversight of a direct manager and this was finally filled August of 2021. More importantly, the Board of Supervisors recently approved a raise for all clinical employees that will help with retention not only for direct services staff but also leadership positions. In addition, the team has experienced staff shortages due to various medical leaves including COVID leave. Cross training staff in other programs has been implemented so program coverage can be in place when leaves of absences are needed. The other challenge is staff misunderstanding of the FSP program and best treatment approach with the criminogenic and mentally ill population which results in a lot of referrals to services not showing due to the lack of engagement and follow up. We have implemented a more structured approach to triaging clients when they show to the clinic, as well as following the FSP guidelines to actively engage in the community to build rapport and ultimately improve treatment outcomes. This approach has already increased treatment compliance and show rates.

CSS Funding: $1,894,461

Clients Served within the Community Corrections FSP Program

Client Demographics

Community Corrections FSP Program 2020-2021 N=234		
	Number	**Percent**
Total by Age Group Served		
▪ Transitional Age Youth	22	10%
▪ Adults	200	85%
▪ Older Adults	12	5%
Gender Identity		
▪ Female	81	35%
▪ Male	153	65%
Race/Ethnicity		
▪ African American	61	26%
▪ Asian / Pacific Islander	12	5%
▪ Hispanic/Latino	60	26%
▪ Native American	10	4%
▪ White/Caucasian	80	34%
▪ Other / Not-Identified	11	5%
Linguistic Group		
▪ English	212	91%
▪ Spanish	3	1%
▪ Other non-English	16	7%

Cost per Client

Number Served	**Total Expenditures**
234	$455,116
Average Annual Cost	**Average Monthly Cost**
$1,945	$162

Client Projections

Clients Served/Projected				
2020-21	**2021-22**	**2022-23**	**2023-24**	**Age Group**
234	240	260	280	Combined
22	24	26	28	TAY
200	204	221	238	Adults
12	12	13	14	Older Adults

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.

Documentation of Achievement in performance outcomes:

Inspire served more than 49 individuals from 7/1/19 thru current (3/31/22). 33 have since closed. 18 Consumers were linked to higher levels of care and nine were successfully discharged to lower levels of care. 16 Consumer remain open with 12 additional in the engagement phase.

Challenges or barriers:

High staff turnover rates and continued staff vacancies. Staff vacancies have included Managers, Clinicians, Case Managers and Peer Support staff. Staffing on this team has been challenging. The program has been unable to maintain a full-time psych tech for several years. Until this past year, Inspire FSP was down 4 positions. Currently they are down only two. Housing for these Intensive FSP consumers is also difficult. The process to obtain SSI benefits and assign someone as requiring a

Rep Payee, is also challenging. SSI has become even more complicated and less user friendly over recent years, even more so with COVID.

CSS Funding: $690,539

Clients Served within the InSPIRE FSP Program

Client Demographics

InSPIRE FSP Program 2020-2021 N=23		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	22	96%
▪ Older Adults	1	4%
Gender Identity		
▪ Female	9	39%
▪ Male	14	61%
Race/Ethnicity		
▪ African American	1	4%
▪ Asian / Pacific Islander	3	13%
▪ Hispanic/Latino	1	4%
▪ Native American	4	17%
▪ White/Caucasian	14	61%
▪ Other / Not-Identified	0	0%
Linguistic Group		
▪ English	22	96%
▪ Spanish	0	0%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	1	4%

Cost per Client

Number Served	**Total Expenditures**
23	$256,883
Average Annual Cost	**Average Monthly Cost**
$11,169	$930

Client Projections

Clients Served/Projected				
2020-21	**2021-22**	**2022-23**	**2023-24**	**Age Group**
23	23	23	23	Combined
22	22	22	22	Adult
1	1	1	1	Older Adults

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.

Documentation of Achievement in performance outcomes:

Members enrolled in the Connect I program were able to secure jobs for the first time in years. Focusing on rehabilitation has offered some consumers the opportunity to re-enroll in school and pursue life interests previously unavailable to them. The program stabilized many members in permanent housing after several years of homelessness. Telecare has also worked with consumers to obtain access to benefits previously unavailable to them i.e., Cal-Fresh, SSI, SSD etc. Family reunification and integration back into the community remains the primary goal of Telecare which has improved throughout the 20/21 fiscal year.

Turning Point's Justicia team goes above and beyond to support the wellness and recovery of members on a daily basis. Program staff continue to act first with kindness, in order to build upon the trusting relationships, they have developed with members which ultimately support their successes. TPCP's strength-based approach continues to result in positive outcomes for its members in SJ County and TPCP is very proud of the continued work and growth of the individuals served. In Q4, TPCP has been able to create additional opportunities for members to more actively participate in their community and support others. TPCP has connected with a local foodbank and every Friday members have the opportunity to go and volunteer at the foodbank with staff support. TPCP staff work beside and with members in order to increase opportunities for social interactions and development while also encouraging volunteer work and active participation as a citizen of the community. As a result, the members participating will be able to include the volunteer work on their resumes to support career development. Also, the team continues to encourage member safety by continuing to provide psychoeducation around COVID-19 and supporting their decisions to get vaccinated. TPCP staff continue to provide linkage to vaccinations for all interested members.

Challenges or barriers:

Perhaps the one biggest challenge that Connect I has faced, since the opening of these programs, is a lack of housing, and a lack of board and care homes. Because of this, most housing solutions tend to be temporary in nature. The lack of board and care homes has increased competition, such that if we share information with another agency about board and care openings, they try to place their clients ahead of ours. This lack of housing has also influenced another barrier—the struggle to find some of our Connect II members. If there were housing resources, they would be part of a more robust discharge planning for these members when they are released from jail, which would increase engagement with them afterward.

The delay in receiving the PAF data from BHS (final data available received mid-Q3) and the lack of an available PAF for all members transferred into the program created delays in TPCP's ability to appropriately report on data and additional work for the Esperanza/Justicia team as they were required to obtain the PAF data after the fact. This increased barriers to accurate reporting since many Esperanza/Justicia members are already challenged with recalling and reporting historical data. TPCP is committed to accurate data collection and reporting; therefore, program staff will continue to collect PAF data to improve the accuracy of reporting on objectives that require baseline data from the PAF. TPCP has had little training on the reporting functions available in Clinician's Gateway; however, we have noticed a discrepancy of process in BHS data entry and have noted errors in the 500 report. TPCP has continued its coordination with both the CATS and Forensics side in order to ensure accuracy. TPCP has struggled with filling the LPT and therapist positions despite numerous interviews and offers being extended. TPCP's budget limits our ability to increase wages for these licensed and/or licensed eligible positions. Additionally, the length of time it takes to credential prescribers resulted in TPCP losing a valuable Nurse Practitioner candidate this fiscal year. TPCP is currently working with a local Locum service in hopes of finding a viable candidate that is already credentialed in the community. Program leadership continues to work closely with TPCP Department of People Operations to fill vacant positions.

CSS Funding: $1,953,752

Clients Served within the Intensive Adult FSP Program

Client Demographics

Intensive Adult FSP Program 2020-2021 N=117		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	100	85%
▪ Older Adults	14	12%
▪ Transitional Aged Youth	3	3%
Gender Identity		
▪ Female	33	28%
▪ Male	84	72%
Race/Ethnicity		
▪ African American	28	24%
▪ Asian / Pacific Islander	6	5%
▪ Hispanic/Latino	12	10%
▪ Native American	8	7%
▪ White/Caucasian	62	53%
▪ Other / Not-Identified	1	1%
Linguistic Group		
▪ English	115	98%
▪ Spanish	0	0%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	1	2%

Cost per Client

Number Served	**Total Expenditures**
117	$2,107,654
Average Annual Cost	**Average Monthly Cost**
$18,014	$1,501

Client Projections

Clients Served/Projected				
2020-21	**2021-22**	**2022-23**	**2023-24**	**Age Group**
117	140	140	140	Combined
100	119	119	119	Adult
14	17	17	17	Older Adults
3	4	4	4	TAY

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.

Documentation of Achievement in performance outcomes:

Connect II continues to maintain high levels of success in keeping members out of hospitals and away from incarceration. During fiscal year 20/21 90% of all enrollees experienced no hospitalizations or no incarcerations. Additionally, the majority of enrollees continued to maintain

court obligations reducing the possibility of recidivism. Telecare remains committed to ensuring all members achieve their personal goals which has led to some reunification of family members.

With the continued global pandemic and the continued increase and severity in COVID-19 diagnosis this quarter in SJ County, TPCP continues to follow our mission with, "Empowering people of all ages and identities to live their best life thought the delivery of quality behavioral health and social services." Although there have been additional barriers that we have experienced as a team for our members, our team continues to go above and beyond to ensure our service delivery and our member's visions for wellness and recovery continue to be met. While we have modified what some of our services look like, we have implemented additional protective elements to help ensure the safety of our members and staff. Our office space, while limited has been separated to help ensure distance not only for use and our members. We have moved desks, furniture, chairs, computers, etc. and implement maximum occupancy in our space. We continue to welcome all our members to our office, however ensure that we are following the CDC, State and County guidelines before anyone enters. Our team has always been creative in their service approach, but we have gotten even more creative with our outdoor space. We have chairs, areas, walks planned and additional daily living activities that are to occur outdoors to help our members continue to feel as though they are receiving their necessary level of care We truly love identifying things that help our members and highlight their strengths! It helps everyone and has helped out team members as well to have fun and get creative as well!

Challenges or barriers:

Like other organizations, the pandemic has limited our ability to meet and plan Connect II services in person. In the past, the program used large white boards to facilitate these meetings and track services. Over the 20/21 fiscal year, they developed an electronic version of these whiteboards, and used them to ensure that the needs of all members were being met. Instead of only reacting to crises, the program now intentionally plans each of services on a daily basis. This has improved member care, which in turn will reduce hospitalization and incarceration.

TPCP continues to experience challenges with Clinician's Gateway and struggled with being able to enter the required data as expected due to lack of access and a lack of training on the system. Other challenges, as mentioned above continue to be the limited housing resources and funds for members in order to obtain housing. TPCP will continue to explore all areas and work towards attempting to find alternative resources to support.

CSS Funding: $1,339,672

Clients Served within the Intensive Justice Response FSP Program

Client Demographics

Intensive Justice Response FSP Program 2020-2021 N=113		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	101	89%
▪ Older Adults	3	3%
▪ Transitional Aged Youth	9	8%
Gender Identity		
▪ Female	42	37%
▪ Male	71	63%
Race/Ethnicity		
▪ African American	35	31%
▪ Asian / Pacific Islander	9	8%
▪ Hispanic/Latino	17	15%
▪ Native American	7	6%
▪ White/Caucasian	43	38%
▪ Other / Not-Identified	2	2%
Linguistic Group		
▪ English	113	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**
113	$1,566,753
Average Annual Cost	**Average Monthly Cost**
$13,865	$1,155

Client Projections

Clients Served/Projected				
2020-21	**2021-22**	**2022-23**	**2023-24**	**Age Group**
113	120	120	135	Combined
101	106	106	120	Adult
3	4	4	4	Older Adults
9	10	10	11	TAY

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.

Documentation of Achievement in performance outcomes:

CVLIHC served 204 unduplicated consumers in FY 19/20 and 232 unduplicated consumers in FY 20/21, an increase of 13.72%. The increase in consumers served was due to the addition of serving the intensive FSP population beginning in FY 19/20. The projected number of unduplicated consumers being served in FY 21/22 is 248, representing an increase of 6.89% increase.

Challenges or barriers:

CVLICH has expressed difficulty in assessing all referrals within three business days due to scheduling conflicts of the referring clinician and consumer, consumer transportation issues, and difficulty in receiving all client information necessary to engage in an assessment. BHS will work with CVLIHC to improve scheduling conflicts, providing consumer transportation, and providing the necessary client information for the assessment engagement.

CSS Funding: $1,054,519

CSS Project 10: High-Risk Transition Team FSP

Project Description

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 contract 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.

Documentation of Achievement in performance outcomes:

High Risk Transition Team's greatest achievement during the 20/21 fiscal year was establishing intervention services prior to consumers release from hospitals and locked facilities. The ability to connect with consumers early has led to many success stories resulting in enriched the lives for program participants. Some achievements include family reunification, medication stabilization, housing stability, as well as fulfilled court obligations.

Challenges or barriers:

The PHF and the CSU have been an excellent source of referrals, but the program has not been able to receive referrals for members coming out of the hospitals and the IMDs. This has kept census low, and program slow to start. Another challenge is that members with a history of elopement often return to crisis, but there hasn’t been an effective mechanism to notify the program when they arrive. The program notified after discharge, but that is often too late to re-engage with them. The program is currently working with the team to create a checklist to ensure Telecare is contacted prior to release.

CSS Funding: $741,600

Client Demographics

High Risk Transition FSP (Services began 4th Quarter of 2020-21) 2020-2021 N=15		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	11	73%
▪ Older Adults	1	7%
▪ Transitional Aged Youth	3	20%
Gender Identity		
▪ Female	5	33%
▪ Male	10	67%
Race/Ethnicity		
▪ African American	4	27%
▪ Asian / Pacific Islander	3	20%
▪ Hispanic/Latino	2	13%
▪ Native American	0	0
▪ White/Caucasian	6	40%
▪ Other / Not-Identified	0	0
Linguistic Group		
▪ English	13	86%
▪ Spanish	0	0%
▪ Other, Asian	1	7%
▪ Arabic or Farsi	0	0%
▪ Other non-English	1	7%

Cost per Client

Number Served	**Total Expenditures**
15	$27,990
Average Annual Cost	**Average Monthly Cost**
$1,866	$155

Client Projections

Clients Served/Projected				
2020-21	**2022-23**	**2023-24**	**2024-25**	**Age Group**
15	60	60	60	Combined
11	44	44	44	Adult
1	4	4	4	Older Adults
3	12	12	12	TAY

CSS Project 11: FSP Adult Residential Treatment Services

Project Description

The Adult Residential Treatment Services (ARTS) program will provide short-term transitional housing to FSP consumers to facilitate a safe and timely placement or transition from a higher-level care facility to a community home-like setting and to prevent individuals from decompensating and escalating into the criminal justice system. This program allows for a longer stay of up to six months to allow for stabilization that will improve the participants' chance of success when they leave the program

Target Population

ARTS will serve adult consumers ages 18 and over who are San Joaquin County residents with a serious and persistent mental illness. A special focus is on those with a co-occurring SUD. Participants will be engaged in a San Joaquin County mental health diversion program, have a history of frequent arrests or law enforcement contacts, and be at risk for escalation in the criminal justice system.

Program Requirements

BHS will partner with one or more Adult Residential Treatment Service providers to provide housing and supportive services to adults, ages 18 and older with serious and persistent mental illnesses and/or co-occuring SUD.

The purpose of the program is to facilitate a safe and timely placement or 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

ARTS shall provide the appropriate level of therapeutic support, staffing and programming for program participants to avoid transitioning to a higher level of care. It is anticipated that residents will move toward a more independent living setting within six months from the date of their admission.
Crisis intervention, treatment plans, and collateral services shall be provided for program participants as follows:

A. Crisis Interventions

• Contractor shall provide prompt access to clinical staff who can evaluate clients in a state of crisis
• Contractor will provide staff to deliver targeted interventions to enable the client to cope with a crisis
• Contractor will be able to provide transportation to the BHS Crisis Stabilization Unit when safe and appropriate or refer situations to BHS mobile crisis resources if necessary.

B. Treatment

• Provide individualized risk-focused assessments and on-going evaluations
• Develop Wellness Recovery Action Plans (WRAP)
• Provide social rehabilitation
• Provide daily living and social development skills
• Provide or arrange for on-site medication support

C. Collateral

• Facilitate collateral visits with BHS and participant families when clinically appropriate and feasible
• Provide transportation to client psychiatric, medical, and court appointments
• Incorporate discharge planning into case management

Clients Served/Projected			
2020-21	**2021-22**	**2022-23**	**2023-24**
Program to begin 2022-23		32	64

CSS Funding: $4,700,000

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

Documentation of Achievement in performance outcomes:

Although COVID-19 required the VSO to implement video-conference and telephone services, these technologies proved to be a positive effect to our Delta College student referral program and readily accepted by student Veterans and their families. VSO was able to provide Mental Health First Aid and ASIST trainings. We were also able to train Delta College students, faculty, and community providers. VSO served a total of 566 Veterans with mental health concerns, lack of mobility, or isolation issues during the fiscal year.

The Family Advocate program was able to assist 192 consumers and/or family members during FY 20/21. This number represents 96% of their goal of reaching 200 individuals despite the COVID-19 restrictions.

Challenges or barriers:

VSO continues to face funding challenges. The program continues to operate at its current caseload without the opportunity to increase services for veterans because of the lack of resources for staff.

We will continue to advocate for more funding and seek grants to hopefully expand the mental health offering for this vulnerable population.

Due to COVID-19, the Family Advocate was not able to provide informational sessions introducing BHS departments/staff and the general community to Family Advocate services. The program anticipates that these sessions will resume next fiscal year as COVID-19 restrictions are lifting.

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

Documentation of Achievement in performance outcomes:

In total, the Peer Navigators completed over 300 visits with consumers during the fiscal year. The Peer Navigators have experienced tremendous success in keeping consumers engaged in treatment services. They have navigated 17-21 clients through the treatment process moving most if not all closer towards their recovery goals. Many of the program participants have maintained positive linkage to BHS resulting in less missed appointments and a better continuation of care. Furthermore, the Peer Navigators have done an amazing job not only educating consumers about resources available to them but assisting them obtaining said benefits.

Challenges or barriers:

One early issue was coordinating Peer Navigation meetings with consumers prior to their release from CRT. This was solved by incorporating a checklist upon release to ensure linkage with the Navigators was established and maintained.

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, childcare 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.

Documentation of Achievement in performance outcomes:

The Wellness Center interacted with 689 unduplicated consumers in FY 19/20 and 457 unduplicated consumers in FY 20/21 representing a 33% decrease. This decrease was due to COVID-19 restrictions which occurred in FY 20/21. The projected number of unduplicated consumers being served in FY 21/22 is 665 an increase of 45%. This projected increase will bring the number of consumers being served back to pre-pandemic levels.

Challenges or barriers:

The Wellness Center is expanding services by providing services at a location in both the north and south county beginning in FY 22/23. The expansion is projected to increase the number of unduplicated consumers being served by 40%.

CSS Funding: $1,053,667

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:
   $15.5 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 current and future Project Based Housing Programs.

   Previous funded housing projects were completed on March 2022 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 individuals with serious mental illnesses.

   In partnership, Behavioral Health Services (BHS) and the Housing Authority of the County of San Joaquin (HACSJ), will acquire property, renovate and construct Park Center to provide 51 units of much-needed permanent supportive housing exclusively for individuals with a serious mental illness. Delta Community Developers Corporation (DCDC), the non-profit

development arm of HACSJ, will convert an existing two story structure at the intersection of Park and Center Streets in Stockton (709 N. Center Street, 722 N. Commerce St., and 39 W. Park Street, Stockton, CA 95202) into 20 one-bedroom apartments, one (1) studio apartment and two (2) two-bedroom apartments, one of which will be for the building manager. Funds will also be used to construct a new, three story building with 28 one-bedroom apartments. There will be a total of 51 units in the proposed development including 50 units for the target population (not including the manager's unit). The new building will have an elevator, a community room, roof deck area, and a management office.

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.

Documentation of Achievement in performance outcomes:

On December 14, 2021 the County Board of Supervisors authorized funding to begin 51 housing units known as Park Center. On March 4, 2022 the County transferred funding to close escrow for Sonora Square, a project for 37 housing units.

Challenges or barriers:

San Joaquin County did not receive funding for the application for the No Place Like Home (NPLH) Competitive Round 3. BHS continues to seek alternate funding sources to complete projects, including low-income housing tax credits, Community Development Block Grant funding, and other grant sources.

CSS Funding: $15,500,000

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.

Documentation of Achievement in performance outcomes:

The Employment Recovery Services Program was able to serve 46 consumers and/or family members during FY 20/21. This number represents 92% of their goal of serving 50 individuals despite the COVID-19 restrictions. In addition, this program reached 75% and above goal achievement on 7 of their 8 total contractual goals which shows that UOP was able to adjust their program and provide services with COVID-19 restrictions being in place.

Challenges or barriers:

Due to COVID-19, UOP put capacity restrictions into place at the Martin Gipson Socialization Center. This limited the number of consumers who could receive services from the ERS program as this program is ran out of the Gipson Center. In addition, UOP was unable to have consumers work in the Hospitality Enclave on the BHS campus due to the COVID restrictions. The program anticipates that the program goals will be able to be achieved next fiscal year as COVID-19 restrictions are lifting.

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.
-

Documentation of Achievement in performance outcomes:

97% of treatment goals and targets for CBIS consumers intervention are being met. Since beginning services in December 2013, the CBIS program has opened and attempted to work with 408 consumers.

Challenges or barriers:
The CBIS program had challenges in meeting with consumers face to face due to COVID-19 restrictions. Some consumers did not feel comfortable meeting in person; additionally, some of the care facilities did not allow visitors due to the pandemic. CBIS attempted to work around COVID

restrictions by providing services via Telehealth. The number of face-to-face visits are improving as COVID restrictions are lifting.

CSS Funding: $666,462

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 manage 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 4: Progressive Housing

The Progressive Housing Program (PHP) is an initiative developed by San Joaquin County Behavioral Health Services, in collaboration with Stockton Self Help Housing, as a response to the growing need for affordable, low barrier housing for individuals who are homeless or deemed to be at risk of homelessness, with suspected serious mental illness and/or co-occurring disorders. Safe and stable housing has been identified as a critical requirement for effective engagement in the mental health treatment and recovery process for this target population.

PHP is an adaptation of the housing first model, integrating the stages of recovery to create a rehabilitative housing environment. The program uses scattered site, single family homes, staffed by a house leader with lived experience in recovery. Each house is designated a level (1-4) that coincides with the level of care provided in that specific home. The levels of care are as follows:

i. **Level 1: Pre-contemplation** - individuals are being assessed, engaging in harm reduction, are linked to appropriate services.
ii. **Level 2: Contemplation and Treatment** – sober living environment. Clients have been assessed and are participating in treatment and supportive services and are responsible for house chores.
iii. **Level 3: Recovery and Treatment** – Clients are stabilized, completing or have completed Independent Living Skills program and are entering into a lease agreement with SSHH to establish a rental history**.**
iv. **Level 4: Graduation** – Clients are living independently and assuming responsibility for the upkeep of their housing while remaining engaged with their supportive services.

The ultimate goal of the program is to stabilize a person's living situation, while simultaneously introducing and providing supportive services to aid the client's eventual transition to independent - permanent housing.

Documentation of Achievement in performance outcomes:

Between the fiscal year of 2018/2019 and now, the capacity for services provided to FSP clients has increased 48% to date and 65.7% increase to all clients overall. A total of 80 clients met criteria for Full Service Partnerships and were provided support in fiscal year 2018/2019. That numbers has increased to 166 clients currently who meet criteria for Full Service Partnerships and are currently receiving support

Challenges or barriers:

With the expansion of housing services and related growth of the client population served, Housing Coordination Services has experienced several challenges relating to the access to affordable homes, staffing, access to supportive resources, and need for training and development. The rising costs

coupled with the highly competitive housing market, limited availability to affordable homes for our scattered site housing program (Progressive Housing). In addition, the cost associated with operations and securing homes increased tremendously. As the programs expanded, the need for additional staff has been hampered by staffing shortages and recruitment challenges. We currently have 1 vacant clinician position and are not able to expand the team to match the growth of services. The impact of COVID led to many roadblocks restricting access to treatment options, ultimately resulting in increased turnover rates for clients and house leaders entering and swiftly exiting the program. The staffing and impact of COVID also includes the barriers experienced with our BHS apartments, limiting staffing and placement options for clients. The initial plan was to have one specialist provide case management services to all the clients in the 7 BHS apartments. Unfortunately, due to staffing shortages, we were not able to meet this expectation. To address the challenges and barriers, the county has implemented salary increases to encourage staff retention and also support recruitment efforts. In addition, a budget modification was approved to increase financial support and improve opportunities to secure homes for our scattered site program. We have also revamped the house leader training to incorporate more professional training and support. Lastly, we have expanded timely access to services for our clients.

Project Operational Budget: $6,948,150

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.

Documentation of Achievement in performance outcomes:

Crisis services continue to provide triage services and screenings, and dispense medication through its med room. Response times for urgent conditions meet the State requirements by 98%.

Since its inception in 2009, Warm-line calls has grown from under 100 calls per month on Year One to a monthly average of 1500 as of February 2022. The phone line service continues to be open 24/7 manned by fulltime and part-time MHOWs with diverse backgrounds and experiences. The Team has also grown from a staff of 1-2 each shift to now a range of 2-5 staff per shift. The Warm-line Support Team's roles have also expanded to providing in-person support for adults and minors during pre-hospitalization and post-hospitalization care.

For FY year 20/21, the Crisis Community Response Team received around 3133 requests for evaluation from local hospitals and law enforcement for immediate response or an average of 261 per month. Of this number, about 40% are placed on a legal holds and subsequently received psychiatric hospitalization/treatment. The program facilitates placement of detained persons in psychiatric hospitals throughout California.

Although requests for evaluation from hospitals and LE increased by 9% from pre-pandemic period, the number of detained persons increased by 12% during the pandemic.

Challenges or barriers:

The pandemic and its ripple-effect posed the greatest challenges on all of our programs (Crisis, Warmline, CCRT, CSU and PHF). Personal and family illness has impacted the program's ability to maintain adequate staffing across all programs at all levels. Staff turnover as a result of retirement and separation, along with recruitment difficulty has also resulted in shortage of staff through the last few years. 24-Hour Services positions are considered hard-to-fill due to the nature of work and shift requirements. Additional tasks and precautionary measures needed to be implemented in the entire facility to mitigate health risks for clients and employees. The program experienced struggles to cover shifts and the various units, staff had to be spread thin. As an essential service and while other parts of the Department had the option to work from home, Crisis (24-Hour Services) continued to operate business as usual and staff had to be physically present in the workplace. This and the need to cover for sick co-workers have led to increased absences related to burn-out and fatigue. In order to address these issues, management utilized various ways to increase morale within the workforce, e.g. gift-giving per shift, staff lunches/snacks, lots of kudos, intensified emotional support, increased team work and capacity-building. The program also continues to

recruit staff and advocate for increased pay or supplemental pay, and improve working conditions, e.g. floor renovations, PPEs, and other modes of protecting health and safety of employees.

CSS Funding: $5,530,257

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 supportive services for Independent Living and Interpersonal Skills programming.

CSS Funding: $3,130,282

VI. 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
- Prevention for Children 0-5
- Mentoring for Transitional Age youth
- CARES Project
- School Based Prevention/Interventions

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 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 2022-23							
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	Prevention for Children 0-5	X					
3	Mentoring for Transitional Aged Youth	X		X			
4	CARES Project	X		X			
5	School-Based Prevention	X		X			
6	Early Interventions to Treat Psychosis		X				
7	Community Trauma Services for Adults				X		

8	Recovery Services for Non-Violent Offenders						X
9	Whole Person Care						X
10	Increasing Recognition of Mental Illness			X			
11	Information and Education Campaign			X		X	
12	Suicide Prevention with Schools			X			
13	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 and or promising practices. Evaluation findings from the 20-21 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/

PEI Funding: $962,502

PEI Project 2: Prevention for Children 0-5

Community Need

The first years of life are a period of incredible growth in all areas of a child's development. As defined by *Zero to Three Early Connections*, Infant and Early Childhood Mental Health is the developing capacity of a child from birth to age 5 to form close and secure adult and peer relationships; to experience, manage and express a full range of emotions; and to explore the environment and learn—all in the context of family, community and culture. Infant and Early Childhood Mental Health is an imperative component of early childhood development, and these skills provide a foundation for all other domains of development, such as cognition, speech and language and motor skills.

According to recent data reported by Child Trends, younger children are maltreated at higher rates than older children. For example, in San Joaquin County children under the age of one year have substantiated child abuse allegations at a rate more than four times that of other age groups. We anticipate the data will continue on this trend as the effects of the pandemic continue.

Furthermore, the emotional well-being of young children is directly tied to the functioning of their caregivers and the families in which they live. When these relationships are abusive, neglectful, or otherwise harmful, they are a significant risk factor for the development of early mental health problems. In contrast, when relationships are reliably responsive and supportive, they can actually provide a safeguard for young children from the adverse effects of other stressors. Therefore, we know that reducing the stressors affecting children also requires addressing the stresses on their families.

Supportive services for the 0-5 population under this project would serve to address all of these critical needs. Currently most programs for this age group are only available to youth placed in foster care. Available data and feedback from the community support the need for a more broad based approach to preventative services for this population.

Project Description

This project aims to offer community-based supportive prevention services to a broader 0-5 population with the goal of helping children and caregivers build secure attachments, promote healthy development, encourage strong emotional health, and prevent emotional disturbances from taking root.

Services will be positive and preventative in nature and consist of monthly to weekly home visits from a trained staff member who provides parenting education and support for optimal family functioning as well as case management and linkage to other community supports as appropriate, in addition to group services and other training opportunities to address identified needs.

Funding will be allocated through contracts with qualified Organizational Providers that demonstrate experience and expertise in serving young children and their families. Contracts will be developed through a public procurement process to identify qualified vendors.

Project Components

Community-based: Weekly services may be provided in children's homes, day cares, schools, or in the community. Services would focus on both the child and the caregiver.

Interventions and support could include but are not limited to:

- Parent/caregiver groups to increase family engagement and promote natural supports and skills
- Individual parent and child screenings
- Guidance in building attachment and secure relationships and increasing positive interactions and communication between parent and child
- Assistance in developing social-emotional skills, building resiliency, improving self-esteem, and encouraging self-regulation
- Activities and interactions that promote healthy social and emotional development
- Collaboration with other providers in a child's life including relatives, care providers, etc.
- Development of interventions for aggressive or other maladaptive behavior
- Encouraging parents' strengths in attuning to their children and coaching them to enhance their responsiveness
- Supporting parents in coping with/understanding their feelings in order to consistently address and reduce any parenting/attachment issues related to the parent's anger, depression, or other mental health struggles

Program will use the ASQ-SE assessment tool: The Ages & Stages Questionnaires®: Social-Emotional (ASQ-SE) is a parent-completed, highly reliable system focused on social and emotional development in young children. It assists to accurately identify behavior and supports further assessment, specialized intervention, or ongoing monitoring in order to help children reach their fullest potential during their most formative early years

The emotional and behavioral needs of vulnerable infants, toddlers, and preschoolers are best met through coordinated services that focus on their full environment of relationships, including parents, extended family members, home visitors, providers of early care and education, and/or mental health professionals. To this end, services may be done in a conjoint effort with schools, pediatricians, Managed Care Plans, Public Health and/or Human Services Agency in the spirit of whole person care

Referrals sources may include but are not limited to:

- Preschools
- Day Cares
- PCP
- WIC
- Public Health

- Direct Referrals

PEI Funding: $1,200,000.00

PEI Project 3: 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, community based organizations and by self-referral utilizing a referral form.

Vocational Training: Program may partner with local businesses to link youth to on-the-job vocational training. Contractor may use funds to reimburse local businesses for hiring youth and providing them with on-the-job vocational training.

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

PEI Funding: $806,467

PEI Project 4: Coping and Resiliency Education 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 at risk of involvement or are 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, individual and group rehabilitative interventions, and referrals to higher levels of care for children who have experienced or at risk of trauma.

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

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

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.

Outreach and Engagement: Aims to inform the public about mental health programs and services for youth, address stigma, and encourage linkage to appropriate services through attendance at community events, health fairs, school functions, etc. Activities focus on reaching a wide diversity of backgrounds and perspectives represented throughout the county as well as creating and sustaining partnerships with schools, community based organizations, faith based organizations, historically disenfranchised communities, and other county departments.

PEI Funding: $1,322,547

PEI Project 5: School-Based Prevention 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 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 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.

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 clinical staff to work with participating schools. Dedicated clinical staff 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 early 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. ***Rehabilitative Groups:*** Facilitate age-appropriate cognitive behavioral or other skill building 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 or promising practice 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. If groups are not feasible due to public health emergencies or other unforeseen circumstances the group material can be done with youth individually.

2. **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.

3. **Referrals:** Referrals to the School Based Prevention Services can come from school staff or caregivers of the students. All children screened will be assessed to determine if they are appropriate for the short-term prevention services or whether they should be immediately referred to more specialized services. All children receiving short-term prevention services will be continuously monitored to determine if, during the services or at completion, they should be referred to more intensive services. If a youth is identified as needing more intensive services, the program will ensure youth is linked to those services.

4. **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.

5. **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.

6. **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.
- Ensure proper documentation
- 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

PEI Funding: $2,578,235

PEI Project 6: 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.

PEI Funding: $934,609

PEI Project 7: 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.

PEI Funding: $2,700,000

PEI Project 8: 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.

PEI Funding: $528,981

PEI Project 9: Whole Person Care

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

The purpose of San Joaquin County's Whole Person Care 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 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.

PEI Funding: $922,525

PEI Project 10: 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.

PEI Funding: $42,616

PEI Project 11: 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.

PEI Funding: $1,756,521

PEI Project 12: 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

Planning conversations will be coordinated 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.

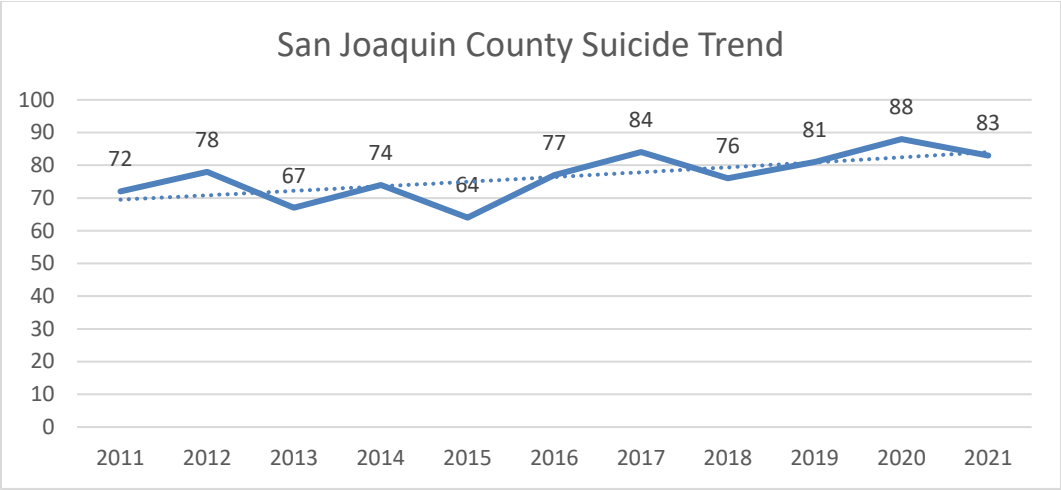
Groups related to any other trends on campus that may perpetuate self-harming or suicidal behavior but are not necessarily directly related to depression. These groups may include topics like bullying, stress management, etc.

PEI Funding: $800,000

PEI Project 13: 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

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

[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

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.

PEI Funding: $633,696

VII. 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 (Ending June 2023)

Project Link: INN Assessment and Respite Center Final Draft 10.20.17.pdf (sjcbhs.org)

Project 2: Progressive Housing (Ending in January 2023)

Project Link: INN Progressive Housing Project Narrative Final.pdf (sjcbhs.org)

Project 3: Home to Stay and Future INN Projects (Planning Stage)

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.

Documentation of Achievement in Performance Outcomes:

- Assessment and Respite Center – Annual Evaluation (located in Section XI of this plan)

Project Operational Budget: $1,830,759

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.

Documentation of Achievement in Performance Outcomes:

- Progressive Housing – Annual Evaluation (located in Section XI of this plan)

Project Operational Budget: $915,380

VIII. 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 publicly 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 2021/22 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. BHS will partner with CalMHSA to provide funding the for the following project 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

IX. 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: $5,269,814

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: $2,800,000

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. Electronic Health Records project, in partnership with CalMHSA, will be funded from this project component.

Project Operational Budget: $1,713,333

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

2021-22 Cultural Competency Plan Update

3 Year PEI Evaluation

Innovation - Assessment and Respite Center – Annual Evaluation

Innovation – Progressive Housing – Annual Evaluation

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
2021-22 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 2021-22 Annual Update to the 2010 Cultural Competency Plan (Annual Update) reviews the efforts of Fiscal Year (FY) 2020-2021 and guides upcoming efforts for FY 2021-2022. 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 continuance of the COVID-19 pandemic occurrence during the 2020-21 FY, many 2020-2021 strategies were approved by the Cultural Competency Committee to carryover to FY 2021-2022.

Criterion 1: Commitment to Cultural Competence

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

FY 2020-2021 Accomplishments: Two significant strategies were implemented to enhance agency commitment to Cultural Competency. These were:

1. Measured and monitored cultural competency standards through the 2020-21 MH and SUD Quality Improvement Work Plans via the monthly Quality Assessment & Performance Improvement (QAPI) Council (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 2021-2022 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 December 30, 2021. (Strategy Carryover from FY 2020-2021 Plan)

2. Develop an action plan to address findings of the CBMCS Survey by May 31, 2022 (Strategy Carryover from FY 2020-2021 Plan)

Criterion 2: Updated Assessment of Service Needs

(CLAS Standard 2, 11)

FY 2020-2021 Accomplishments: BHS implemented a comprehensive community planning process with these components:

- Seven community stakeholder discussions about the needs and challenges experienced by mental health consumers, with a focus on the diverse range of consumers served.
- Two targeted discussion groups with mental health consumers, family members
- 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. The assessment of service needs is detailed in the 2021-2022 MHSA Annual Update to the Three Year Program and Expenditure Plan, pages 8 through 16. (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 including 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 (28% of participants while comprising 41% 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 impede 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 Latinx, African American, Asian, or Native American than is reflective of the general population in San Joaquin County.
- Feedback from self-reported demographics indicated that adult consumers represented 7% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQIA+).

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 statistically identical with the statewide average
- The penetration rate for Latino/Hispanic communities (2.57%) is lower than the statewide average of 3.83% and just slightly lower with the rate of other medium-sized counties (2.74%).

Data provided by CALEQRO for SUD Medi-Cal Beneficiaries CY 2019 (as of this draft CY 2020 was unavailable) 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 2021-2022 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, 2022.
- BHS will develop online and paper stakeholder 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, 2022.
- BHS will distribute and collect needs assessment surveys by March 15, 2022.
- BHS will complete an annual MHSA assessment of needs by April 1, 2022.
- Develop online and paper SUD needs assessment surveys May 15, 2022. (Strategy Carryover from 20-21 Plan)
- Distribute and collect SUD needs assessment surveys by June 1, 2022. (Strategy Carryover from 20-21 Plan)
- Complete analysis of SUD assessment survey by June 15, 2022. (Strategy Carryover from 20-21 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 December 30,2021. (Strategy Carryover from 19-20 Plan)
- Develop strategies and an action plan to address CBMCS findings by May 31, 2022. (Strategy Carryover from 19-20 Plan)

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

(CLAS Standard 1, 10, 14)

FY2020-21 Accomplishments

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

Excerpts from the UC Davis Evaluation Report (Narrative/Data):

Over the past four years, the Homeward Bound Initiative has continued its progress towards meeting the project goals and objectives. Between August 2018 – July 2021 994 unique Proposition 47 eligible individuals were enrolled in the Homeward Bound Initiative. Of those, 976 consumers have received mental health services, 569 have received SUD counseling, 322 have received MAT, and 777 have received a primary care appointment. In total, 11.47% of consumers identified as Black/African American, which is an over-representation relative to San Joaquin County population estimates. However, Asian and Hispanic/Latinx consumers were under-represented. To date, the program has been highly successful at engaging consumers who identify as homeless (n=284, 21.88% of the sample). Once engaged in care, individuals

from these historically underserved groups engaged and remained in substance use disorder care at levels at least comparable to those who report not being homeless, and other racial and ethnic groups. However, consistent with the broader literature, disparities in access to MAT appear to be evident, with a lower proportion of Black/African American individuals initiating MAT.

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%	34%	39.54%
Hispanic/Latinx	41.9%	28%	22.35%
Asian	15.7%	11%	3.62%
African American	7%	17%	11.47%
Other	4%	8%	13%

Across race and ethnicity, 39.54% of individuals identified as White non-Hispanic, 22.35% as Hispanic/Latinx, 11.47% as Black/African American, 3.62% identified as Asian, 2.62% as Alaskan Native or Native American, 0.90% identified as Native Hawaiian or Pacific Islander, and 4.83% as having more than one race. In total, 65.59% of consumers identified as male. At the point of the assessment 21.88% identified as homeless, defined as individuals either living on the street or a place not for habitation, in temporary shelters, or in other transitional housing.

One of the main aims of the Homeward Bound project was to increase access and engagement to community behavioral health services in San Joaquin County amongst historically underserved groups, namely Black and Latinx communities.
The population of San Joaquin County was 752,660 in 2018 according to the American Community Survey (U.S. Census Bureau, 2019), of which 41.9% identified as of Hispanic/Latinx ethnicity, 7% identified themselves as Black, 31% as White, 15.7% as Asian, while 4.4% identify as a member of another minority group. As compared to the racial and ethnic breakdown of the census data, Non-Hispanic Whites were overrepresented in the Homeward Bound treatment sample by 8.54%%, and Black/African American individuals were overrepresented by 4.47%. Hispanic/Latinx individuals across all races were found to be underrepresented by 16.86%, and Asian underrepresented by 12.08%. Given the lack of data regarding treatment need by racial and ethnic groups within the San Joaquin County region, firm conclusions cannot be drawn from these findings. However, the figures overall suggest that the Initiative has been successful at engaging Black/African American individuals in community behavioral healthcare, but continues to experience challenges in engaging Hispanic/Latinx individuals. Additionally, the findings appear to indicate that residents who identify as Asian are also significantly underrepresented.

FY 2021-2022 Strategies:

- The Cultural Competency Committee will review data from the Fourth Year Evaluation Report related to race and ethnicity to provide recommendations for further engagement of the Latinx and Asian population, by May 31, 2022.

- Develop AdHoc Subcommittee to work with QAPI to perform a root cause analysis to identify factors contributing to low Hispanic/Latino penetration rates and initiate culturally competent quality improvement activities to address health equity (2021 EQRO Recommendation) by May 31,2022
- Adhoc Subcommiitee will Define the Problem; Assemble Data; locate root causes; corrective/preventive solutions; create actionable strategies to implement solution; monitor solution and confirm it works by December 30, 2022

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 MHSA Consortium has become a vehicle through which the Cultural Competency Committee informs stakeholders about BHS Cultural Competency efforts.

FY 2020-2021 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 2021-2022 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, 2022.
- Elicit, suggest, review, monitor and support at least two new strategies to increase penetration and retention rates for identified community groups by June 30, 2022. (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, 2022.

Criterion 5: County Culturally Competent Training Activities

(CLAS Standard 4)

FY 2020-2021 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 2022-2022 Strategies:

- Create subcommittee to explore additional cultural competency and health equity trainings to enhance and deepen health equity knowledge throughout the system of care by June 30, 2022

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

(CLAS Standard 7)

FY 2020-21 Accomplishments:

- BHS Hispanic staff members increased by 19 employees, increasing the percentage of Hispanic staff by 2% 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 CY2020)	SUD Medi-Cal Beneficiaries % (CALEQRO CY-19)	County % (Census)
Caucasian/White	208	28%	16.2%	28.8%	34%
Hispanic	253	34%	46.1%	46.3%	41%
Asian/Pacific Islander	140	19%	14.9%	1.5%	14.%

Black/African American	91	12%	9.4%	14.5%	7%
Native American	12	1%	.3%	.4%	.5%
Other	33	5%	13.2%	8.5%	3%
Total	737	100%	100%	100%	100%

FY2021-2022 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, 2022. (Strategy Carryover from 19-20 Plan)

Criterion 7: County System Language Capacity

(CLAS Standard 5,6,8)

FY 2020-2021 Accomplishments:

- BHS continues to maintain an in-house database of language capacity of BHS Staff
- BHS improved in language capacity in Spanish and 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 Spanish, Cambodian, Vietnamese, and Hmong Languages. Laotian and American Sign Languages continue to show major disparity.

Primary languages spoken by clients and staff	# of Clients	# of BHS Staff Providing Direct Services (20-21)	Staff to client ratio	# of Clients	# of BHS Staff Providing Direct Services (2019-20)	Staff to client ratio
English	13,887	737	1:19	16,082	698	1:23
Spanish	780	89	1:9	996	68	1:15
Cambodian	184	5	1:36	257	2	1:128
Vietnamese	74	5	1:15	116	5	1:23
Laotian	36	0	n/a	48	0	n/a
Hmong	29	6	1:5	41	5	1:8
Tagalog	4	26	1:1	11	23	1:1
Arabic and Farsi	21	4	1:5	26	3	1:7
Chinese (Mandarin and Cantonese)	7	2	1:3	8	1	1:8
American Sign Language	6	0	n/a	9	0	n/a
Korean	2	1	1:2	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 Laotian and utilize American Sign Language by June 30, 2022.

Criterion 8: County Adaptation of Services

(CLAS Standard 12)

2020-21 Accomplishments:

- Contracts Management included 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 2021-2022 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 Flyer
4. 20-21 MHSA Annual Update to the Three Year Mental Health Services Act Program and Expenditure Plan, pages 8-16
5. San Joaquin County-specific Data provided by CALEQRO for MH and SUD
6. Boilerplate Contract Language – Cultural Competency
7. Contract Monitoring Tool – Item 6b/6d

Attachment 1: BHS MH QAPI Work Plan (Sections 5.H.1-5.H.4)

5. Structure and Operations								
5.H. Cultural Competency- The MHP incorporates cultural competency principles in the		Goals	Target	FY19/20	FY 20/21	Data Source	Frequency of Review	Action Plan
5.H.1	The MHP identifies strategies and resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its eligible.	Create workforce that is representative of the population.	By 6/30/2022, BHS will increase the Hispanic/Latino proportion of staff to 36%.	32%	34%	Human Resources	Quarterly	Enact recruitments for language-specific positions. Assess opportunities for recruitment in cultural arenas of the community and implement two strategies.
5.H.2	The MHP implements strategies and uses resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its eligible.	Improve cultural competency of staff.	As described in the Cultural Competence Plan, 100% of staff and contractors hired during FY21/22 will receive online Cultural Competency Training within 12 months of employment	81%	Unable to track	Department Managers	Quarterly	Managers and supervisors will require new staff to complete online cultural competence training during the initial probationary period.
5.H.3	The MHP implements strategies and uses resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its eligible.	Improve cultural competency of staff.	By 4/30/2022, SJCBHS will have identified gaps in the Cultural Competency knowledge base of BHS staff members and partners.	N/A	N/A	I.S. Survey	Quarterly	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.
5.H.4	The MHP implements strategies and uses resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its eligible.	Improve cultural competency of staff.	By 6/30/2022, BHS will develop an action plan to address the findings of the CBMCS Survey.	N/A	N/A	I.S. Survey	Quarterly	Analyze the findings from the CBMCS Survey and develop an action plan to address the findings from the CBMCS Survey.

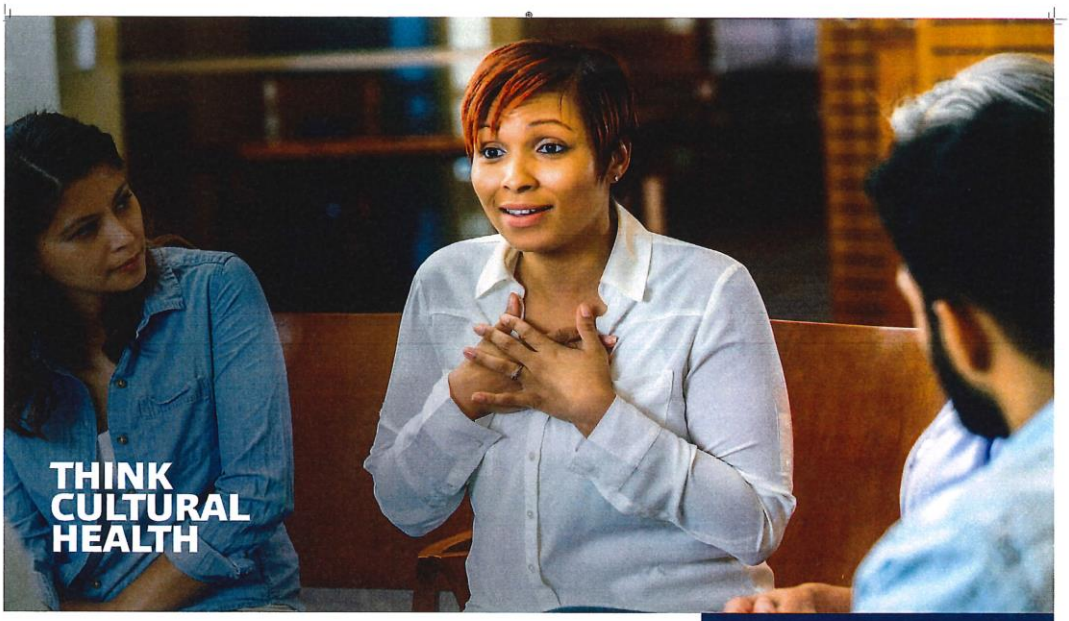
Attachment 2: BHS SUD QAPI Work Plan (Sections 2d, 3a1, 6a-6c)

2d	By 6/30/2022 increase penetration rates of Hispanic beneficiaries to 0.82%	**0.50%**			Penetration data	1. The Plan will continue Increase number of Spanish-speaking staff to improve access for monolingual Spanish-speaking clients. 2. The Plan will provide staff training on use of Language Line - including additional training on using Language Line for telephone contacts. 3. The Plan will provide advertising and resources in Spanish for distribution in prominent areas. 4. The Plan will monitor the penetration rate on a regular basis (how often can the information be pulled in order to get accurate data?)		Cultural Competence Committee/Eric

	By 6/30/2022 increase consumer/family member participation in Cultural Competency 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	1. The Plan 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
3a	By 6/30/2022 at least 50% of "open" BHS SUD clients receiving treatment will participate in Treatment Perception Survey.				UCLA Survey Results	1. The Plan will ensure the survey information is accessible to consumers in multiple formats. 2. The Plan will ensure all county and contracted providers receive the survey information. 3. The Plan will send reminder emails to the county and contracted programs during the survey week. 4. The Plan will examine the participation results of the survey and develop strategies for improvement where it is needed. 5. Residential clients will be surveyed quarterly		QAPI

6a	By 6/30/2022 increase number of Spanish-speaking direct-service staff from one FTE to three FTEs.	**3**			NACT	1. The Plan will review findings in QAPI Council and Cultural Competency Committee to establish recruitment objectives for fiscal year.		Ethnic Services Manager
6b	By 6/30/2022 100% of staff will be trained in Cultural Competency and new staff will complete it within 12 months of hire.	100%			TPS	1. The Plan's SUD managers and supervisors will track required staff trainings - including Cultural Competence - and document staff completion. 2. The Plan will monitor the contractors on a monthly basis to ensure trainings are completed.		SAS Coordinator SAS Managers
6c	By 6/30/2022 Cultural Competency Committee will add four new members.				Cultural Competence Committee meeting minutes and sign in sheets	1. The Plan 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

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):

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

Community Discussions:

- 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
- 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:

- 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:

- 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

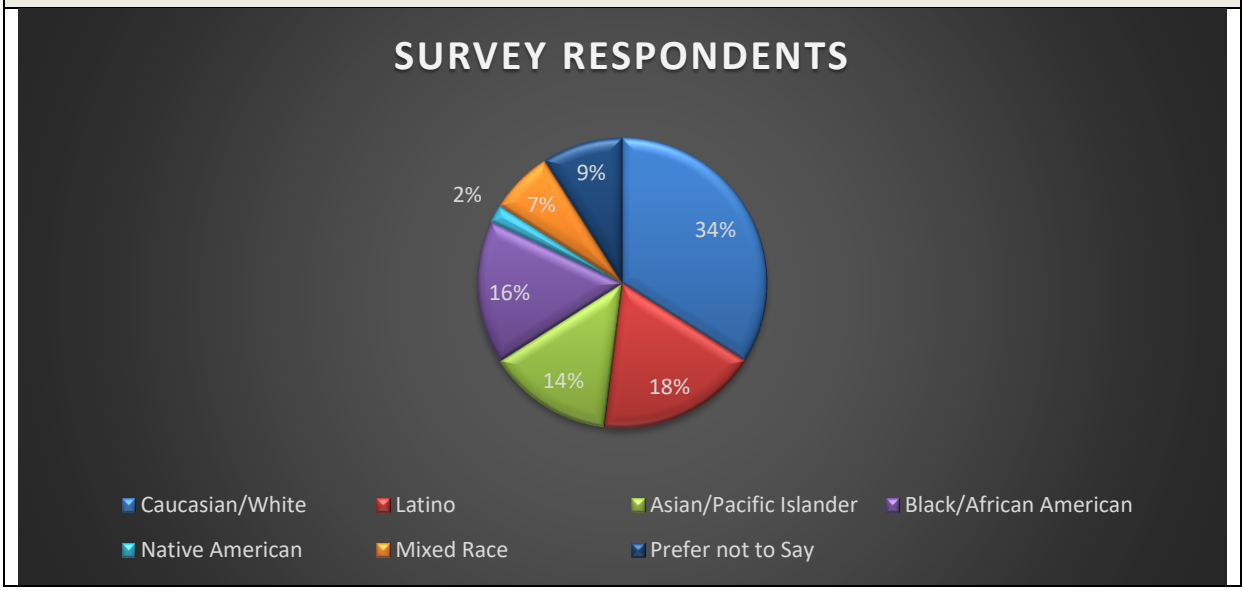
In March of 2021, BHS distributed electronic surveys to consumers, family members, and stakeholders to learn more about the perspectives, needs, and lives of clients served through mental health programs. Surveys were completed online with multiple-choice answers and responses were tallied through Survey 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		Gender	Percent

Under 18	10%	Male	30%
18-25	4.5%	Female	64%
26-59	55%	Trans	1%
60 and over	23%	Prefer not to say	5%
Prefer not to say	6%		

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.

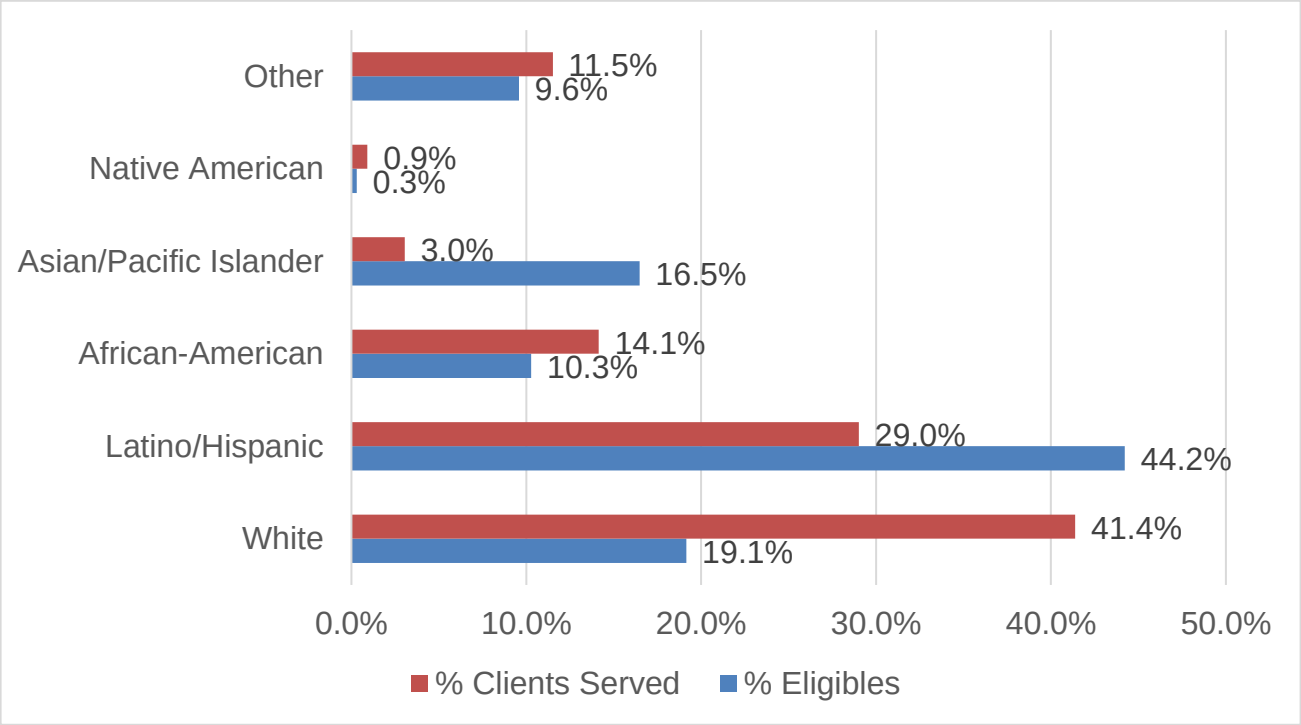
- Work with Human Services Agency to identify isolated older adults with escalating mental health symptoms. Convene a workshop for Adult Protective Services staff on the prevention and early interventions services available in the community, and tips for accessing mental health interventions for mild 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.

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

CALEQRO PERFORMANCE MEASURES CY 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	46,691	16.2 %	3,075	29.3 %
Latino/Hispanic	133,061	46.1 %	3,415	32.5 %
African-American	27,199	9.4 %	1,587	15.1 %
Asian/Pacific Islander	42,915	14.9 %	929	8.9 %
Native American	765	0.3 %	50	0.5 %
Other	38,252	13.2 %	1,439	13.7 %
Total	**288,883**	**100 %**	**10,495**	**100 %**

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



Attachment 6: 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 Three Year Prevention and Early Intervention Evaluation Report

San Joaquin County Behavioral Health Services

Fiscal Years 2018/19, 2019/20, 2020/21

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 a Prevention and Early Intervention Report annually, as well as a Three-Year Prevention and Early Intervention Program and Evaluation Report to the Mental Health Services Oversight and Accountability Commission (MHSOAC). This report has been compiled to meet that requirement, including both annual data as well as the three-year evaluation component.

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. Table 1 illustrates the distribution of SJCBHS's PEI Projects into these seven Program and Strategy categories:

1. Prevention
2. Intervention
3. Outreach for increasing recognition of early signs of mental illness
4. Stigma and discrimination reduction
5. Suicide prevention
6. Access and linkage to treatment programs
7. Timely access to services for underserved populations

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 evaluation findings for three fiscal years: 2018/19, 2019/20, and 2020/21 per Section 3560.020 of the CCR.

COVID-19 Considerations

The coronavirus pandemic emerged in the third quarter of Fiscal Year 2019/20 and continued throughout the remainder of the reporting period (2020/21). As a result, for some programs, activity levels decreased, and participation dropped in relation to previous fiscal years.

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[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] A copy of the regulations may be found at https://mhsoac.ca.gov/wp-content/uploads/PEI-Regulations_As_Of_July-2018.pdf

Table 1. Program and Strategy Categories

San Joaquin County PEI Projects	Program Category	Required Strategies	
		Access & Linkage to Treatment	Timely Access to Services for Underserved Populations
Skill-Building for Parents and Guardians	Prevention	X	X
Mentoring for Transitional Age Youth (TAY)	Prevention	X	X
Coping and Resilience Education Services (CARES)	Prevention	X	X
Early Intervention to Treat Psychosis (TEIR)	Early Intervention	X	X
School Based Interventions	Prevention & Early Intervention	X	X
Juvenile Justice Project (JJC)	Prevention & Early Intervention	X	X
Community Trainings - Outreach	Outreach for Increasing Recognition	X	X
Community Trainings - Stigma	Stigma & Discrimination Reduction	X	X
Suicide Prevention Project	Suicide Prevention	X	X
LEAD - Recovery Services for Nonviolent Offenders	Timely Services for Underserved Populations	X	
Whole Person Care	Access and Linkage to Treatment		X

Key Findings

The following is a summary of key findings from fiscal year 2020/21 and the three-year program evaluation.

Prevention Projects

Skill-building for Parents and Guardians: Three community-based organizations offered 136 courses, served 1,280 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 during the three-year evaluation period revealed that across the programs, 80% of participants had gained knowledge, skills, behaviors, or improved attitudes about parenting.

Transitional Age Youth: In FY 2020/21, two community-based organizations provided evidence-based mentoring to 409 youth aged 16-25 with emotional and behavioral health difficulties. Three-year evaluation analysis found that roughly two-thirds of participants showed improvements in overall needs and strengths over the course of their participation (67%). A similar proportion (65%) graduated or completed their goals before concluding their participation.

Coping and Resilience Education Services (CARES): 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 221 children and 94 caregivers during the 2020/21 fiscal year. Three-year evaluation analysis found that among parents who completed the program, 86% experienced a reduction in stress and 87% of children experienced a reduction in pediatric symptoms.

Early Intervention Projects

Early Intervention and Recovery (TEIR): Telecare provided an integrated set of promising practices intended to slow the progression of psychosis to 62 transitional age youth and their family members over the course of the 2020/21 fiscal year. Altogether, 47 clients have been discharged during the three-year evaluation period, with a total of 33 (70%) completing program objectives. Of the 25 clients with matched pre/post CANSAs[3] (with a participation interval of at least one year) 72% demonstrated improvement in the Strengths Domain. Roughly half showed improvement in Risk Behaviors (56%), Life Functioning Domain (52%) and Behavioral Health Needs (52%).

[3] The CANSA is San Joaquin County's combined version of the CANS/ANSA.

Prevention and Early Intervention Projects

School Based Interventions: New to PEI programs in 2020/21, two community-based organizations provided prevention and intervention services to 220 students through partnerships with schools. Forty-six (46) rehabilitative groups were initiated, offering 241 sessions. In addition, providers facilitated 175 support team meetings involving school personnel, students and or families. Training was provided to 31 parents/caregivers and 275 school personnel. Out of 130 students participating in group sessions, 71% graduated (attending at least half of the sessions). Program evaluation found that 66% of matched pre-post CANSA scores showed overall improvement in needs and strengths.

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. Three hundred and fifty-five (355) youth were evaluated, 157 received a comprehensive psychosocial assessment and 88 received prevention or early intervention treatment during the 2020/21 fiscal year. The three-year program evaluation found that among the 27 youth detained long enough to receive 60-day follow-up CANSA assessments, 74% showed improvement in the Strengths Domain. A slightly smaller portion saw improvement in Risk Behaviors (67%), Life Functioning Domain (59%) and Behavioral Health Needs (48%).

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

NAMI's Outreach for Increasing Recognition of Early Signs of Mental Illness program: During the 2020/21 fiscal year, San Joaquin County's chapter of National Alliance on Mental Illness delivered 15-hour NAMI Provider Education classes to nine behavioral health providers (potential responders). NAMI's Stigma and Discrimination Reduction Program provided In Our Own Voices presentations, Family to Family and Peer to Peer trainings to 183 participants. The three-year program evaluation found 74% showed positive change in attitudes, knowledge and/or behaviors related to mental illness and 82% showed positive change related to seeking mental health services.

Suicide Prevention

Suicide Prevention Program: During fiscal year 2020/21, the Child Abuse Prevention Council (CAPC) facilitated a Yellow Ribbon Suicide Prevention Campaign in 12 high-risk high schools within the county, reaching 6,239 individuals. The program trained 432 school personnel and 190 youth "gatekeepers," and additionally, provided more intensive SafeTalk training to 42 community members throughout the county. The three-year program evaluation found that on average, 86% of Yellow Ribbon Campaign recipients demonstrated an increase in ability to recognize signs, symptoms and risks of suicide. A similar portion (84%) demonstrated greater knowledge about

professional and peer resources available to help people at risk of suicide. Nearly all (97%) of SafeTalk participants were more knowledgeable about how to intervene as a result of their training.

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 summary of fiscal year 2020/21 referrals to mental health treatment, referrals to County mental health providers in particular, and known linkages to treatment, as defined by having attended at least an intake assessment. In total, there were 443 referrals made, including 330 to treatment, of which 246 were to SJCBHS administered programs. Records document 129 known linkages to treatment, with 104 occurring within 60 days of referral.

	Referrals			Linkage	
Program	To MH treatment or PEI	To MH treatment	To County MH treatment	Within fiscal year	Within 60 days[4]
Skill-Building for Parents and Guardians	43	30	24	3	2
Mentoring for Transitional Age Youth (TAY)	63	49	49	17	11
Coping and Resilience Education Services (CARES)	9	9	9	8	7
Early Intervention to Treat Psychosis (TEIR)	7	5	3	1	0
School Based Interventions	10	5	1	1	1
Juvenile Justice Project (JJC)	113	113	75	45	38
Suicide Prevention Program	146	67	33	13	9
LEAD - Recovery Services for Nonviolent Offenders	11	11	11	5	3
Whole Person Care	41	41	41	36	33
Totals	**443**	**330**	**246**	**129**	**104**

[4] Because state regulations do not define the maximum interval between referral and treatment, we report the number of individuals linked to treatment 1) within the same fiscal year as referral and 2) within sixty days of referral

Prevention

Skill Building for Parents and Guardians

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 2020/21, 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 (CC) provided Nurturing Parenting Program (NPP) groups
- Parents by Choice (PBC) provided Positive Parenting Program (Triple P) groups

Project Outputs

In the 2020/21 fiscal year, the Skill Building project served a total of 1,280 parents and guardians. The following table shows that 637 (50%) graduated (i.e., completed the program). Participants attended an average of 5 sessions.

Skill-Building for Parents and Guardians				
Outputs FY 2020/21				
	CAPC-PC	CC-NPP	PBC - Triple P	Total Skill-building
Unduplicated parent/guardian participants	761	127	392	1,280
Unduplicated individuals graduated*	235	80	322	637
Percent who completed/graduated	31%	63%	82%	50%
Groups delivered	46	23	67	136
Sessions delivered	552	268	411	1,231
Average participants per group	16.5	5.5	5.9	9.4
Average sessions per group (dosage offered)	12.0	11.7	6.1	9.1
Average sessions attended per participant (dosage received)	4.6	7.8	5.4	5.1

*Graduation definitions: 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 of the 15 Parent Café sessions.

Demographic forms were collected upon intake or initiation of services. Complete demographic tables from 2020/21 are included in the appendix to this report.

Participant Outcomes

Each of the three Skill Building for Parents and Guardians programs followed a different evidence-based curriculum and implemented an applicable validated instrument to measure progress towards intended outcomes[5].

Parent Cafés (Child Abuse Prevention Council)

Participants in CAPC Parent Cafés completed a Protective Factors survey during their first and last session of the program. The table below shows that they were able to survey 801 participants over the three-year reporting period. Highest gains were demonstrated in *knowledge of parenting skills* (97% showed improvement). Overall, 89% of participants showed improvement over the course of their engagement in the program.

Skill-Building for Parents and Guardians *Program: Parent Cafés (Child Abuse Prevention Council)*		
Outcomes- 3 Years FY 2018/19, 2019/20, 2020/21		
Instrument: Protective Factors Survey Frequency of administration: First and last session		
Unduplicated individuals served	2,326	
Number of graduates	801	34%
Number of graduates w/ matched pre/post	801	100%
Number who showed improvement in:		
Knowledge of parenting skills	774	97%
Access to support	730	91%
Parental resiliency	725	91%
Social connections	707	88%
Parent/child relationships	635	79%
Total participants who showed improvement*	**714**	89%

* Based on average number who showed improvement in each domain

[5] Each parenting program has selected a validated instrument specific to their own curricula; they are not used for comparing program outcomes across the project.

Nurturing Parenting Program (Catholic Charities)

Participants in Catholic Charities Nurturing Parenting Program completed the Adult Adolescent Parenting Inventory (AAPI) during their first and last session of the program. The table below shows that the program was able to collect matched inventories from 433 participants over the past three years. Highest gains were demonstrated in *levels of empathy* and *beliefs in corporeal punishment*, both areas showing improvement among 85% of participants. On average, 73% of participants showed improvement over the course of their engagement in the program.

Skill-Building for Parents and Guardians *Program: Nurturing Parenting Program (Catholic Charities)*		
Skill-Building Outcomes- 3 Years FY 2018/19, 2019/20, 2020/21		
Instrument: Adult Adolescent Parenting Inventory (AAPI) Administered first and last session		
Unduplicated individuals served	997	
Number of graduates	444	45%
Number of graduates w/ matched pre/post	433	98%
Number who showed improvement in:		
Inappropriate expectations	304	70%
Low level of empathy	370	85%
Belief in corporeal punishment	368	85%
Reverse family roles	259	60%
Restricts power and independence	277	64%
Total participants who showed improvement*	**316**	73%

* Based on average number who showed improvement in each domain

Positive Parenting Program (Parents by Choice)

The Positive Parenting Program included three components: Triple P (general parenting classes), Parents of Teens, and Family Transitions (Co-parenting). Each class used a different tool to measure progress towards outcomes. The table below shows:

- PPP saw the greatest success in the Triple P classes, where 82% of participants showed improvement (on average across the targeted domains).
- Sixty-eight percent (68%) of the participants in the Parents of Teens class showed improvement.
- Family Transitions saw 71% of participants improve.

Skill-Building for Parents and Guardians *Program: Positive Parenting Program (Parents by Choice)*		
Outcomes- 3 Years FY 2018/19, 2019/20, 2020/21		
Unduplicated individuals served	1,455	
Number of graduates	1,173	76%
Number of graduates w/ matched pre/post:	1,173	100%
	Showed Improvement	
Regular Triple P classes: Parenting Tasks Checklist (PTC) & Parenting Scale (PS) [n=714]		
Setting self-efficacy (PTC)	586	82%
Behavioral self-efficacy (PTC)	583	82%
Laxness and Overreactivity (PS)	584	82%
Total*	584	82%
Parents of Teen classes: Conflict Behavior Questionnaire (CBQ) & Parenting Scale (PS) [n=202]		
Conflict behavior (CBQ)	133	66%
Laxness and Overreactivity (PS)	141	70%
Total*	137	68%
Family Transitions: Acrimony Scale & Depression Anxiety Stress Scale (DASS) [n=257]		
Acrimony Scale	177	69%
DASS (Depression, Anxiety, Stress) Scale	189	74%
Total*	183	71%
Total participants for all programs who showed overall improvement*	**904**	77%

* Based on average number who showed improvement in each domain

Cost/Benefit Analysis

The following table shows several key indicators of performance 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 $327 per individual served, $656 per graduate, and $757 per graduate who demonstrated improvement in parenting skills.

Skill-Building for Parents and Guardians	
Expenditure/Benefit FY 2020/21	
	Total
Program expenditures	*$541,443*
Unduplicated individuals served	1,280
Expenditure per individual served	*$423*
Number who graduated	637
Expenditure per graduate	*$850*
Number who showed improvement*	552
Expenditure per individual who showed improvement	*$981*

*As defined under Participant Outcomes

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the Skill Building for Parents and Guardians program during the 2020-21 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental materials.

- The project made 30 referrals to mental health treatment. Twenty-four (24) of the referrals were for treatment provided, funded, administered, or overseen by County mental health programs. The average duration of untreated mental illness was 9.8 months.
- Of the 24 County-referred individuals, 3 (13%) were known to have engaged in treatment, defined as attending at least an intake assessment. Two (8%) engaged in treatment within 60 days.
- The average interval between referral and treatment was 12.5 days.

Skill-Building for Parents and Guardians				
Access and Linkage to Treatment Strategy FY 2020/21				
	CAPC	CC	PBC	Total Project
Referrals				
Individuals referred to MH treatment	3	8	19	30
Individuals referred to County administered MH treatment	3	8	13	24
Duration of untreated mental illness (months)				
Average	n/a	9.8	n/a	9.8
Standard deviation	n/a	3.8	n/a	3.8
Linkages to County administered MH treatment within fiscal year				
# Engaged	1	1	1	3
% Engaged	33%	13%	8%	13%
Calendar days between referral and treatment - Average	7.0	18.0	n/a	12.5
Standard deviation	-	-	n/a	7.8
Linkages to County administered MH treatment within 60 days[6]				
# Engaged	1	1	0	2
% Engaged	33%	13%	0%	8%
Calendar days between referral and treatment - Average	7.0	18.0	-	12.5
Standard deviation	-	-	-	7.8

n/a= data not available

Timely Access to Services for Underserved Populations Strategy

Approved claims penetration rates indicate that in San Joaquin County Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with County administered services than the overall County population. For this reason, SJBHS identified these two populations as the focus of the strategy for timely access to services.

The following is a summary of referrals to mental health treatment and PEI programs for these two underserved populations during the 2020/21 fiscal year. Detailed tables are included in the supplemental file.

[6] Starting in 2020/21, SJBHS defines a linkage to treatment as engagement within 60 days. The prior definition included individuals who linked to service before the end of the fiscal year. Both measures are included in the current report.

- During the 2020-21 fiscal year, Skill Building for Parents and Guardians referred 13 Hispanic/Latino individuals to mental health treatment or another PEI program; this represents 30% of all Skill Building for Parents and Guardians referrals.
- Of those, there were 2 known linkages to County mental health treatment.
- No Asian and Pacific Islander individuals were referred to mental health treatment or different PEI programs during the 2020/21 fiscal year.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the Skill Building for Parents and Guardians 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.
- Catholic Charities program reached out by phone to community members with a family or personal need. Nurturing Parenting participants were reminded about service availability once per week or anytime the class topic mentions a high risk personal or family situation.
- CAPC used social media to connect Parent Café Participants to services. Staff posted information about community resources on the Parent Café/CAPC Facebook page. Participants were able to use the chat feature to reach out to their facilitator and request support with applying to services.
- CAPC staff made themselves available to parents through phone or text to help them follow-up on referrals even after the class ended.
- CAPC group facilitators focused on building resiliency during group sessions, especially once they began screening for ACEs. In discussions, they ask participants what healing looks like for them and what they would like to do differently with their children to make sure they grow up in a loving and supportive home. These discussions inspired and motivated participants to take advantage of resources that support them and their children's well-being.

Mentoring for Transitional Age Youth

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.

TAY Mentoring uses the evidence-supported Transition to Independence (TIP) service model. Services focus on the five domains that TIP is designed to impact:

1. Employment and Career
2. Educational Opportunities
3. Living Situation
4. Personal Effectiveness and Wellbeing
5. Community Life Functioning

In FY 2020/21, 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)

Project Outputs

In FY 2020/21, the TAY Mentoring Project served a total of 409 individuals. 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.

Mentoring for Transitional Age Youth			
Outputs FY 2020/21			
	CAPC	WCYFS	Total Project
Unduplicated individuals served	216	193	409
Unduplicated individuals enrolled during fiscal year	183	141	324
Number of individuals who graduated*	103	103	206
Percent who graduated (among all individuals served)	48%	53%	50%
Number of sessions delivered	1,049	1,590	2,639
Average number of sessions delivered per individual	4.9	8.2	6.5
Organizational Survey fidelity scores (average)	77%	97%	87%
TIP Practice Probes fidelity scores (average)	92%	76%	84%

*Graduated=completed at least one self-identified goal

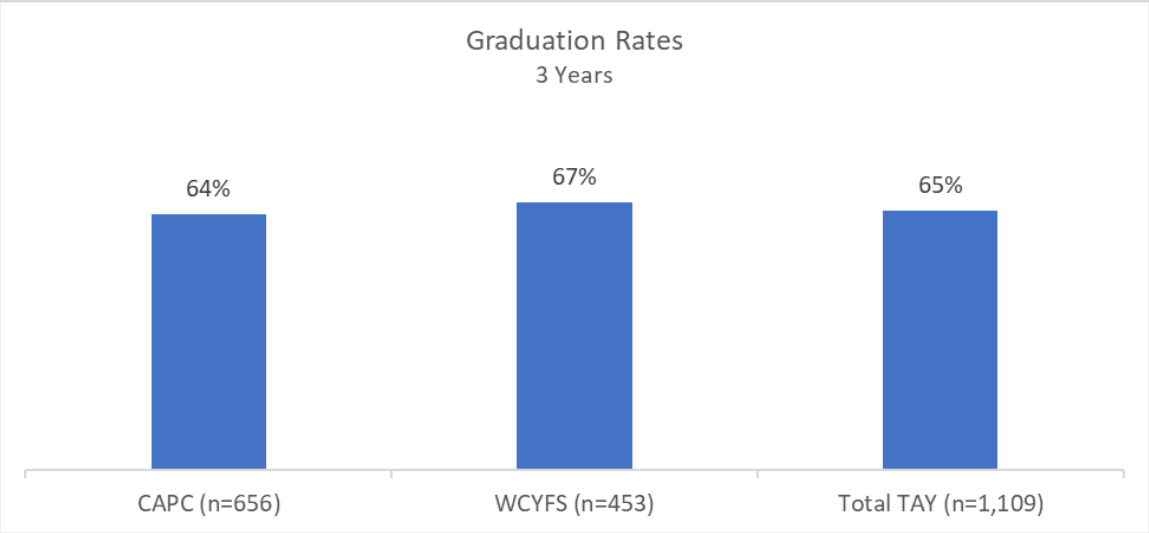
Demographic forms were collected upon intake or initiation of services. Complete demographic tables from 2020/21 are included in the appendix to this report.

Participant Outcomes

The TAY program measured impacts by evaluating their progress in three outcome areas: graduation rates, progress toward self-identified goals (measured by TIP Tracker), and reduction in risk (as measured by assessing needs and strengths using an abbreviated CANSA).

Graduation rates

Graduation from this program was defined as participants having completed at least one of their self-identified program goals. According to the records across three years, 65% of the participants served graduated (completed their goals).

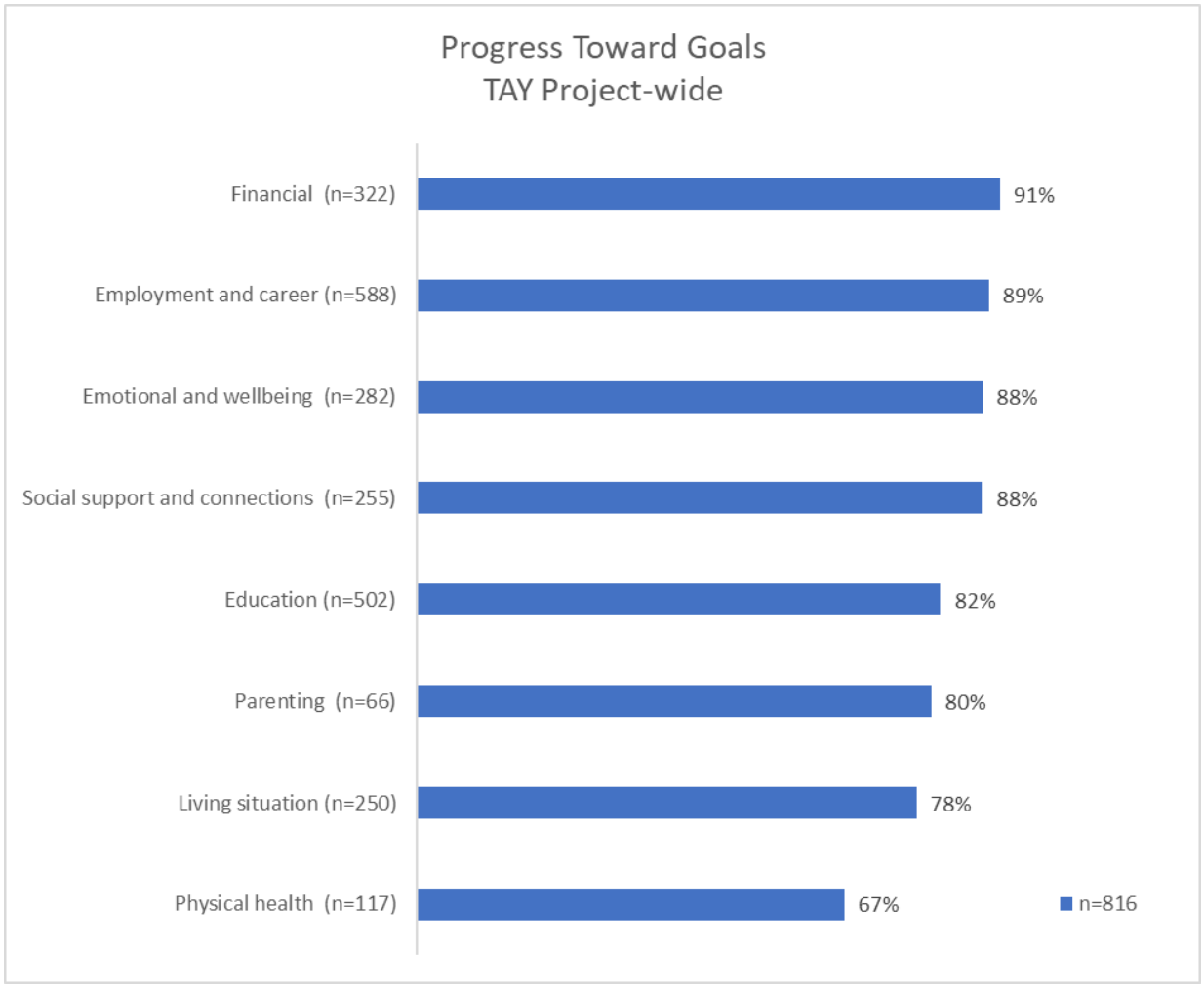


Progress towards self-identified goals

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 figure shows percentage of participants who showed improvement in meeting their self-identified goals.

Taken together across three years of data collection, TAY participants were most successful in the areas of finance, employment, emotional wellbeing, and social support. The category that proved most challenging was physical health.

The TIP categories of employment and education were the most common targeted goals (as indicated by the total number of participants that identified goals in that category).

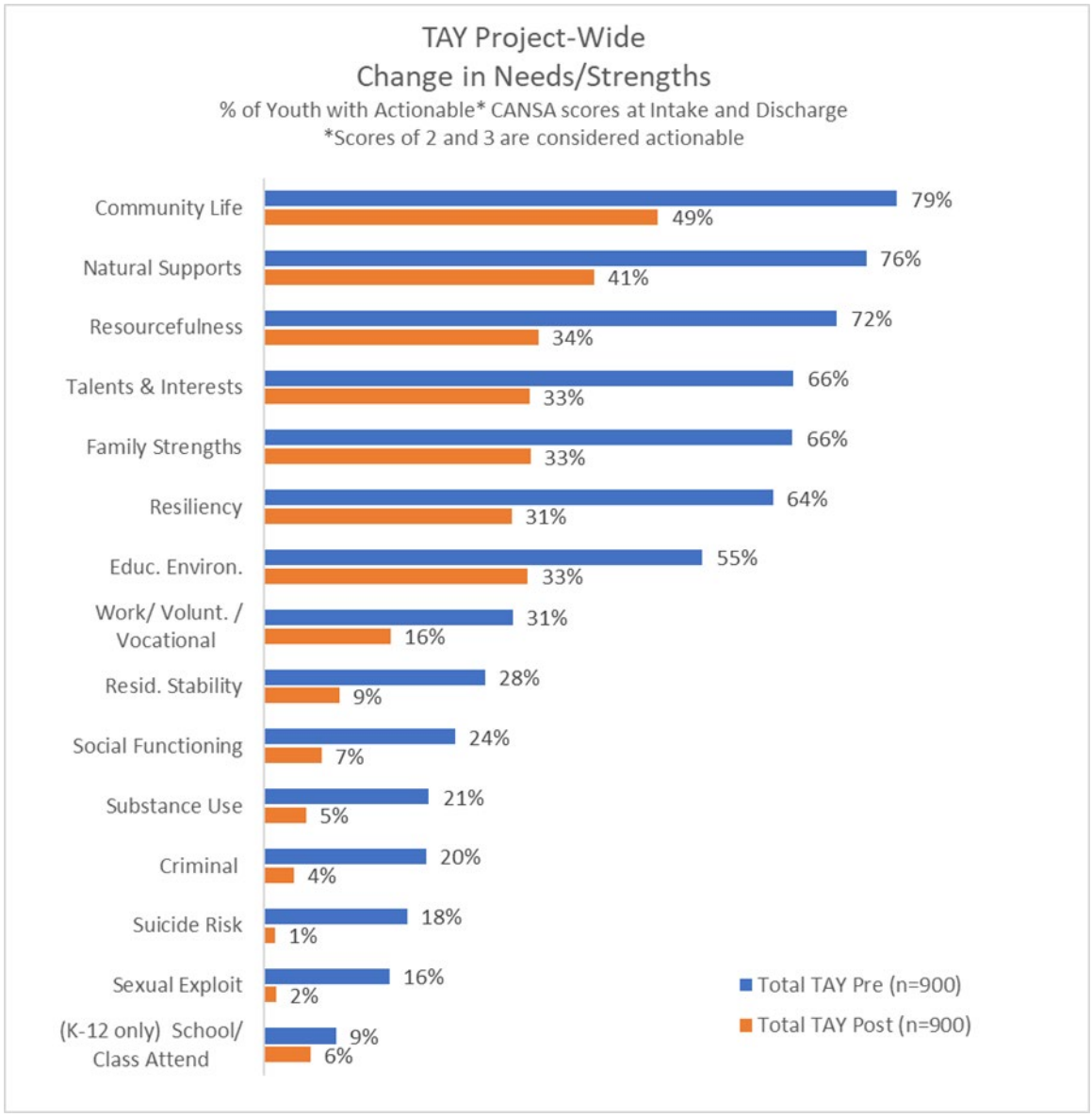


Note: the sample size noted with each set of bars denotes the cumulative number of participants who identified a goal in that category.

Reduced risk

The third area of outcomes involved changes in participant needs and strengths, measured with an abbreviated 15-item CANSA tool administered at intake and discharge. The 15 items that were selected for inclusion in the evaluation were the needs and strengths that program managers felt could be addressed through the TIP model.

At intake and at discharge, participants were scored on these 15 areas. A score of a 2 or a 3 indicates a need in that designated area. The figure below shows that the most prevalent issues faced by TAY participants involved a deficit of protective strengths related to *community life, natural supports* and *resourcefulness*. For example, 79% of TAY participants presented with needs in their *community life* when starting with the TAY program. This dropped to 49% at discharge, a significant improvement. Participants showed improvements in all 15 areas.



The fifteen CANSA ratings were summed to form an overall needs score. The score at the beginning of services was compared to the score at the end of services. Two-thirds of students (67%) showed decreased scores, indicating a reduction in need and/or increase in strengths.

Cost/Benefit Analysis

The following table shows several key indicators of performance for the TAY project as a whole, including costs of the project (represented by amounts invoiced) as well as the cost per participant and cost per graduate.

The project cost $1,699 per individual served and $3,374 per graduate.

Mentoring for Transitional Age Youth	
Expenditure/Benefit FY 2020/21	
	Total
Program Expenditures	*$695,004*
Unduplicated individuals served	409
Expenditures per individual served	*$1,699*
Number who graduated	206
Expenditures per graduate	*$3,374*

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the TAY Mentoring Project during the 2020-21 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental materials.

- The project made referrals for 49 to mental health treatment, all of which were for treatment provided, funded, administered, or overseen by County mental health programs.
- The average duration of untreated mental illness was 10.8 months.
- Of the 49 County-referred individuals, 17 (35%) were known to have engaged in treatment before the end of the fiscal year. Eleven engaged within 60 days, with an average interval of 12.7 days between referral and treatment.

Mentoring for Transitional Age Youth			
Access and Linkage to Treatment Strategy FY 2020/21			
	CAPC	WCYFS	Total TAY
Referrals			
Individuals referred to MH treatment	21	28	49
Individuals referred to County administered MH treatment	21	28	49
Duration of untreated mental illness (months)			
Average	10.8	n/a	10.8
Standard deviation	10.2	n/a	10.2
Linkages to County administered MH treatment within fiscal year			
# Engaged	4	13	17
% Engaged	19%	46%	35%
Calendar days between referral and treatment - Average	42.5	63.8	58.8
Standard deviation	66.7	80.8	76.3
Linkages to County administered MH treatment within 60 days[7]			
# Engaged	3	8	11
% Engaged	14%	29%	22%
Calendar days between referral and treatment - Average	9.7	13.9	12.7
Standard deviation	14.2	8.6	9.8

n/a=data not available

[7] Because state regulations do not define the maximum interval between referral and treatment, we report the number of individuals linked to treatment 1) within the same fiscal year as referral and 2) within sixty days of referral

Timely Access to Services for Underserved Populations Strategy

The following is a summary of 2020/21 referrals to treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[8]. Summary tables are included in the supplemental file.

- During the 2020-21 fiscal year, TAY referred 63 transition age youth to mental health treatment or another PEI program. This included twelve (12) Hispanics/Latino individuals, representing 19% of all TAY referrals.
- Three (3) Asian and Pacific Islander program participants were referred to mental health treatment or another PEI program which represents 5% of all TAY referrals.
- There were no known linkages to County mental health treatment for either of these underserved populations.

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 describe 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 program monitors all referrals at case management meetings through Apricot (case management software). Follow up on all referrals and appointments with potential clients is initiated by the TAY Specialist within 24 hours. 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.

[8] Approved claims penetration rates indicate that in San Joaquin County, Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

Coping and Resilience Education Services (CARES)

Project Description

CYS's CARES project serves children and youth (ages 5-18), and their caregivers, who are at risk for CPS involvement, exposed to trauma, or referred by Child Welfare, but who do not meet medical necessity for specialty mental health services. 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. Families receive trauma-informed training using the Parents Reach Achieve and Excel through Empowerment Strategies (PRAXES) curriculum. Staff provide one-on-one and group support.

Project Outputs

In the 2020/21 fiscal year, the CARES project served a total of 315 individuals—221 children and 94 parents/caregivers. 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 (CIM/YIM) and parents/caregiver (PRAXES) curriculums.

Coping and Resilience Education Services (CARES)	
Outputs FY 2020/21	
Number of individuals who attended an outreach event	308
Number of children/youths referred to program	184
Number of children served in the program*	221
Number of caregivers served in the program*	94
Unduplicated number of participants	**315**
Number of adults who completed PRAXES curriculum	16
Number of children who completed CIM/YIM curriculum	49
Total number of individuals who completed (graduated) from program	**65**

*Includes rollovers from previous fiscal year

Demographic forms were collected upon intake or initiation of services. Complete demographic tables from 2020/21 are included in the appendix to this report.

Participant Outcomes

The CARES program used the Parental Stress Index at intake and discharge. The index has four sub-domains: Defensive Responding (DR), Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC). Eighty-six percent (86%) of the 76 matched pre- and post-tests demonstrated a reduction in stress across each of the 4 domains.

Coping and Resilience Education Services (CARES)						
Outcomes- 3 Years FY 2018/19, 2019/20, 2020/21						
Instrument: Parental Stress Index Administered at program initiation and completion						
Number of participants	191					
Number of matched pre/post tests	76					
	DR	PD	P-CDI	DC	Total Stress	% Reduced stress
Number of individuals showing reduction in stress	58	64	57	66	65	86%
Average Pre-Score	20.3	33.0	33.6	36.8	104.2	
Average Post-Score	15.4	24.7	25.8	28.6	79.3	
Average difference	4.8	8.3	7.8	9.0	24.8	
Standard Deviation of Difference	6.3	11.5	10.2	9.6	26.7	

CARES used the Pediatric Symptom Checklist to measure youth risk. Of the 233 youth who received matched pre- and post-screenings, 203 (87%) showed a reduction in symptoms.

Coping and Resilience Education Services (CARES)		
Outcomes- 3 Years FY 2018/19, 2019/20, 2020/21		
Instrument: Pediatric Symptom Checklist Administered at program initiation and completion		
Number of matched pre and post tests	233	
PSC-35 score		
Number of individuals showing reduction in symptoms	203	87%
Average Pre-Score	21.6	
Average Post-Score	13.0	
Average Difference	8.7	
Standard Deviation of Difference	9.0	

Cost/Benefit Analysis

The following table shows key indicators of performance for the CARES program, including costs of the project, cost per participant, and cost per individual who showed improved outcomes.

The programs cost $6,131 per individual served and $7,088 per participant who demonstrated improvement.

Coping and Resilience Education Services (CARES)	
Expenditure/Benefit FY 2020/21	
Program Expenditures	*$1,040,851*
Unduplicated individuals served	315
Expenditures per individual served	*$3,304*
Number who showed improvement*	272
*Expenditure per individual who showed improvement**	*$3,820*

*As defined under Participant Outcomes and extrapolated from existing sample

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the CARES program during the 2020-21 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental materials.

- The project made referrals for nine (9) individuals, all of which were mental health referrals for treatment provided, funded, administered, or overseen by County mental health programs.
- The average duration of untreated mental illness was 1.3 months.
- Of the nine County-referred individuals, eight (89%) were known to have engaged in treatment, defined as attending at least an intake assessment before the end of the fiscal year. Seven (78%) engaged in treatment within 60 days[9], with an average interval of 33 days between referral and treatment.

[9] Because state regulations do not define the maximum interval between referral and treatment, we report the number of individuals linked to treatment 1) within the same fiscal year as referral and 2) within sixty days of referral

Timely Access to Services for Underserved Populations Strategy

The following is a summary of 2020/21 referrals to mental health treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[10]. Summary tables are included in the supplemental file.

- During the 2020-21 fiscal year, CARES made nine (9) referrals to mental health treatment or another PEI program. This included (1) Hispanic/Latino individual, representing 11% of all CARES referrals.
- Of those, there were no known linkages to County mental health treatment.
- No Asian and Pacific Islander individuals were referred to mental health treatment or different PEI programs during the 2020/21 fiscal year.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the CARES program 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.
- CARES ensures access and follow through on referrals by clear communication via phone and email between supervisor, program clinician, and all other staff. When referrals are received by fax or email, the supervisor ensures that a clinician makes contact and attempts a screening within 3 business days. The referral source is kept updated throughout the screening/intake process.
- CYS staff are also encouraged to submit referrals for unserved children and youth who do not meet medical necessity for a higher level of mental health treatment or who have siblings who may benefit from preventative-level support.

[10] Approved claims penetration rates indicate that in San Joaquin County Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

Intervention

Early Intervention to Treat Psychosis (TEIR)

Project Description

The Telecare Early Intervention and Recovery Services (TEIR) Project 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. 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

In FY 2020/21, the TEIR Project provided early intervention services to a total of 62 unduplicated individuals. 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.

Telecare Early Intervention and Recovery Services (TEIR)	
Outputs FY 2020/21	
Number of early psychosis outreach presentations delivered	33
Number of individuals who received presentations	63
Number of early psychosis screenings completed	19
Number of screenings that resulted in program eligibility	15
Total unduplicated count of individuals receiving early intervention*	62
Average number of individuals receiving services per quarter*	46
Number of family members who participated in program*	29

*Includes individuals continuing services from previous fiscal year

Demographic forms were collected at the time of initiating services. Complete demographic tables from 2020/21 are included in the appendix to this report.

Participant Outcomes

The TEIR program tracked progress toward outcomes two ways: program completion rates and needs/strengths as measured by the CANSA.

Program completion rates

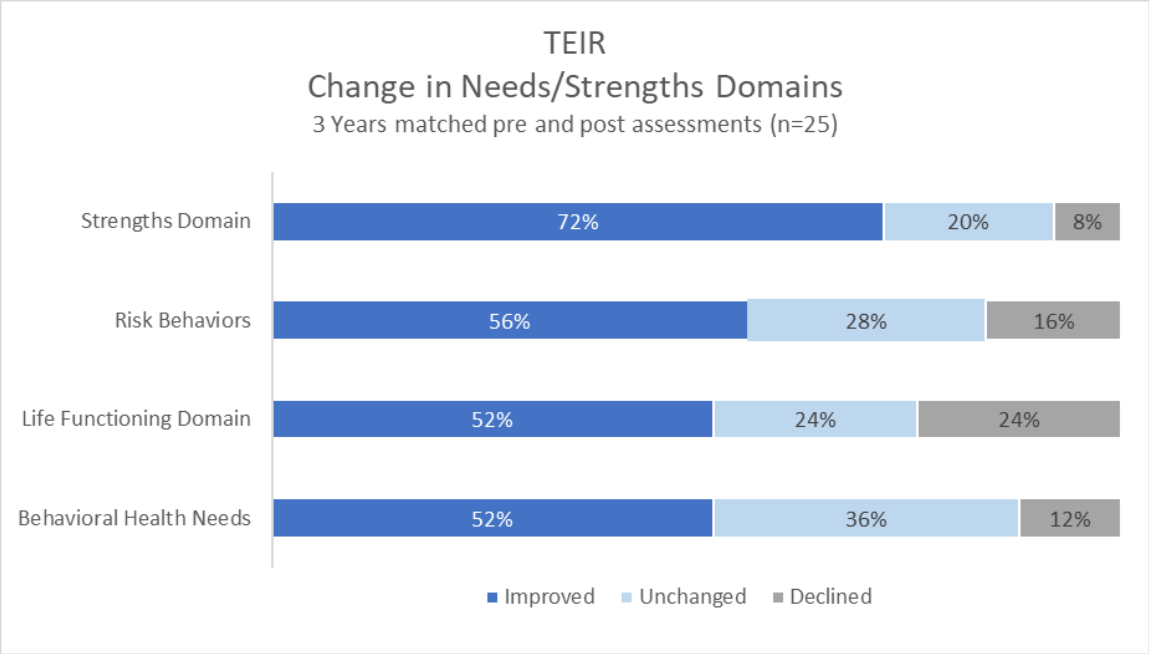
TEIR intends to maximize the number of participants who discharge from services having completed program objectives. The table below shows the status for each of the clients discharged during the three-year period. A total of 33 discharged clients completed program objectives (70%).

Telecare Early Intervention and Recovery Services (TEIR)		
Three- Year Program Completion Rates		
	Count	%
Completed program objectives - did not transition to another mental health program	17	36%
Completed program objectives - transitioned to a lower level of care with BHS	5	11%
Completed program objectives - transitioned to a lower level of care with a community-based resource	11	23%
Did not complete program objectives - voluntarily dropped out of program and did not seamlessly transition to another mental health program	5	11%
Did not complete program objectives - discharged to higher level of care (e.g., IMD/Locked)	3	6%
Did not complete program objectives - discharged to jail or prison	0	0%
Moved out of the area, but successfully transitioned to another early intervention program	2	4%
Can't find client/lost to services	3	6%
Realization that client does not meet minimum program requirements (i.e., no psychosis)	1	2%
Total discharges	47	

Reduction in risk factors (CANS/ANSA Outcomes)

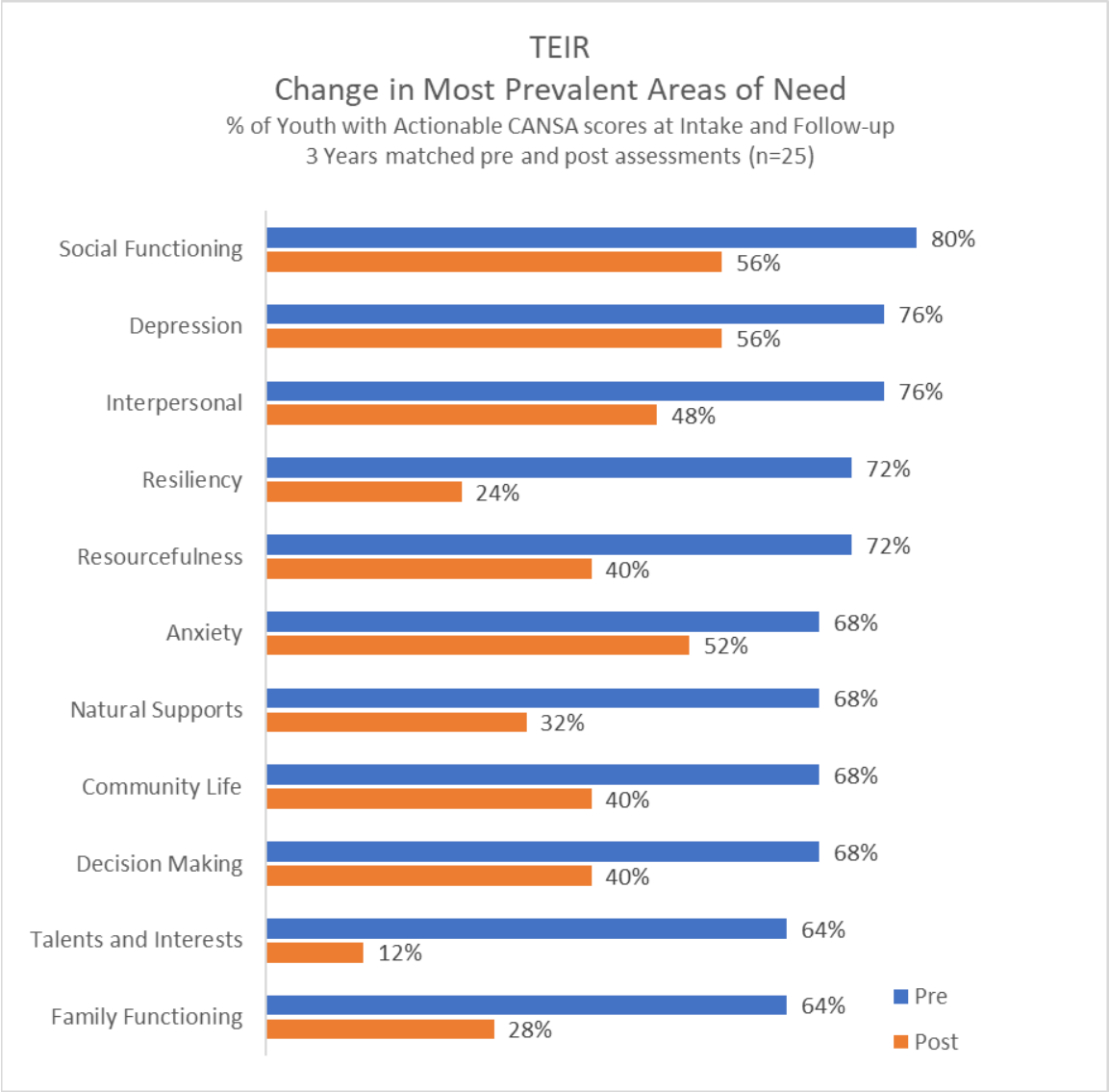
TEIR participants were assessed using the CANSA at intake, 6-month intervals, and at discharge from the program. During the three-year evaluation period, there were 25 matched intake and follow-up assessments among clients who received services for a minimum of one year.[11]

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. Seventy-two percent (72%) of clients had an overall improvement in the Strengths domain. Just over half of clients demonstrated improvements in Risk Behaviors (56%), Life Functioning (52%), and Behavioral Health Needs (52%). Behavioral Health Needs proved to be the domain most resistant to change (36% unchanged), while Life Functioning saw the largest decline (24%).



In addition to the Needs/Strength domains, our analysis explored the prevalence of specific needs or strengths that comprise the domains. The figure below shows the eleven areas that had the highest rates of actionable scores. Eighty percent (80%) of clients presented with actionable scores for Social Functioning at intake. This dropped to 56% at follow-up. Depression and Interpersonal Needs were other top issues that saw significant reduction. Resiliency saw one of the largest shifts, with a drop from 72% to 24% presenting an actionable score.

[11] The analysis matches the most recent assessment completed with the earliest assessment completed. The current analysis was limited to clients who engaged for at least one year, but the interval between intake and discharge assessments varied.



The figures 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 TEIR program cost $16,210 per individual served.

Telecare Early Intervention and Recovery Services (TEIR)	
Expenditure/Benefit FY 2020/21	
Program Expenditures	*$1,005,023*
Unduplicated individuals served	62
Expenditures per individual served	$16,210

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the TEIR program during the 2020-21 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental materials.

- The project made referrals for five (5) individuals to mental health treatment. Three (3) of the five mental health referrals were for treatment provided, funded, administered or overseen by County mental health programs.
- The average duration of untreated mental illness was 24 months.
- Of the three (3) County-referred individuals, one (1) was known to have engaged in treatment, defined as attending at least an intake assessment before the end of the fiscal year[12]. The interval between referral and treatment was 82 days.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of 2020/21 referrals to treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[13]. Summary tables are included in the supplemental file.

- During the 2020-21 fiscal year, TEIR referred seven (7) individuals to mental health treatment or another PEI program. This included four (4) **Hispanic/Latino** individuals, representing 57% of all TEIR referrals.
- Of those, there was one (1) known linkage to County mental health treatment. At this time, it is not possible to track linkages to non-County mental health or other PEI

[12] Because state regulations do not define the maximum interval between referral and treatment, we report the number of individuals linked to treatment 1) within the same fiscal year as referral and 2) within sixty days of referral

[13] Approved claims penetration rates indicate that in San Joaquin County, Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

programs, so ostensibly, more could have received the services to which they were referred.

- No Asian and Pacific Islander individuals were referred to mental health treatment or different PEI programs during the 2020/21 fiscal year.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and TEIR 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.
- TEIR follows a 24-hour follow-up protocol with two individuals in charge of getting back with the referral within this timeframe.
- To support timely access, all staff are trained to conduct screenings.

Prevention and Early Intervention (Combined)

School Based Intervention for Children and Youth

Project Description

School Based Interventions provide brief mental health counseling and early intervention services, including 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 project focuses on a team concept, partnering school personnel with clinical staff in the classroom.

In FY 2020/21, the School Based Interventions Project was delivered by two community-based providers:

- Child Abuse Prevention Council of San Joaquin County (CAPC)
- Sow A Seed Community Foundation

Project Outputs

In the 2020/21 fiscal year, the School Based Interventions project served a total of 220 students. The vast majority participated in preventative services, with two students enrolling in intervention services.

School Based Interventions			
Outputs FY 2020/21			
	CAPC	SAS	Total
Enrolled in prevention services	139	80	219
Enrolled in early intervention services	2	0	2
Unduplicated individuals served	140	80	220
Individual case management provided (hours)	130.8	29.9	160.7
Group services			
Groups initiated	22	24	46
Number of sessions delivered	167	74	241
Average number of sessions per group	7.6	3.1	5.2
Unduplicated number of students who participated in group services	86	44	130
Total number of sessions attended (duplicated participant count)	162	131	293
Average number of sessions attended per student	1.9	3.0	2.3
Number of students who graduated*	73	19	92
Support team meetings (involving contractor, school personnel, and students, and/or parents/caregivers)			
Number of student support team meetings	171	4	175
Training			
Number of parent/caregiver trainings/presentations	3	0	3
Number of parents/caregivers trained	31	0	31
Number of school personnel trainings/presentations	45	6	51
Number of school personnel trained	221	54	275

*Graduated=attended 50% or more of group sessions provided

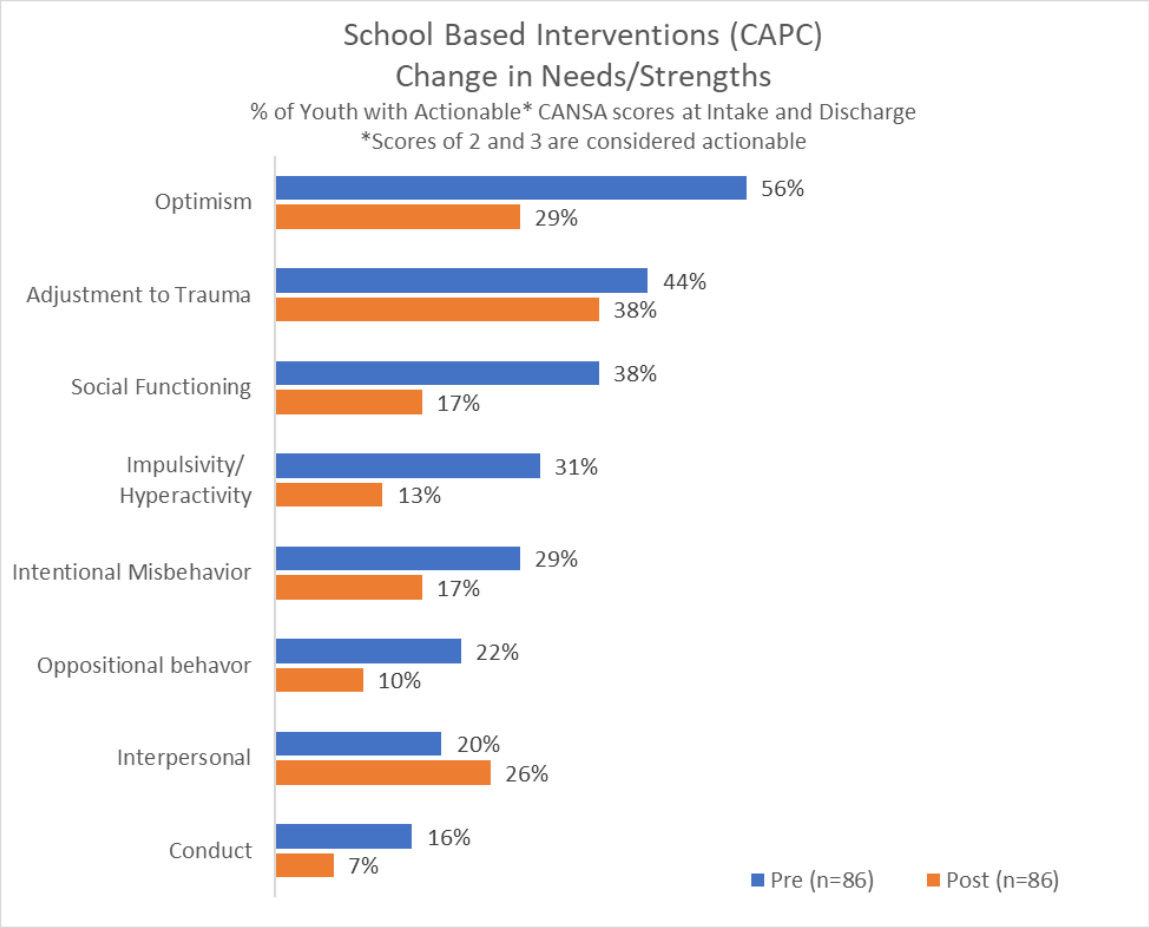
Demographic forms were collected at the time of initiating services. Complete demographic tables from 2020/21 are included in the appendix to this report.

Participant Outcomes

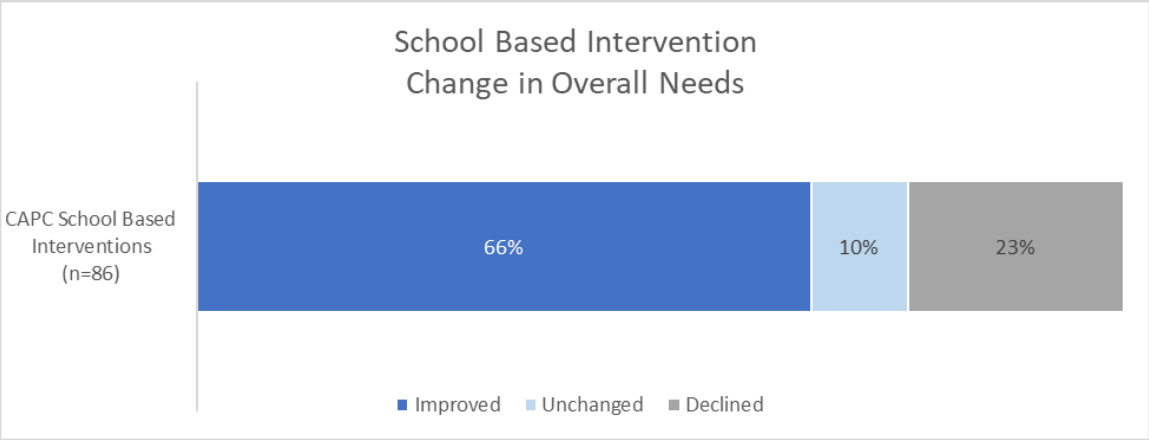
School based prevention services were intended to result in reduced needs and increased strengths. These outcomes were measured with an abbreviated 8-item CANSA tool administered at the beginning and end of services. The eight items that were selected for inclusion in the evaluation were the areas of need that program managers felt could be addressed through the program activities.

At the beginning and end of CAPC services, participants were scored on these eight areas. A score of a 2 or a 3 indicated an actionable need in the designated area. The figure below shows that the

most prevalent issues faced by participants involved *optimism, adjustment to trauma* and *social functioning*. In seven of the eight areas, students showed a reduction in need. Just over half of the students (56%) presented with needs in *optimism* when starting with the program. This dropped to 29% at the time of concluding services.



The eight CANSA ratings were summed to form an overall Needs score. The score at the beginning of services was compared to the score at the end of services. Two-thirds of students (66%) showed decreased scores, indicating a reduction in need, and conversely an improvement in strengths.



Cost/Benefit Analysis

The following table shows several key indicators of performance for the School Based Interventions project, including costs of the project, cost per participant, and cost per individual who showed improvement. The programs cost $1,303 per individual served, $1,974 per student who demonstrated improvement in overall needs.

School Based Interventions	
Expenditure/Benefit FY 2020/21	
	Total
Program Expenditures	*$286,557*
Unduplicated individuals served	220
Expenditures per individual served	*$1,303*
Percent who showed improvement*	66%
*Expenditures per individual who showed improvement**	*$1,974*

*As defined under Participant Outcomes and extrapolated from existing sample

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the School Based Interventions program during the 2020-21 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental materials.

- The project made mental health treatment referrals for five individuals, one (1) of which was for treatment provided, funded, administered, or overseen by County mental health programs.
- The average duration of untreated mental illness was 36 months.
- The one County-referred individual was known to have engaged in treatment (defined as attending at least an intake assessment) five days after referral.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of 2020/21 referrals to treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[14]. Summary tables are included in the supplemental file.

- During the 2020-21 fiscal year, School Based Interventions referred ten (10) individuals to mental health treatment or another PEI program. This included three (3) Hispanic/Latino individuals, representing 30% of all referrals.
- Of those, there was one known linkage to County mental health treatment.
- No Asian and Pacific Islander individuals were referred to mental health treatment or different PEI programs during the 2020/21 fiscal year.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the School Based Interventions 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.
- SAS School Based Interventions engaged families and communicated with parents so that families have a solid understanding of services. Staff called families prior to group meetings to encourage student attendance and did a parent check-in at least twice during the program.
- The CAPC staff reported that all referrals were contacted within 24 hours. Their goal was to meet the needs of the clients and families through the development of a collaborative relationship.

[14] Approved claims penetration rates indicate that in San Joaquin County, Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

Juvenile Justice Project

Project Description

The Juvenile Justice Project was delivered by BHS's Children and Youth Services Division (CYS). CYS provides behavioral health evaluations and transition services for youth detained at San Joaquin County's Juvenile Justice Center (JJC). Upon detention, JJC staff administered a MAYSI-II screening. CYS evaluated 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 agreed to participate in CYS services they received a comprehensive behavioral health assessment, including an intake CANSA. Youth determined to be SMI/SED received early intervention-oriented mental health services whereas those who were not SMI/SED receive prevention-oriented services. If youth were detained for 60 days or longer, they received a follow-up CANSA assessment, which was used to measure outcomes related to mental status, risk and protective factors.

Project Outputs

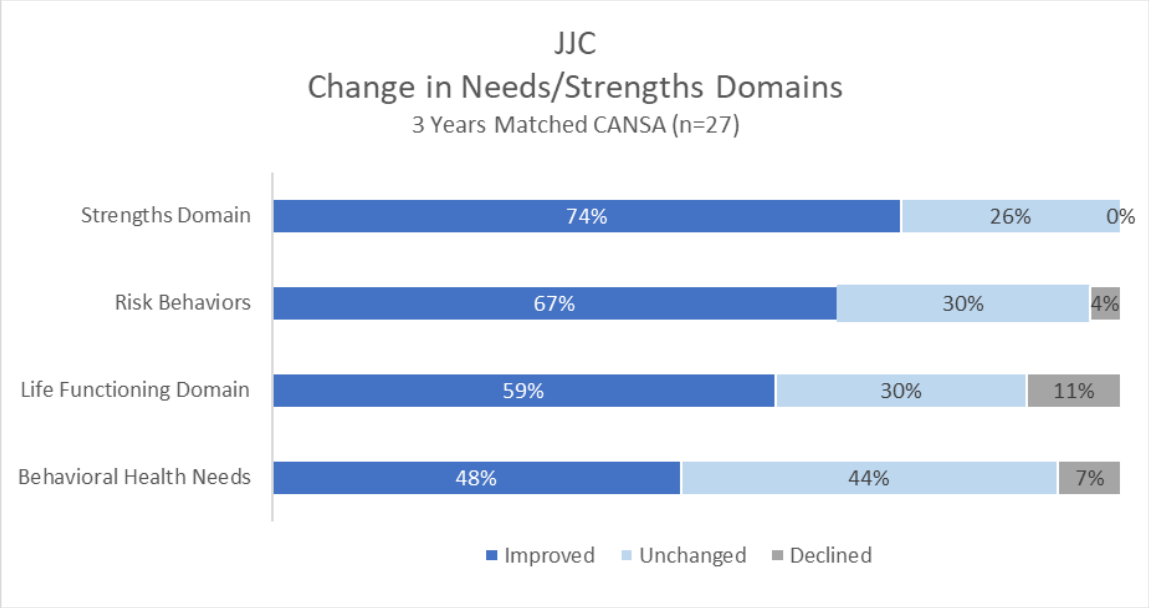
In FY 2020/21 CYS conducted 355 evaluations of youth entering the juvenile detention facility. Of those, 157 were detained long enough and agreed to a comprehensive psychosocial assessment. Eighty-eight of those who were identified as severely emotionally disturbed received at least one early intervention service. Five who were not SED participated in prevention services. In total, the Juvenile Justice Project served a total of 93 unduplicated youth with PEI services.

Juvenile Justice Project			
Outputs FY 2020/21			
	n	%	
Number who had a brief evaluation	355		
Number who received a comprehensive psychosocial assessment (i.e., in detention long enough, agreed to an assessment)	157	44%	% of all evaluated youth
Intervention Services			
Number with SMI/SED who were eligible for early intervention services	121	77%	% who were evaluated that qualified for early intervention
Number with SMI/SED who received at least one early intervention service	88	73%	% of eligible who received early intervention services
Prevention Services			
Number without SMI/SED who were eligible for prevention services	15	10%	% who were evaluated and qualified for prevention services
Number without SMI/SED who received at least one prevention service	5	33%	% of eligible who received prevention services
Total			
Total receiving PEI services	93	68%	% of eligible youth who received at least one service

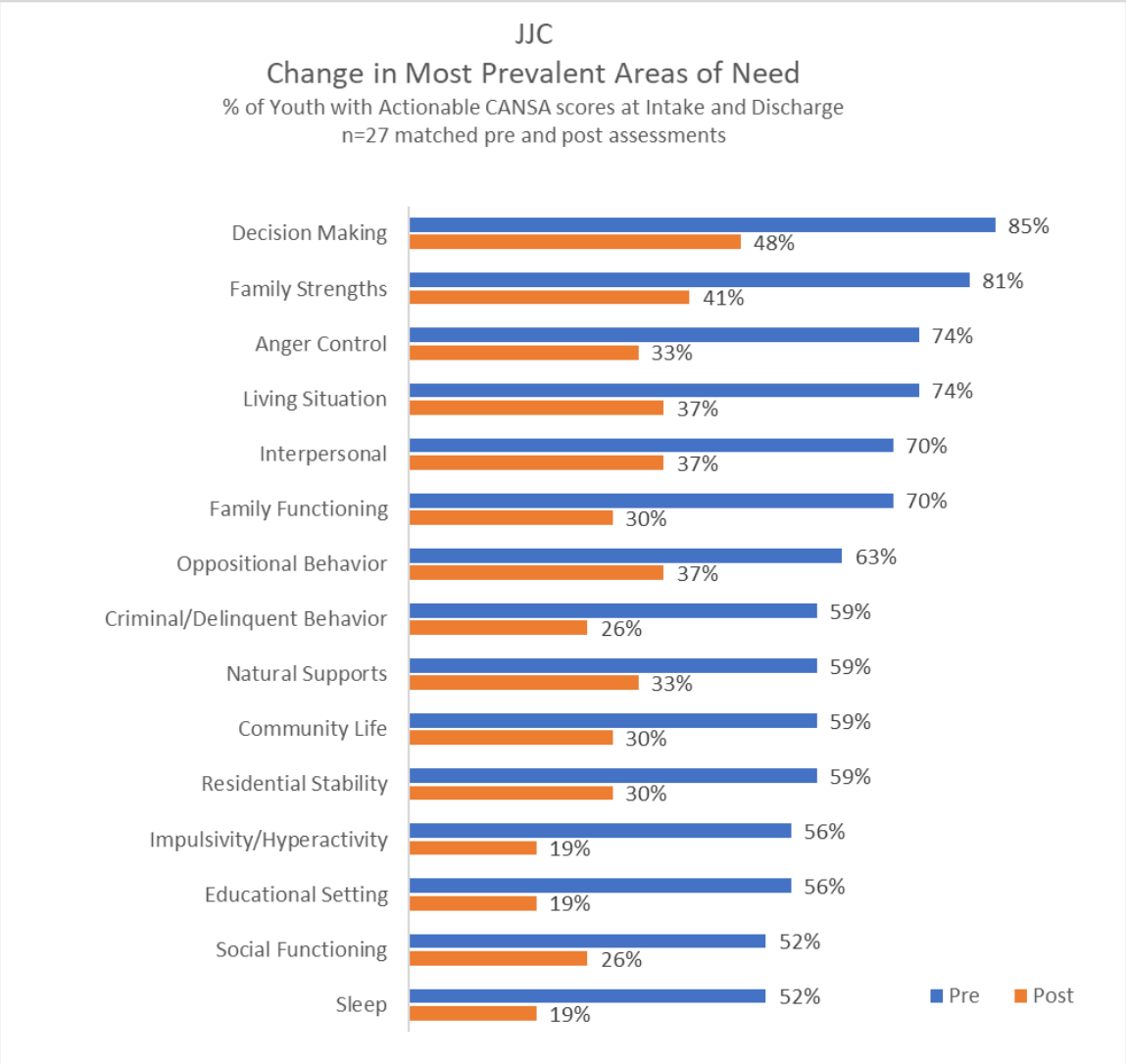
Demographic forms were collected at the time of initiating services. Complete demographic tables from 2020/21 are included in the appendix to this report.

Participant Outcomes

A CANSA assessment was completed at intake and at 60-day intervals during participants' detention period. Because few youths were detained for more than 60 days, over a three year period there were only 27 matched datasets (from intake to most recent assessment). 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. Seventy four percent (74%) of clients had an overall improvement in the Strengths domain. Two-thirds of clients demonstrated improvements in Risk Behaviors (67%). Behavioral Health Needs proved to be the domain most resistant to change (48% improvement, 44% unchanged).



In addition to the Needs/Strength domains, our analysis explored the prevalence of more specific needs that comprise the domains. The figure below shows the fifteen specific needs areas that had the highest rates of actionable scores. Eighty-five percent (85%) of clients presented with actionable scores for Decision Making at intake. The percentage of clients with actionable scores at discharge dropped to 48%. There were improvements in all 15 areas. Family Strengths and Anger Control were other particularly high-need areas that saw significant improvement during the time engaged with the Juvenile Justice Project.



Cost/Benefit Analysis

The following table shows key indicators of performance, including costs of the project as well as cost per participant. The Juvenile Justice Project cost $7,457 per individual assessed and $12,589 per individual who received prevention or early intervention treatment.

Juvenile Justice Project	
Expenditure/Benefit FY 2020/21	
Program Expenditures	*$1,170,752*
Unduplicated individuals assessed	157
Expenditures per individual assessed	*$7,457*
Unduplicated individuals served with PEI services	93
Expenditures per individual served	$12,589

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the Juvenile Justice Project during the 2020-21 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental materials.

- The project made 113 referrals to mental health treatment. Seventy-five (75) of the referrals were for treatment provided, funded, administered, or overseen by County mental health programs.
- Of the 75 County-referred individuals, 52 (69%) were known to have engaged in treatment, defined as attending at least an intake assessment within the fiscal year. Thirty-eight (51%) engaged in treatment within 60 days, with an average of 17.8 days between referral and treatment.
- Data on the duration of untreated mental illness were not collected at the time of referral.

Juvenile Justice Project	
Access and Linkage to Treatment Strategy FY 2020/21	
Referrals	
Individuals referred to MH treatment	113
Individuals referred to County administered MH treatment	75
Duration of untreated mental illness (months) - Average	n/a
Standard deviation	n/a
Linkages to County administered MH treatment within fiscal year	
# Engaged	52
% Engaged	69%
Calendar days between referral and treatment - Average	66.3
Standard deviation	101.8
Linkages to County administered MH treatment within 60 days[15]	
# Engaged	38
% Engaged	51%
Calendar days between referral and treatment - Average	17.8
Standard deviation	18.2

n/a= data not available

[15] Because state regulations do not define the maximum interval between referral and treatment, we report the number of individuals linked to treatment 1) within the same fiscal year as referral and 2) within sixty days of referral

Timely Access to Services for Underserved Populations Strategy

The following is a summary of 2020/21 referrals to treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[16]. Summary tables are included in the supplemental file.

- During the 2020-21 fiscal year, the Juvenile Justice Project referred 62 Hispanic/Latino individuals to mental health treatment or another PEI program; this represents 55% of all 113 referrals.
- Of those, there were 28 known linkages to County mental health treatment within the fiscal year.
- The Juvenile Justice Project referred five Asian and Pacific Islander individuals to mental health treatment or different PEI programs during the 2020/21 fiscal year, representing 4% of all referrals.
- Of those, there was one known linkage to County mental health treatment within the fiscal year.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the Juvenile Justice 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.
- JJC staff followed up with youth who initially declined services to see if they had reconsidered and later wanted services.
- JJC staff worked with Social Workers and Probation Officers to facilitate linkage to post-release services for dependents and wards.

[16] Approved claims penetration rates indicate that in San Joaquin County, Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

Outreach for Increasing Recognition of Early Signs of Mental Illness

NAMI Outreach for Increasing Recognition of Early Signs of Mental Illness

Project Description

Outreach for Increasing Recognition of Early Signs of Mental Illness was delivered by National Alliance on Mental Illness San Joaquin (NAMI). NAMI's Provider Education introduces mental health professionals to the unique perspectives of people with mental health conditions and their families. Participants develop enhanced empathy for their daily challenges and recognize the importance of including them in all aspects of the treatment process.

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.

Project Outputs

NAMI delivered one online Provider Education class to nine (9) Behavioral Health Providers. Demographic tables from 2020/21 are included in the supplemental materials.

Cost/Benefit Analysis

The following table shows the amount invoiced by the provider for both the *Outreach for Early Recognition (OER) 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 OER or SDR programming was $340.

Outreach for Increasing Recognition of Early Signs of Mental Illness and Stigma and Discrimination Reduction	
Expenditure/Benefit FY 2020/21	
Program Expenditures (OER and SDR combined)	*$65,004*
Total individuals trained in Stigma and Discrimination Reduction programming (IOOV, F2F, P2P)	183
Total individuals trained in Outreach for Early Recognition	9
Total number of individuals trained	191
Expenditure per individual trained	*$340*

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 another PEI program or to a higher level of mental health treatment.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and NAMI 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.
- Information about SJCBHS and other services are shared with program participants. NAMI program leaders provide confidential follow-up support upon request.

Stigma and Discrimination Reduction

NAMI Stigma and Discrimination Reduction Program

Project Description

Community Trainings to reduce stigma and discrimination are provided by NAMI volunteers throughout San Joaquin County.

Project Outputs

A total of 183 individuals were reached through the Stigma and Discrimination Reduction Project in FY 2020/21.[17] The following table shows the type and number of each training/workshop offered and the number of individuals reached.

NAMI Stigma and Discrimination Reduction Program		
Output FY 2020/21		
	Number of trainings/ workshops provided	Number of individuals reached
In Our Own Voice (IOOV) 60 to 90-minute presentations by two trained speakers describing personal experiences living with mental health challenges and achieving recovery	15	116
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.	3	53
Peer to Peer (P2P) 10-session class to help adults living with mental health challenges achieve and maintain wellness taught by Peer Mentors living in recovery	1	14
TOTAL	**19**	**183**

Demographic forms were collected at the time of initiating services. Demographic tables from 2020/21 are included in the supplemental materials.

[17] NAMI Stigma and Discrimination Reduction Programming reached 694 individuals in FY 2018/19 and 418 in FY 2019/20. The declining participation is likely due to COVID-19 and related closures and social distancing.

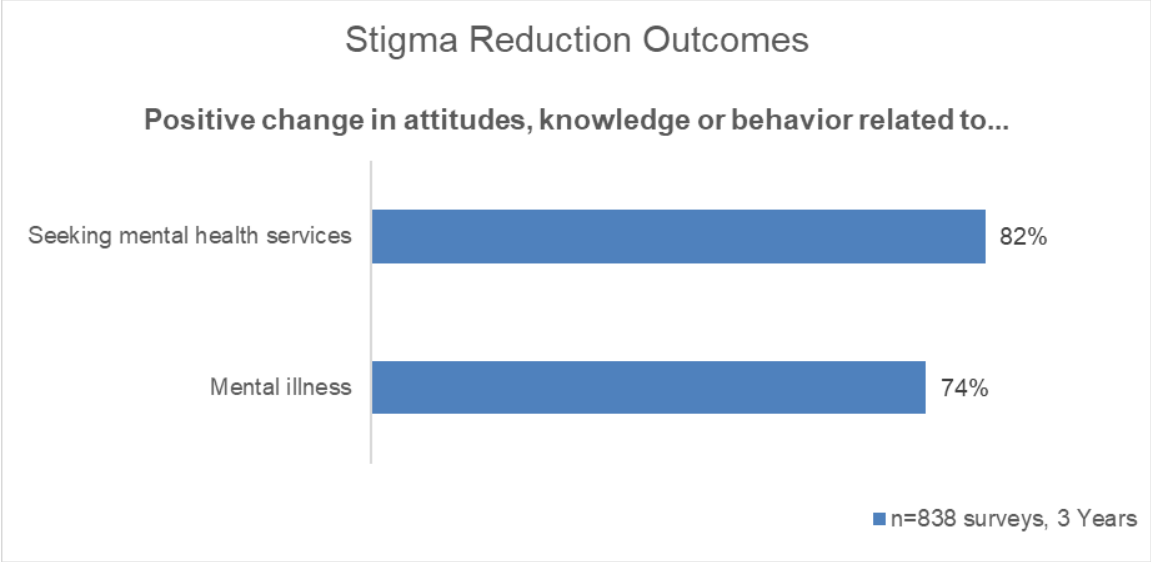
Participant Outcomes

As indicated in the PEI regulations, Stigma and Discrimination Reduction Programs target the following outcomes:

- Improved attitudes, knowledge and/or behavior related to mental illness
- Improved attitudes, knowledge and/or behavior related to seeking mental health services

To measure this, NAMI facilitators distributed evaluation surveys with a set of retrospective Likert Scale items asking participants to rate the degree to which their attitudes had shifted as a result of the program. Surveys were distributed at the conclusion of classes and trainings. Across three years, NAMI collected 838 surveys.

Most (82%) showed a positive change in attitudes toward seeking mental health services. A slightly smaller portion showed a positive change in attitudes towards mental illness (74%).[18]



[18] Analysis was based on surveys from IOOV

Cost/Benefit Analysis

The following table shows the amount invoiced by the provider for both the *Outreach for Early Recognition (OER) 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 OER or SDR programming was $341.

Outreach for Increasing Recognition of Early Signs of Mental Illness and Stigma and Discrimination Reduction	
Expenditure/Benefit FY 2020/21	
Program Expenditures (OER and SDR combined)	*$65,004*
Total individuals trained in Stigma and Discrimination Reduction programming (IOOV, F2F, P2P)	183
Total individuals trained in Outreach for Early Recognition	8
Total number of individuals trained	191
Expenditure per individual trained	*$341*

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 another PEI program or to a higher level of mental health treatment.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the NAMI SDR program 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.
- Information about SJCBHS and other services are shared with program participants. NAMI program leaders provide confidential follow-up support upon request.

Suicide Prevention

Suicide Prevention Project

Project Description

The CAPC-led project 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, CAPC 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 provided depression screenings, referrals, and school-based depression support groups.

Project Outputs

In the 2020/21 fiscal year, the Suicide Prevention Project reached 6,602 participants. The following table presents a detailed breakdown of the number of individuals reached by various program activities. Yellow Ribbon Campaign was the largest component, reaching 5,765 students.

Suicide Prevention	
Outputs FY 2020/21	
Total reached (duplicated count)	6,602
Total reached (unduplicated count)	6,239
Yellow Ribbon Campaign Messaging	5,765
Be a Link® Adult Gatekeeper Training	432
Ask 4 Help® Youth Gatekeeper Training	190
SafeTalk Training	42
Depression Screening	156
CAST Support Group Participants	12
Break Free from Depression Support Group Participants	5
Billboard Campaign Estimated Reach	150,000

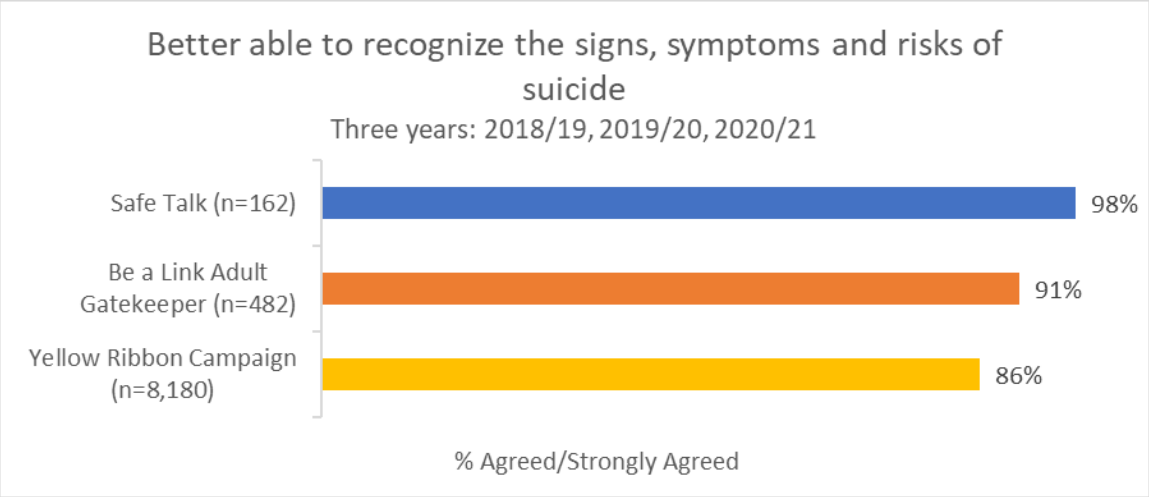
Demographic forms were collected at the time of initiating services. Complete demographic tables from 2020/21 are included in the appendix to this report.

Participant Outcomes

The overall goal of the program is to identify and refer individuals at risk for self-harming and suicidal behaviors and to reduce stigma associated with help-seeking behavior. Across the three-year evaluation period, the Suicide Prevention Project evaluated their progress towards three intended outcomes.

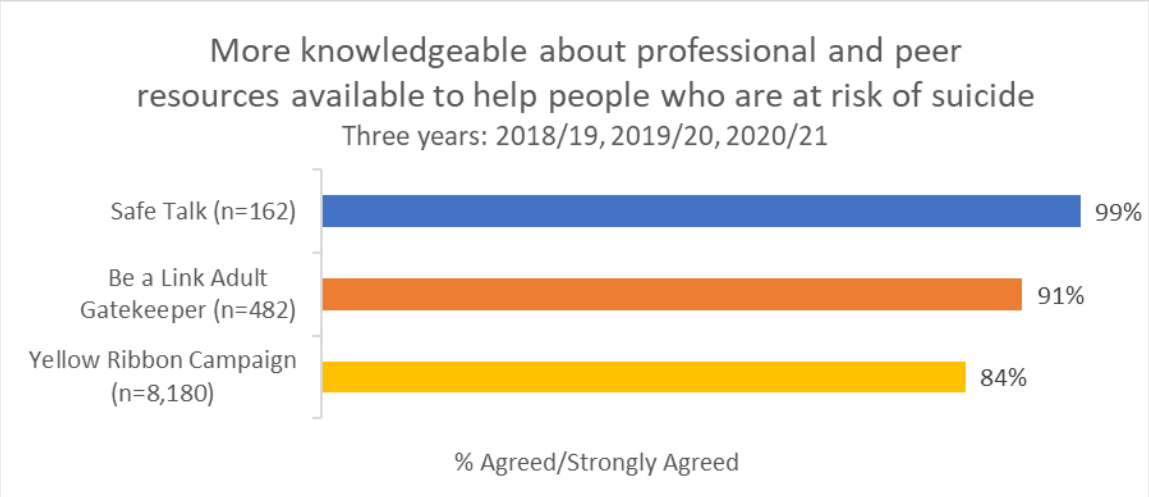
Increased knowledge of warning signs, symptoms and risks

Participants were asked to indicate, as a result of the training, the extent to which they were better able to recognize the signs, symptoms and risks of suicide. The figure below shows that a solid majority (86%) of students participating in the Yellow Ribbon Campaign *agreed* or *strongly agreed* that they were better able to recognize the symptoms and risks of suicide. An even larger portion felt this way after participating in Be a Link (91%) and SafeTalk (98%).



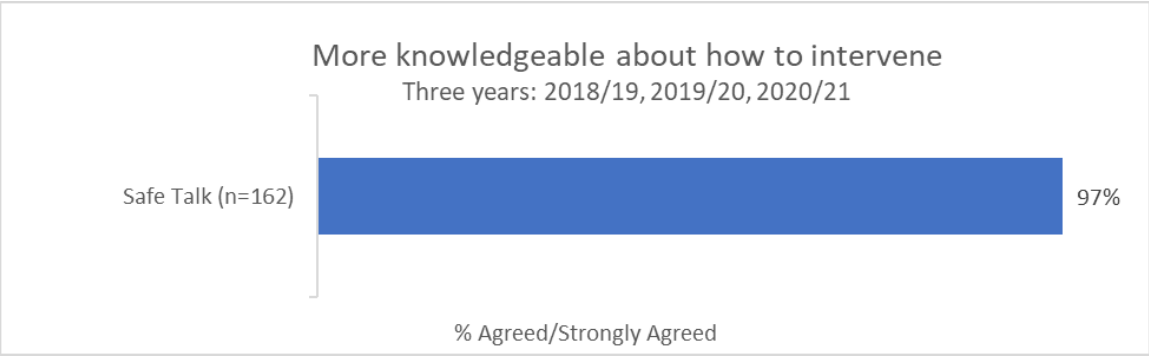
Increased understanding of how to ask for help

Suicide Prevention programming is intended to increase awareness about professional and peer resources that are available to help people who are at risk of suicide. The figure below shows that more than 8 out of 10 students in the Yellow Ribbon Campaign *agreed* or *strongly agreed* that they were more knowledgeable about resources available for people who are at risk of suicide. Nine out of ten (91%) of participants in Be a Link felt this way, and it was nearly unanimous among the participants in SafeTalk (99%).



Increased knowledge about how to intervene

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. The vast majority (97%) *agreed* or *strongly agreed* that they were more knowledgeable about how to intervene as a result of the training.



Cost/Benefit Analysis

The following table shows several key indicators of performance. The programs cumulatively cost $71 per individual served or, $84 per participant who demonstrated improvement in intended outcomes.

Suicide Prevention	
Expenditure/Benefit FY 2020/21	
Program Expenditures	*$479,464*
Total Reached*	6,602
Expenditure per individual served^*	*$71*
Percent who showed improvement/positive change**	85%
*Expenditure per individual who showed improvement/positive change**^*	*$84*

*Some individuals may have been counted more than once due to participation in multiple programs

^Based on 98% of total budget allocated to relevant program components.

**As defined under Participant Outcomes and extrapolated from FY 2020-21 sample

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the Suicide Prevention Project during the 2020-21 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental materials.

- The project made referrals for 67 to mental health treatment. Thirty-three (33) of the 67 of the mental health referrals were for treatment provided, funded, administered, or overseen by County mental health programs.
- The average duration of untreated mental illness was 13.6 months.
- Of the 33 County-referred individuals, 13 (39%) were known to have engaged in treatment, defined as attending at least an intake assessment. Nine (27%) engaged in treatment within 60 days (10 days on average).

Suicide Prevention	
Access and Linkage to Treatment Strategy FY 2020/21	
Referrals	
Individuals referred to MH treatment	67
Individuals referred to County administered MH treatment	33
Duration of untreated mental illness (months) - Average	13.6
Standard deviation	16.9
Linkages to County administered MH treatment within fiscal year	
# Engaged	13
% Engaged	39%
Calendar days between referral and treatment - Average	114.2
Standard deviation	168.4
Linkages to County administered MH treatment within 60 days[19]	
# Engaged	9
% Engaged	27%
Calendar days between referral and treatment - Average	10.0
Standard deviation	9.4

Timely Access to Services for Underserved Populations Strategy

The following is a summary of 2020/21 referrals to treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[20]. Summary tables are included in the supplemental file.

- During the 2020-21 fiscal year, the Suicide Prevention Project referred 56 **Hispanic/Latino** individuals to mental health treatment or another PEI program; this represents 38% of the Suicide Prevention Project's 146 referrals.
- Of those, there were ten (10) known linkages to County mental health treatment.
- During the 2020-21 fiscal year, the Suicide Prevention Project referred 14 **Asian and Pacific Islander** individuals to mental health treatment or another PEI program; this represents 10% of all 146 referrals.

[19] Because state regulations do not define the maximum interval between referral and treatment, we report the number of individuals linked to treatment 1) within the same fiscal year as referral and 2) within sixty days of referral

[20] Approved claims penetration rates indicate that in San Joaquin County, Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

- Of those, there were two (2) known linkages to County mental health treatment.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the Suicide Prevention 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.
- Throughout the year, the Suicide Prevention Project provided updated lists of additional services and contact information to school staff and students.
- Mental Health Specialists engaged with school contacts to ensure they were receiving referrals and connecting with students. Depending on the severity of symptoms, project staff followed up within one week, and at 30-60-90 day intervals in order to ensure connection to appropriate services.
- The Suicide Prevention Project noted that staff increased contact with parents in FY 2020-21.
- Project staff placed a program overview flyer and their contact information in every school staff's mailbox.

Timely Access to Services for Underserved Populations

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 behavioral health 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 repeat non-serious, nonviolent offenders with behavioral concerns and provide rehabilitation services that help to reduce negative outcomes associated with untreated mental health concerns such, as arrest, incarceration, homelessness, and prolonged suffering.

Project Outputs

In the 2020/21 fiscal year, the LEAD project served 38 individuals, 30 of whom were admitted in the previous fiscal year and 8 in this fiscal year. On average, individuals received 908 minutes (15 hours) of service.

Recovery Services for Nonviolent Offenders (LEAD)	
Outputs FY 2020/21	
Total individuals served*	38
Individuals admitted during fiscal year	8
Total numbers of contacts	708
Average number of contacts per individual served	19
Total minutes of service	34,503
Average minutes per individual	908
Average hours per individual	15

*Includes individuals continuing services from prior fiscal year

Demographic forms were collected at the time of initiating services. Demographic tables from 2020/21 are included in the supplemental materials.

Cost/Benefit Analysis

The following table shows costs of the project and cost per individual served.

Recovery Services for Nonviolent Offenders (LEAD)	
Expenditure/Benefit FY 2020/21	
Program Expenditures	*$198,261*
Unduplicated individuals served	38
Expenditures per individual served	$5,217

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from LEAD during the 2020-21 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental materials.

- The LEAD project made referrals for 11 individuals for mental health treatment provided, funded, administered, or overseen by County mental health programs.
- The average duration of untreated mental illness was 16 months.
- Five of the referred individuals (45%) were known to have engaged in treatment before the end of the fiscal year. Three of them (27%) engaged in treatment within 60 days, with an average of 18 calendar days between referral and treatment.

Timely Access to Services for Underserved Populations Strategy

Approved claims penetration rates indicate that in San Joaquin County Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population. For this reason, SJBHS identified these two populations as the focus of the strategy for timely access to services. The LEAD project did not make referrals to either of these identified underserved populations.

Unhoused people, as an unserved population

LEAD works closely with unhoused clients, focusing efforts on timely access for that population. Nine of the eleven referrals (82%) from the LEAD program were made for individuals experiencing homelessness. Four of the referred individuals (36%) engaged in treatment before the end of the fiscal year, with an average of 30 days between referral and treatment. Three of the referred individuals (27%) engaged in treatment within 60 days.

Recovery Services for Nonviolent Offenders (LEAD)	
Timely Access to Services for Underserved Populations FY 2020/21	
Individuals referred to MH treatment or PEI	*11*
Underserved population: Homeless	
Individuals referred to MH treatment or PEI	9
Proportion of all referrals to MH treatment or PEI	82%
Individuals referred to County administered MH treatment	9
Linkages to County administered MH treatment within fiscal year	
# Engaged	4
% Engaged	44%
Calendar days between referral and treatment - Average	30.3
Standard deviation	26.7
Linkages to County administered MH treatment within 60 days	
# Engaged	3
% Engaged	27%
Calendar days between referral and treatment - Average	18.0
Standard deviation	13.1

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the LEAD 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.
- LEAD 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 Treatment

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, but otherwise underserved. 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 homeless or at risk for homelessness upon discharge from an institution.

Project Outputs

In the 2020/21 fiscal year, the WPC project served 137 individuals, 83 of whom continued services from the prior fiscal year and 54 who initiated services in 2020/21. On average, individuals received 789 minutes (13 hours) of service.

Whole Person Care (WPC)	
Outputs FY 2020/21	
Total unduplicated individuals served*	137
Individuals admitted during fiscal year	54
Total numbers of contacts	1,913
Average number of contacts per individual served	14
Total minutes of service	108,102
Average minutes per individual	789
Average hours per individual	13

*Includes individuals continuing services from prior fiscal year

Demographic forms were collected at the time of initiating services. Complete demographic tables from 2020/21 are included in the appendix to this report.

Cost/Benefit Analysis

The following table shows costs of the project and cost per individual served.

Whole Person Care (WPC)	
Expenditure/Benefit FY 2020/21	
Program Expenditures	*$524,631*
Unduplicated individuals served	137
Expenditures per individual served	$3,829

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the WPC program during the 2020-21 fiscal year. Detailed data on referrals, including full demographic information, is provided in the supplemental materials.

- The project made referrals for 41 individuals to treatment provided, funded, administered, or overseen by County mental health programs. The average duration of untreated mental illness was 34.8 months
- Of the 41 County-referred individuals, 36 (88%) were known to have engaged in treatment within the fiscal year. Thirty-three (80%) engaged in treatment within 60 days, with an average of 11 days between referral and treatment.

Whole Person Care (WPC)	
Access and Linkage to Treatment Strategy FY 2020/21	
Referrals	
Individuals referred to MH treatment	41
Individuals referred to County administered MH treatment	41
Duration of untreated mental illness (months) - Average	34.8
Standard deviation	49.5
Linkages to County administered MH treatment within fiscal year	
# Engaged	36
% Engaged	88%
Calendar days between referral and treatment - Average	21.2
Standard deviation	40.1
Linkages to County administered MH treatment within 60 days[21]	
# Engaged	33
% Engaged	80%
Calendar days between referral and treatment - Average	10.9
Standard deviation	15.1

[21] Because state regulations do not define the maximum interval between referral and treatment, we report the number of individuals linked to treatment 1) within the same fiscal year as referral and 2) within sixty days of referral

Timely Access to Services for Underserved Populations Strategy

The following is a summary of 2020/21 referrals to treatment and PEI programs for the two underserved populations identified by SJCBHS as a focus for the Timely Access strategy[22]. Summary tables are included in the supplemental file.

- During the 2020-21 fiscal year, WPC referred eleven **Hispanic/Latino** individuals to mental health treatment or another PEI program; this represents 27% of WPC's 41 referrals. Of those, there were nine known linkages to County mental health treatment.
- Two **Asian and Pacific Islander** individuals were referred to mental health treatment or different PEI programs during the 2020/21 fiscal year, representing 5% of WPC's 41 referrals. One was known to have engaged in treatment.

Unhoused people, as an unserved population

WPC maintains a focus on the homeless population. For this reason, we also looked at timely access for homeless clients. The table below shows that 29 of the 41 referrals were for clients known to be homeless, representing 71% of all WPC referrals. Twenty-five of these were known to have engaged in treatment within the fiscal year, with an average interval of 25.5 days. Twenty-two individuals (76%) engaged in treatment within 60 days.

Whole Person Care (WPC)	
Timely Access to Services for Underserved Populations FY 2020/21	
Individuals referred to MH treatment or PEI	*41*
Underserved population: Homeless	
Individuals referred to MH treatment or PEI	29
Proportion of all referrals to MH treatment or PEI	71%
Individuals referred to County administered MH treatment	29
Linkages to County administered MH treatment within fiscal year	
# Engaged	25
% Engaged	86%
Calendar days between referral and treatment - Average	25.5
Standard deviation	46.3
Linkages to County administered MH treatment within 60 days*	
# Engaged	22
% Engaged	76%
Calendar days between referral and treatment - Average	10.7
Standard deviation	13.9

[22] Approved claims penetration rates indicate that in San Joaquin County, Asian and Hispanic/Latino community members are underserved. These two populations have lower engagement with county administered services than the overall county population.

Encouraging Access to Services and Follow Through

The following are ways in which SJCBHS and the WPC 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.
- WPC case managers provide warm handoffs to help clients who are referred to services participate in the services to which they are referred. Many clients struggle to access services; and offering transportation has enabled greater follow through
- WPC encourages healthy relationships between clients and case managers so that clients remain engaged and open to discussing sensitive issues, barriers, or need for additional information or education.

Appendix: Demographic Tables

Skill-Building for Parents and Guardians

Demographics FY 2020/21				
	CAPC-PC	CC-NPP	PBC - Triple P	Total
Number of participants (unduplicated)	761	127	392	1,280
Number of demographic forms collected	610	125	392	1,127
Race				
American Indian or Alaska Native	1	0	6	7
Asian	4	0	34	38
Black of African American	11	0	84	95
Native Hawaiian or other Pacific Islander	2	0	7	9
White	104	49	224	377
Other	308	74	1	383
More than one race	2	0	15	17
Decline to answer	178	2	21	201
Ethnicity				
Hispanic or Latino as follows:				
Caribbean	1	0	1	2
Central America	2	5	7	14
Mexican/Mexican-American	394	118	512	1,024
Puerto Rican	0	0	0	0
South American	0	0	0	0
Other	1	0	1	2
Non-Hispanic as follows:				
African	1	0	82	83
Asian Indian/South Asian	0	0	11	11
Cambodian	1	0	6	7
Chinese	2	0	2	4
Eastern European	2	0	3	5
European	0	0	73	73
Filipino	1	0	13	14
Japanese	0	0	2	2
Korean	0	0	3	3
Middle Eastern	1	0	4	5
Vietnamese	0	0	9	9
Other	6	1	0	7
More than one ethnicity	2	0	7	9
Decline to answer	196	1	20	217
Age				

0-15 Children/Youth	0	0	0	0
16-25 TAY	16	2	14	32
26-59 Adult	416	117	311	844
60+ Older Adult	2	4	48	54
Decline to answer	176	2	19	197
Veteran Status				
Yes	1	0	27	28
No	427	120	346	893
Decline to answer	182	5	19	206
Children of participants				
Ages 0-5	296	46	110	452
Ages 6 - 15	548	190	307	1,045
Ages 16 - 25	224	114	91	429
Decline to answer	187	16	21	224
Sex Assigned at Birth				
Male	16	9	113	138
Female	417	115	261	793
Decline to answer	177	1	18	196
Current gender identity				
Male	16	9	110	135
Female	417	115	258	790
Transgender	0	0	4	4
Genderqueer	0	0	1	1
Questioning or unsure of gender identity	0	0	1	1
Another gender identity	0	0	0	0
Decline to answer	179	1	18	198
Sexual Orientation				
Gay or Lesbian	0	0	22	22
Heterosexual or Straight	344	123	337	804
Bisexual	1	0	7	8
Questioning or unsure of sexual orientation	0	0	5	5
Queer	0	0	0	0
Another sexual orientation	0	0	0	0
Decline to answer	267	2	21	290
Disability*				
Mental (excluding: Mental Illness)	2	0	1	3
Physical/mobility	0	0	31	31
Chronic health condition (including chronic pain)	1	2	35	38
Difficulty seeing	0	1	37	38
Difficulty hearing	1	0	22	23

Other	1	0	4	5
No disability	415	110	268	793
Decline to answer	190	11	20	221
Primary Language				
English	68	14	219	301
Spanish	355	120	136	611
Cambodian	0	0	7	7
Other	7	1	11	19
Decline to state	180	1	19	200

*Mental or physical impairment lasting more than 6 months and limiting major life activity but is not the result of a severe mental illness

Mentoring for Transitional Age Youth

Demographics FY 2020/21			
	CAPC	WCYFS	Total TAY
Number enrolled	183	141	324
Number of demographic forms collected	183	141	324
Race			
American Indian / Alaska Native	4	2	6
Asian	9	8	17
Black or African American	30	55	85
Native Hawaiian / Pacific Islander	4	2	6
White	27	21	48
Other	65	26	91
More than one race	44	21	65
Decline to answer	0	6	6
Ethnicity			
Hispanic or Latino as follows:			
Caribbean	0	0	0
Central America	3	1	4
Mexican/Mexican-American	71	45	116
Puerto Rican	2	0	2
South American	0	0	0
Other	8	2	10
Non-Hispanic as follows:		0	
African	21	41	62
Asian Indian/South Asian	3	2	5
Cambodian	0	1	1
Chinese	0	0	0
Eastern European	1	0	1
European	9	1	10
Filipino	2	2	4
Japanese	0	0	0
Korean	0	1	1
Middle Eastern	2	1	3
Vietnamese	1	0	1
Other	13	15	28
More than one ethnicity	46	15	61
Decline to answer	1	14	15
Age			
0-15 Children/Youth	0	0	0
16-25 TAY	183	141	324
26-59 Adult	0	0	0

60+ Older Adult	0	0	0
Decline to answer	0	0	0
Veteran Status			
Yes	0	0	0
No	183	141	324
Decline to answer	0	0	0
Children of participants			
Ages 0-5	31	31	62
Ages 6 - 15	1	1	2
Ages 16 - 25	0	0	0
Decline to answer	0	3	3
Sex Assigned at Birth			
Male	74	55	129
Female	109	84	193
Decline to answer	0	2	2
Current gender identity			
Male	75	51	126
Female	99	82	181
Transgender	1	3	4
Genderqueer	1	0	1
Questioning or unsure of gender identity	1	0	1
Another gender identity	6	1	7
Decline to answer	0	4	4
Sexual Orientation			
Gay or Lesbian	6	24	30
Heterosexual or Straight	143	84	227
Bisexual	22	9	31
Questioning or unsure of sexual orientation	4	1	5
Queer	1	0	1
Another sexual orientation	7	6	13
Decline to answer	0	17	17
Disability*			
Yes:			
Mental (excluding: Mental Illness)	10	10	20
Physical/mobility	4	3	7
Chronic health condition (including chronic pain)	1	1	2
Difficulty seeing	6	5	11
Difficulty hearing	2	0	2
Other	8	3	11
No disability	154	108	262
Decline to answer	0	10	10

Primary Language			
English	148	138	286
Spanish	28	2	30
Cambodian	0	0	0
Other	7	0	7
Decline to answer	0	1	1

*Mental or physical impairment lasting more than 6 months and limiting major life activity but is not the result of a severe mental illness

Coping and Resilience Education Services (CARES)

Demographics FY 2020/21			
	Children	Adults	Total
Number of participants (unduplicated, including those rolled over from the previous year)	221	94	315
Number of demographic forms collected	99	55	154
Race			
American Indian or Alaska Native	7	2	9
Asian	0	0	0
Black of African American	28	10	38
Native Hawaiian or other Pacific Islander	1	0	1
White	41	29	70
Other	13	10	23
More than one race	5	2	7
Decline to answer	4	2	6
Ethnicity			
Hispanic or Latino as follows:			
Caribbean	0	0	0
Central America	2	1	3
Mexican/Mexican-American	46	25	71
Puerto Rican	4	0	4
South American	0	1	1
Other	3	2	5
Non-Hispanic as follows:			
African	16	6	22
Asian Indian/South Asian	0	0	0
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
European	1	1	2
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	0	0
Vietnamese	0	0	0
Other	13	10	23
More than one ethnicity	5	4	9
Decline to answer	9	5	14
Age			
0-15 Children/Youth	91	0	91
16-25 TAY	8	3	11
26-59 Adult	0	47	47

60+ Older Adult	0	3	3
Decline to answer	0	2	2
Veteran Status			
Yes	n/a	0	0
No	n/a	55	55
Decline to answer	n/a	0	0
Sex Assigned at Birth			
Male	56	3	59
Female	43	52	95
Decline to answer	0	0	0
Current gender identity			
Male	30	3	33
Female	25	51	76
Transgender	0	0	0
Genderqueer	0	0	0
Questioning or unsure of gender identity	0	0	0
Another gender identity	0	0	0
Decline to answer	43	1	44
Sexual Orientation			
Gay or Lesbian	30	1	31
Heterosexual or Straight	25	49	74
Bisexual	0	2	2
Questioning or unsure of sexual orientation	0	0	0
Queer	0	0	0
Another sexual orientation	0	0	0
Decline to answer	43	3	46
Disability*			
Mental (excluding: Mental Illness)	4	4	8
Physical/mobility	1	3	4
Chronic health condition (including chronic pain)	0	3	3
Difficulty seeing	2	1	3
Difficulty hearing	0	1	1
Other	5	1	6
No disability	86	44	130
Decline to answer	3	0	3
Primary Language			
English	89	47	136
Spanish	10	8	18
Cambodian	0	0	0
Other	0	0	0
Decline to state	0	0	0

*Mental or physical impairment lasting more than 6 months and limiting major life activity but is not the result of a severe mental illness

Telecare Early Intervention and Recovery Services (TEIR)

Telecare Early Intervention and Recovery Services (TEIR)	
Demographics FY 2020/21	
Number of participants (unduplicated, including those rolled over from the previous year)	62
Number of demographic forms collected	18
Race	
American Indian or Alaska Native	0
Asian	1
Black of African American	3
Native Hawaiian or other Pacific Islander	0
White	5
Other	4
More than one race	4
Decline to answer	0
Ethnicity	
Hispanic or Latino as follows:	
Caribbean	0
Central America	1
Mexican/Mexican-American	4
Puerto Rican	0
South American	0
Other	2
Non-Hispanic as follows:	
African	5
Asian Indian/South Asian	0
Cambodian	0
Chinese	1
Eastern European	0
European	0
Filipino	0
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other	6
More than one ethnicity	3
Decline to answer	0
Age	
0-15 Children/Youth	4
16-25 TAY	14

26-59 Adult	0
60+ Older Adult	0
Decline to answer	0
Sex Assigned at Birth	
Male	10
Female	8
Decline to answer	0
Current gender identity	
Male	10
Female	6
Transgender	0
Genderqueer	0
Questioning or unsure of gender identity	0
Another gender identity	1
Decline to answer	2
Disability	
Mental (excluding: Mental Illness)	14
Physical/mobility	0
Chronic health condition (including chronic pain)	2
Difficulty seeing	0
Difficulty hearing	0
Other	0
Decline to answer	6
Primary Language	
English	16
Spanish	2
Cambodian	0
Other	0
Decline to state	0

*Mental or physical impairment lasting more than 6 months and limiting major life activity but is not the result of a severe mental illness

School Based Intervention for Children and Youth

Demographics FY 2020/21			
	CAPC	SAS	Total
Number of participants (unduplicated)	139	80	219
Number of demographic forms collected	138	60	198
Race			
American Indian or Alaska Native	1	0	1
Asian	1	0	1
Black or African American	19	2	21
Native Hawaiian or other Pacific Islander	1	0	1
White	27	5	32
Other	66	50	116
More than one race	22	2	24
Decline to answer	1	1	2
Ethnicity			
Hispanic or Latino as follows:			
Caribbean	0	0	0
Central America	0	2	2
Mexican/Mexican-American	79	43	122
Puerto Rican	0	0	0
South American	0	0	0
Other	0	4	4
Non-Hispanic as follows:			
African	0	1	1
Asian Indian/South Asian	0	1	1
Cambodian	0	0	0
Chinese	0	0	0
Eastern European	0	0	0
European	0	0	0
Filipino	0	0	0
Japanese	0	0	0
Korean	0	0	0
Middle Eastern	0	1	1
Vietnamese	0	0	0
Other	44	0	44
More than one ethnicity	12	0	12
Decline to answer	2	9	11
Age			
0-15 Children/Youth	135	56	191
16-25 TAY	3	4	7
Decline to answer	0	0	0

Sex Assigned at Birth			
Male	67	43	110
Female	71	17	88
Decline to answer	0	0	0
Current gender identity			
Male	67	11	78
Female	71	2	73
Transgender	0	0	0
Genderqueer	0	0	0
Questioning or unsure of gender identity	0	0	0
Another gender identity	0	0	0
Decline to answer	0	0	0
Sexual Orientation			
Gay or Lesbian	1	1	2
Heterosexual or Straight	136	12	148
Bisexual	0	0	0
Questioning or unsure of sexual orientation	1	0	1
Queer	0	0	0
Another sexual orientation	0	0	0
Decline to answer	0	2	2
Disability*			
Mental (excluding: Mental Illness)	0	0	0
Physical/mobility	0	1	1
Chronic health condition (including chronic pain)	0	0	0
Difficulty seeing	0	0	0
Difficulty hearing	0	0	0
Other	0	4	4
No disability	138	51	189
Decline to answer	0	4	4
Primary Language			
English	136	n/a	136
Spanish	2	21	2
Cambodian	0	0	0
Other	0	39	0
Decline to answer	0	0	0

*Mental or physical impairment lasting more than 6 months and limiting major life activity but is not the result of a severe mental illness

Juvenile Justice Project

Demographics FY 2020/21	
Number of Unduplicated individuals served	157
Number of individuals for whom demographic information is available	120
Race	
American Indian or Alaska Native	3
Asian	5
Black of African American	30
Native Hawaiian or other Pacific Islander	3
White	14
Other	50
More than one race	13
Decline to answer	1
Ethnicity	
Hispanic or Latino as follows:	
Caribbean	0
Central America	0
Mexican/Mexican-American	60
Puerto Rican	0
South American	1
Other Hispanic	5
Non-Hispanic as follows:	
African	6
Asian Indian/South Asian	2
Cambodian	1
Chinese	0
Eastern European	0
European	1
Filipino	1
Japanese	0
Korean	0
Middle Eastern	0
Vietnamese	0
Other	16
More than one ethnicity	10
Decline to answer	17
Age	
0-15 Children/Youth	34
16-25 TAY	85
26-59 Adult	0
60+ Older Adult	0

Decline to answer	1
Veteran Status	
Yes	0
No	117
Decline to answer	3
Sex Assigned at Birth	
Male	108
Female	11
Decline to answer	1
Current gender identity	
Male	107
Female	11
Transgender	0
Genderqueer	1
Questioning or unsure of gender identity	0
Another gender identity	0
Decline to answer	1
Sexual Orientation	
Gay or Lesbian	0
Heterosexual or Straight	109
Bisexual	4
Questioning or unsure of sexual orientation	1
Queer	0
Another sexual orientation	2
Decline to answer	4
Disability*	
Mental (excluding: Mental Illness)	1
Physical/mobility	0
Chronic health condition (including chronic pain)	2
Difficulty seeing	2
Difficulty hearing	1
Other	3
Decline to answer	0
Primary Language	
English	101
Spanish	16
Cambodian	1
Other	1
Decline to state	1

*Mental or physical impairment lasting more than 6 months and limiting major life activity but is not the result of a severe mental illness

Suicide Prevention Project

Demographics FY 2020/21			
	Yellow Ribbon	Depression Screening	Total
Number of participants	6,199	157	6,356
Number of demographic forms collected	3,619	157	3,776
Race:			
American Indian or Alaska Native	39	0	39
Asian	616	15	631
Black of African American	228	12	240
Native Hawaiian or other Pacific Islander	61	2	63
White	732	27	759
Other	951	58	1,009
More than one race	667	40	707
Decline to answer	307	2	309
Ethnicity			
Hispanic or Latino as follows:			
Caribbean	6	0	6
Central America	101	0	101
Mexican/Mexican-American	1,072	66	1,138
Puerto Rican	16	0	16
South American	17	0	17
Other	180	3	183
Non-Hispanic as follows:			
African	96	11	107
Asian Indian/South Asian	164	4	168
Cambodian	84	7	91
Chinese	25	2	27
Eastern European	14	3	17
European	143	14	157
Filipino	183	4	187
Japanese	10	0	10
Korean	6	0	6
Middle Eastern	56	0	56
Vietnamese	67	2	69
Other	114	7	121
More than one ethnicity	716	25	741
Decline to answer	514	8	522
Age			
0-15 Children/Youth	2,549	88	2,637
16-25 TAY	736	68	804
26-59 Adult	174	0	174
60+ Older Adult	8	0	8

Decline to answer	145	1	146
Veteran Status			
Yes	25	0	25
No	3,299	155	3,454
Decline to answer	264	1	265
Sex Assigned at Birth			
Male	1,584	51	1,635
Female	1,867	101	1,968
Decline to answer	158	2	160
Current gender identity			
Male	1,569	50	1,619
Female	1,765	97	1,862
Transgender	11	1	12
Genderqueer	39	6	45
Questioning or unsure of gender identity	46	0	46
Another gender identity	7	0	7
Decline to answer	173	2	175
Sexual Orientation			
Gay or Lesbian	72	8	80
Heterosexual or Straight	2,522	123	2,645
Bisexual	284	11	295
Questioning or unsure of sexual orientation	106	3	109
Queer	15	2	17
Another sexual orientation	84	2	86
Decline to answer	525	7	532
Disability*			
Mental (excluding: Mental Illness)	172	4	176
Physical/mobility	39	1	40
Chronic health condition (including chronic pain)	44	1	45
Difficulty seeing	187	0	187
Difficulty hearing	28	1	29
Other	62	8	70
No disability	2,687	137	2,824
Decline to answer	466	3	469
Primary Language			
English	2,553	133	2,686
Spanish	630	17	647
Cambodian	17	0	17
Other	234	4	238
Decline to state	175	2	177

*Mental or physical impairment lasting more than 6 months and limiting major life activity but is not the result of a severe mental illness

Whole Person Care

Demographics FY 2020/21	
Number of participants	137
Number of demographic forms collected	116
Ages	
0-15	0
16-25	6
26-59	101
60+	7
Decline to answer	2
Race	
American Indian or Alaskan Native	2
Asian	3
Black or African American	20
Native Hawaiian or other Pacific Islander	0
White	25
Other	11
More than one race	0
Decline to answer	55
Ethnicity	
Hispanic or Latino as follows:	
Caribbean	0
Central America	2
Mexican/Mexican-American	16
Puerto Rican	0
South American	0
Other	1
Non-Hispanic as follows:	
African	10
Asian Indian/South Asian	1
Cambodian	0
Chinese	0
Eastern European	3
European	7
Filipino	0
Japanese	1
Korean	0
Middle Eastern	0
Vietnamese	0
Other	3
More than one ethnicity	1
Decline to answer	71

Primary Language	
English	0
Spanish	1
Other	0
Decline to answer	115
Sexual Orientation	
Gay or Lesbian	0
Heterosexual or Straight	6
Bisexual	0
Questioning or unsure	0
Queer	0
Another sexual orientation	0
Decline to answer	110
Disability*	
Communication - difficulty seeing	2
Communication - difficulty hearing & speech	1
Communication - other	1
Mental disability	28
Physical/mobility disability	8
Chronic health	5
Other	2
Decline to answer	62
No Disability	7
Veteran status	
Yes	3
No	48
Decline to answer	65
Sex assigned at birth	
Male	54
Female	36
Decline to answer	26
Current Gender identity	
Male	43
Female	28
Transgender	0
Genderqueer	0
Questioning or unsure of gender identity	0
Another gender identity	0
Decline to answer	45

*Mental or physical impairment lasting more than 6 months and limiting major life activity but is not the result of a severe mental illness

The San Joaquin County Homeward Bound Initiative

Deliverable 8: Year 3 Evaluation Report

Executive Summary

The aim of the Homeward Bound Initiative is to significantly expand the delivery of community-based care to residents of San Joaquin County, with an emphasis on reducing recidivism and providing behavioral healthcare to historically underserved groups. These include individuals who are either homeless or at risk of homelessness; non-serious, non-violent offenders with frequent contacts with the criminal justice system; individuals with substance-use disorders; and Latinx and African American individuals who have been an underserved group in the region. The initiative plans to achieve these goals by delivering respite services, case management, psychotherapy, and medication-assisted treatment (MAT). These services will be delivered by Community Medical Centers (CMC), a federally qualified health center (FQHC) with an established track record in providing health and social care to San Joaquin County residents. The services will be accessible via a multitude of pathways and supported by extensive links with other community and governmental agencies. The provision of these additional services is expected to lead to improved functional and recovery outcomes for consumers, in turn leading to the reduced incidence of recidivism and contacts with the criminal justice system in the San Joaquin County area.

Major Findings

In the 12 months since the two-year evaluation report, CMC, SJCBHS, and community partners have continued their progress meeting early goals and objectives. Analysis of preliminary client-level data is consistent with these findings, and early conclusions suggest the Homeward Bound Initiative has also made promising strides toward meeting primary objectives for client outcomes concerning access to and engagement in care, improving racial and ethnic inequities in service utilization, reducing client reconviction, and functional improvements following treatment.

Conclusions

Overall, the Homeward Bound Initiative is successfully delivering a broad range of behavioral healthcare services to individuals with mild-to-moderate behavioral health conditions. Future evaluation reports will continue to reassess client-level outcomes as more client-level data become available and the quality of the data continues to improve over time.

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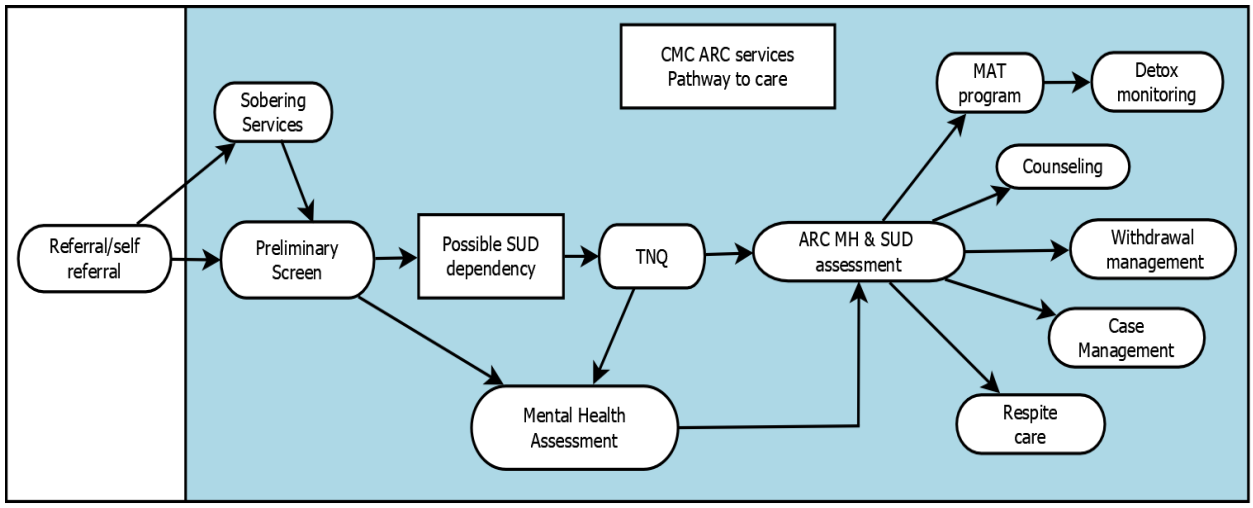
Project Description

The Homeward Bound Initiative represents a significant expansion of community-based behavioral health services, designed to improve behavioral health outcomes for the residents of San Joaquin County. The overarching goal of the Homeward Bound Initiative is to improve access to behavioral health care services for all county residents by increasing pathways to care. The program places an emphasis on supporting vulnerable and underserved populations, including: 1) non-serious, non-violent offenders with trauma or other mental health concerns, 2) high-risk individuals with substance use disorders (SUD) who are homeless, and/or who have frequent contacts with law enforcement, and 3) Black/African American and Latinx individuals who are underserved through traditional, existing behavioral health services.

The Homeward Bound Initiative focuses on 1) *service expansion* through the creation of the Assessment and Respite Center (ARC) with co-located withdrawal management services; 2) *system strengthening* through shared data use agreements and expedited referral pathways between providers; and 3) *service enhancement* by delivering wrap-around housing and case management services for those individuals that require intensive services to achieve recovery from behavioral health conditions. The ARC is a community-based treatment facility managed by Community Medical Centers (CMC), a not-for-profit healthcare network with an established track record of delivering health and social care services to individuals in the Stockton area for over 50 years. A conceptual model detailing the new system of care delivered by CMC via the Homeward Bound Initiative is presented below in Figure 1.

Figure 1: The Homeward Bound Initiative CMC/ARC Pathway to Care

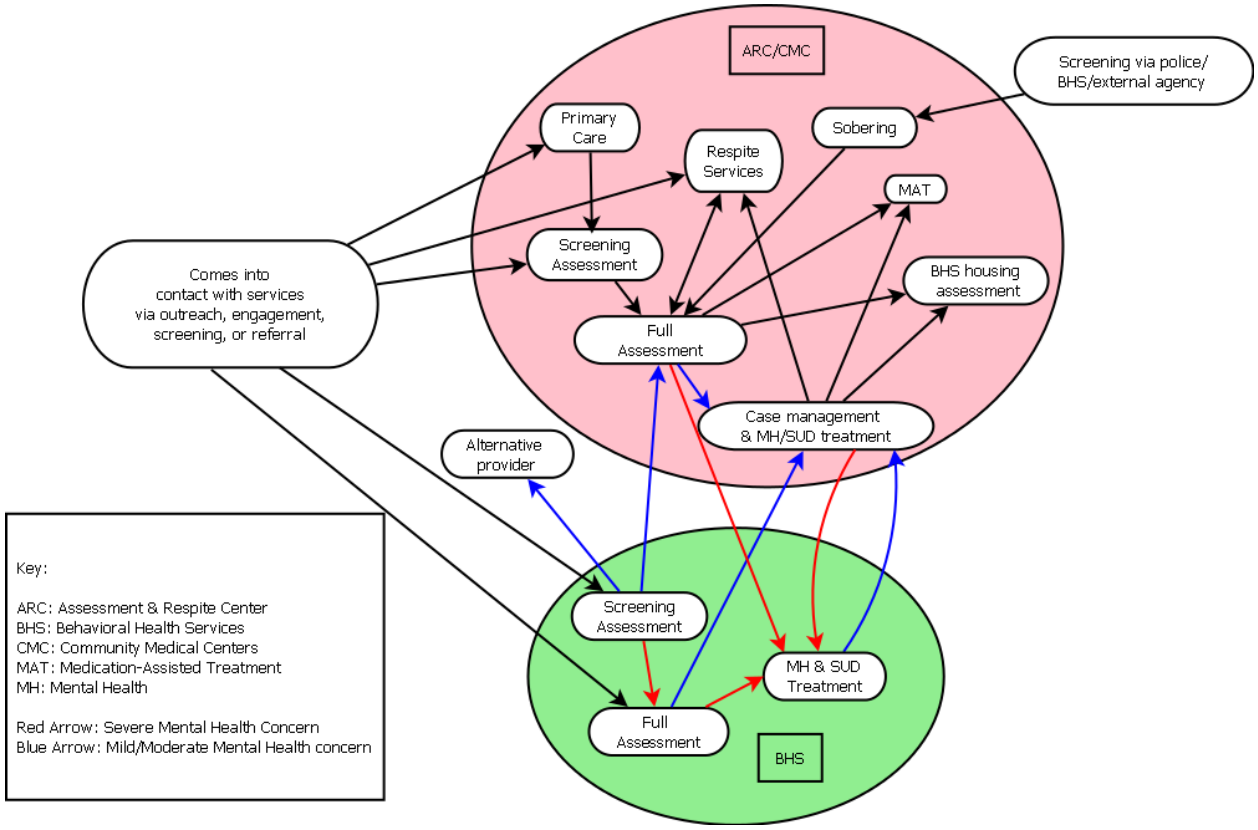


ARC = Assessment and Respite Center; CMC = Community Medical Centers; MAT = Medication Assisted Treatment; SUD = Substance Use Disorder; TNQ = Treatment Needs Questionnaire.

The Homeward Bound system-of-care allows clients to access services delivered by the ARC via a multitude of entry pathways. These include services referrals via community partners (e.g., Stockton Shelter for the Homeless, St. Marys' Dining Room), emergency services, San Joaquin County Behavioral Health Services (SJCBHS), law enforcement, and self-referral. If the individual accesses CMC services while intoxicated, they will be offered sobering services, which consists of sobering beds available on the premises. Once sober, or if they access services when not intoxicated, they will be offered a brief screening assessment to identify treatment needs, in addition to access to respite services to address any immediate basic needs (thirst, hunger, hygiene). In the event of a positive screen, or based on the clinician's clinical judgment, the individual will then be offered a full behavioral health assessment, followed by services which could include MAT, withdrawal management, case management, and/or other forms of therapy, dependent upon need. Individuals in receipt of services delivered within the ARC will also be eligible for both physical and mental health care, delivered by existing CMC co-located primary care services.

In addition to the expansion and enhancement of services offered by CMC, a second critical component of the Homeward Bound Initiative includes the establishment of expedited referral pathways between CMC and San Joaquin County Behavioral Health Services (BHS). Figure 2 depicts how ARC services fit within the broader context of available care delivered under the Homeward Bound Initiative. If an individual with a severe mental health condition engages with services at CMC, they will receive an expedited referral to San Joaquin County BHS including a "warm handoff," with details from the CMC assessment passed on to BHS to minimize any duplicate assessments. In cases where a screening or full assessment at San Joaquin County BHS takes place, and the individual is deemed to be experiencing a mild-to-moderate behavioral health concern, the individual will then be referred directly to CMC with a "warm hand-off." Minimizing these barriers to appropriate care should, in turn, improve access and engagement to appropriate treatment, potentially leading to better outcomes overall.

Figure 2: The Homeward Bound Initiative Full System of Care



Reducing Convictions amongst Clients with a Criminal Justice History

In addition to addressing gaps in the substance use continuum of care, and increasing access to underserved groups, another key aim of the project is to reduce recidivism amongst individuals with behavioral health disorders. For the purses of this study, consistent with the California Board of State Community Corrections requirements, recidivism is defined as follows:

"The conviction of a new felony or misdemeanor committed within three years of release from custody or committed within three years of placement on supervision for a previous criminal conviction (PC Sec. 6046.2(d))."

"Committed" refers to the date of the offense, not the date of conviction.

Goals and Objectives

The Homeward Bound Initiative combines project goals as stated in 1) the "Project Evaluation Plan" section of the Proposition 47 grant proposal (Proposition 47), submitted to the California Board of State and Community Corrections in February 2017, and 2) the goals and objectives stated in the *Purpose of the Innovation* section of the Assessment and Respite Center Innovation Plan Document, submitted to the California Mental Health Services Oversight and Accountability Commission (MHSOAC). Where goals and objectives are closely related or overlap each other they have been combined and synthesized for clarity.

Goal 1. Reduce systemic gaps that lead to the underutilization of mental health services.
Objectives:

- To address structural limitations of the current model of care that leads to the underutilization of appropriate services in people with mental illnesses and co-morbid substance use disorders.
- To provide stabilization services, respite care, withdrawal management, housing, and case management, when necessary, to facilitate consumer engagement in mental health treatment.

Goal 2. Improve access to mental health services for underserved groups.
Objectives:

- To provide mental health services to non-violent offenders with trauma or other mental health concerns.
- To provide mental health services to high-risk individuals with substance use disorders who are homeless, and/or have frequent law enforcement contact associated with their behavioral health concerns.
- To increase the number and proportion of Black/African American and Latinx individuals who utilize community behavioral health services.

Goal 3. Reduce gaps in the substance use disorder continuum of care.
Objectives:

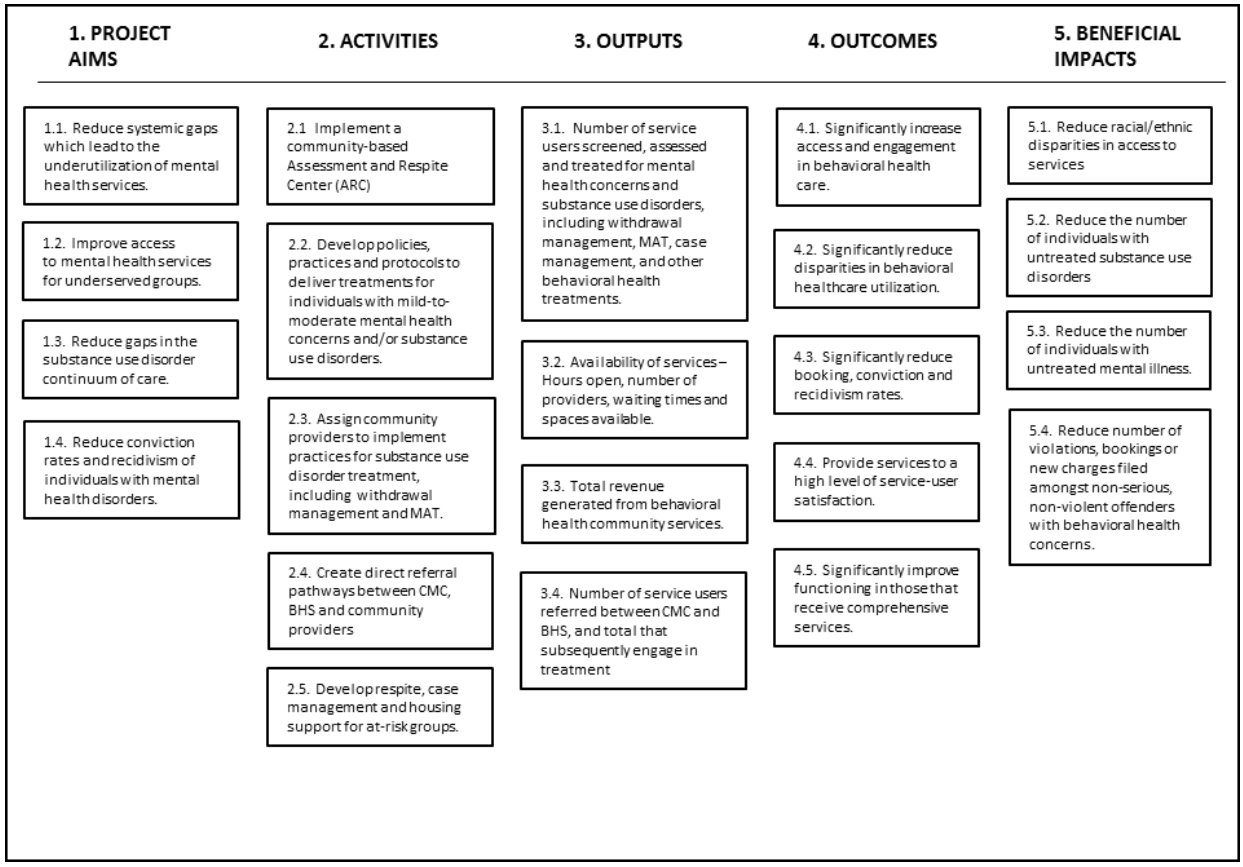
- To provide effective substance use treatment services, ensuring that providers are trained in effective treatment practices, and are assigned to deliver services.
- To provide effective substance use treatment services, allowing former offenders to receive diversion programming and/or direct their own recovery efforts.

Goal 4. Reduce conviction rates and recidivism of individuals with mental health disorders.
Objectives:

- Improve the quality of life of consumers with prior non-violent convictions; individuals with substance use disorders; those that are homeless or at risk of homelessness; and any other populations that have frequent contact with law enforcement associated with their behavioral health concerns.
- Reduce the number of incarcerations among non-violent offenders with untreated mental health and/or substance use disorders and reduce the rate of recidivism in this population.

Logic Model

Figure 3: Logic Model of the Homeward Bound Initiative



Methods

Study Design

The evaluation of the Homeward Bound initiative will primarily consist of a longitudinal observation study, following clients from the point of the assessment at the ARC, until their discharge from CMC services. The exception to this includes client conviction status amongst individuals with a prior criminal justice history, which will be followed up for three years post-

baseline regardless of whether they are engaged or discharged from care. Through the implementation of the project, prospective clients will be added to the current dataset until the final summative evaluation is completed in Year 5.

Target Population

All adults who access services delivered through the Homeward Bound Initiative will be included in the analysis. The analysis will include all service data collected between the opening of the ARC on 1/1/2018, until 6/05/2020. The clients included in this evaluation will include everyone who is either referred or self-referred to the ARC or utilizes the sobering facilities during a period of intoxication.

Data Collection Procedures

In line with current practices, if the client does not already have an electronic medical record (EMR) at CMC, one is created at the first appointment. The EMR contains all the client's demographic information and an ongoing record of their care. During their first appointment, the client will complete the Patient Health Questionnaire (PHQ-9) and the Generalized Anxiety Disorder Scale (GAD-7). During this, or any subsequent appointments, if it becomes evident the client may be experiencing a SUD, they are encouraged to complete the Treatment Needs Questionnaire (TNQ). If this screening form identifies any intravenous drug use, prior receipt of MAT, use of cocaine or benzodiazepines, or alcohol misuse, then the client is referred to complete a full behavioral health assessment. During the assessment, the client is instructed to complete the Client Satisfaction Questionnaire (CSQ-8), the Drug Abuse Screening Test (DAST) for a more detailed exploration of their drug use history if they reported prior drug use, and the CAGE Substance Abuse Screening Tool (CAGE) if they report a history of alcohol problems. The individual will then be referred to receive either withdrawal management, MAT, counseling, case management, and/or respite care, based on the outcome of the assessment. Individuals referred to receive MAT will complete the Office-Based Opioid Treatment Stability Index (OBOT) at the initiation of treatment, and then at monthly intervals to review patient stability and recovery outcomes. As part of ongoing care all clients will complete the PHQ-9 and the GAD-7 based on clinical need, and then every six months from the baseline assessment date. These data are used to both inform care, and track symptom progression over time. All the data is stored within the CMC EMR, and at each reporting stage, this data is extracted by CMC analysts and provided to the evaluation team for analysis.

In addition to the data held in CMC's EMR, CMC was required to collect annual conviction data for each client that reported a criminal justice history at the ARC intake assessment stage. This was conducted to meet the Board of State and Community Corrections (BSCC) reporting requirements. To achieve this, CMC staff manually checked the Superior Court of San Joaquin County public court records of all BSCC-eligible clients every 12 months post the baseline assessment. These records were available at the following address: https://cms.sjcourts.org/fullcourtweb/mainMenu.do?&PageSize=0&Index=0. In cases where the client is convicted of a new felony or misdemeanor post assessment, this information was

added to a separate recidivism tracking sheet developed by the evaluation team. This check was completed three times over the course of three years for each client.

To link both the recidivism and EMR datasets, an analyst based at CMC assigned all clients with a unique identification (ID) number. These datasets were then both submitted to the evaluation team separately via the secure, Health Insurance Portability and Accountability Act (HIPAA)-compliant MyResearch system, hosted by the University of California, San Francisco. Once the evaluation team received the datasets, they were merged via the anonymized unique identifiers.

Measures

In the current evaluation the analysis will focus on the data from the following sources:

Patient Health Questionnaire (PHQ-9)

The Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001) is a brief, 9-item instrument designed to diagnose depression and measure depression severity. Items concern different features of depression such as anhedonia, depressed mood, and loss of appetite, and depression is diagnosed by a PHQ-9 score of 10 or greater. As a severity measure, the scale ranges from 0-27, with a higher score indicating more severe depression. In this evaluation, all participants will complete the PHQ-9 at the point of assessment, and then every 6-months until the point of discharge in clients who receive services at CMC**.**

Generalized Anxiety Disorder Scale (GAD-7)

The Generalized Anxiety Disorder Scale (GAD-7; Spitzer et al., 2006) is a 7-item questionnaire designed to both diagnose and measure the severity of anxiety the responder has experienced over the past 2 weeks. Items relate to symptoms such as uncontrollable worrying, irritability, and restlessness. Each item is rated on a scale of 0 (“not at all” bothered) to 3 (bothered “nearly every day”). The authors suggest a score of 10 or higher as a reasonable cut-off point for identifying cases of GAD. The scale will be administered by all clients at the point of assessment, and in clients who receive services at CMC, the GAD-7 will be re-administered at 6-monthly intervals until the point of discharge.

The Drug Abuse Screening Test (DAST)

The Drug Abuse Screening Test (DAST; Skinner 1982) is a 20-item self-report questionnaire designed to measure the degree of problems the client experiences as a consequence of their drug use. Each item requires a dichotomous yes/no response and includes items relating to interpersonal conflicts, occupational problems, criminal activities, side effects, guilt, addiction, and treatment related to drug use. American Society of Addiction Medicine (ASAM) placement criteria suggest that a score ≤ 5 indicates a low-level impact of drug abuse, 6-10 indicates moderate, 11-15 indicates substantial, and ≥ 16 indicates a severe impact, with the individual likely requiring intensive treatment services. Clients will complete the DAST at CMC at the point of assessment with the SUD counselor.

The CAGE Substance Abuse Screening Tool

The CAGE Substance Abuse Screening Tool (Ewing, 1984) is a four-item questionnaire used to identify responders who may potentially be misusing alcohol. Each item requires a dichotomous yes/no response and asks the responder whether they have ever felt that they should cut down on their drinking, if they get annoyed because people criticize their drinking, if they have felt guilty regarding drinking, or if they have ever had a drink first thing in the morning to alleviate symptoms of alcohol addiction or a hangover. The typical cutoff used for the CAGE is two positive answers. Clients will complete the CAGE in CMC at the point of assessment with the SUD counselor.

Office-Based Opioid Treatment Stability Index

The Office-Based Opioid Treatment Stability Index (OBOT; Nordstrom et al., 2016) is an 8-item provider-completed questionnaire designed to assess how stable each client is with regards to their SUD treatment. Each item requires a dichotomous yes/no response and includes questions such as whether the client tested positive for a recent urine drug screen; if they endorse having used illicit substances, alcohol or benzodiazepines; if the client reports losing their prescriptions or running out of medication, or if they are experiencing cravings. In the event of any positive response, the client is considered "unstable" and as a result may require more frequent provider support. In this initiative, the OBOT will be administered by all clients in receipt of MAT after one month of initiating the treatment, and then in 3-month intervals from that point to monitor adherence to the program.

Treatment Needs Questionnaire (TNQ)

The Treatment Needs Questionnaire (TNQ, Brooklyn and Sigmon, 2017) is a 20-item self-report questionnaire used to identify appropriate candidates for community-based treatment for SUD. Each item requires a yes/no response, and is scored a 0, 1, or 2 based upon the severity of at-risk behaviors endorsed. Clients who score ≤ 5 are considered excellent candidates for community-based treatment, 6-10 are considered appropriate candidates with a tightly structured program and counseling, 11-15 are considered appropriate for community treatment by a certified addiction physician, while those who score ≥ 16 are considered appropriate for more intensive services. The TNQ will be delivered to all clients externally referred to CMC for behavioral services by the Health Navigator as part of a preliminary screening assessment as part of a process to identify those appropriate for a full behavioral health assessment with a qualified behavioral health clinician.

Client Satisfaction Questionnaire (CSQ-8)

Clients' satisfaction will be assessed using the CSQ-8 (Larsen et al., 1979). The CSQ is an 8-item Likert questionnaire where responders rate each item from 1-4, with a higher score representing greater satisfaction with treatment. The CSQ-8 has been extensively used in various healthcare settings and has been validated for use in SUD populations (Wilde and Henriks, 2005). Clients receiving services at SJCBHS will complete the CSQ-8 during their full

assessment. Clients receiving care at CMC will complete the CSQ-8 at the point of assessment and after each episode of care.

Intervention

Components to be delivered as part of the Homeward Bound Initiative include MAT, withdrawal management, sobering, case management, respite services, mental health treatment, and SUD counseling from a recovery counselor. The services are delivered consistent with the ASAM guidelines at both level 1 and level 2 degrees of intensity (i.e., "ambulatory withdrawal management with and without extended on-site monitoring"). In conjunction with these additional services, clients will be eligible, based on need, to receive ongoing co-located physical and mental health care as part of CMC's existing services.

MAT is the use of medications in combination with supportive therapies to treat SUD. The ARC primarily administers two medications; suboxone (buprenorphine and naloxone) for the treatment of opioid use disorders and naltrexone for the treatment of alcohol use disorders. Buprenorphine suppresses the physical signs and symptoms associated with opioid withdrawal and is an effective intervention in the maintenance treatment of opioid dependence (Mattick et al., 2014). Naltrexone blocks feelings of intoxication and euphoria and has been found to reduce self-reported cravings and alcohol use (Hendershot et al., 2017).

The recovery counseling component of care is typically delivered both in a group format and on an individual basis. Both treatment formats are delivered by qualified recovery counselors, and the focus of these treatments is to support the individual in their SUD recovery. If either during the assessment or ongoing SUD treatment the client is identified as having additional mental health needs, then they are referred to a CMC behavioral health clinician for additional services.

For those who present to the ARC intoxicated – either via a self-referral or a referral from law enforcement or other community partners – they will be offered a safe space to achieve sobriety. Once sober, an assessment and additional care services will be offered, based on need.

In addition to mental health and substance use treatment, the Homeward Bound Initiative will aim to provide a range of additional supportive services delivered as part of case management and respite care. This may extend from addressing immediate basic needs (e.g., providing food, basic hygiene support, etc.) to providing long-term case management, housing support, and employment assistance. Depending upon the nature of the support required, these services will be delivered by ARC providers or referred out to community partners.

By addressing immediate needs and engaging clients in SUD treatment, this should in turn facilitate engagement with mental health services also delivered by CMC. For clients who meet criteria for the receipt of behavioral health services but are not yet ready to fully engage in treatment, case management services will be provided by CMC providers to build rapport,

engage the client, address basic needs, and provide an additional pathway to SUD or mental health treatment.

Analysis Plan

The quantitative analysis detailed in the current report focuses on service delivery, expansion and receipt of services, access to and engagement in care amongst underserved groups, treatment outcomes, and client recidivism status.

The quantitative analysis utilizes program-level data to examine the Homeward Bound Initiative in four key areas:

1) improvements in client access to and engagement in care
2) behavioral healthcare service utilization amongst underserved groups
3) reconviction among clients with a criminal justice history
4) functional improvements in clients with mild-to-moderate behavioral health concerns

Analysis of improvements in client access and engagement in care focuses on trends in client assessments and treatment over time as defined by client baseline months, defined as the month in which a client's first assessment at the ARC was completed. We focus on the level and trend in the number of clients by baseline month in assessments, mental health treatment, and SUD counseling. We also assess changes in the duration from baseline month to first month of SUD counseling to understand how program maturation has impacted client wait times to begin counseling. Additionally, we examine separately the number and share of clients engaged in mental health treatment or SUD counseling at least six months over time.

Analysis of behavioral healthcare service utilization among underserved populations was accomplished by examining the demographics of the client population, including the share of clients in mental health treatment and SUD counseling at least six months. We assess the utilization of services by underserved groups by comparing Homeward Bound service utilization by race and ethnicity to their respective rates within the general population. According to compiled results from the National Survey on Drug Use and Health, an annual nationwide survey of individuals aged 12 year and older, substance use disorders do not very substantially across race and ethnicity (SAMHSA, 2018).

Analysis of reconviction among clients with a criminal justice history focuses on the share of persons with a criminal justice history among all clients over time, the reconviction rate at 12 and 24 months from enrollment, and reconviction rates over time among clients in treatment at least six months compared to clients in treatment fewer than six months.

In this report, the analysis of functional improvements in clients with mild-to-moderate behavioral health concerns is limited to clients with mild-to-moderate depression. Clients with mild-to-moderate depression were identified using the PHQ-9 questionnaire administered

during the client's initial assessment; we define this initial PHQ-9 as the client's baseline PHQ-9 score. We assess the share of clients receiving the PHQ-9 questionnaire in each month since their baseline month, where a client's baseline PHQ-9 is indexed as month 1. We also estimate the mean month-to-month change in subsequent PHQ-9 scores relative to the mean baseline PHQ-9 score using fixed-effects panel regression to control for unobserved client characteristics that are constant in time and correlated with PHQ-9 scores.

This analysis utilizes client-level data from the CMC combined with service data from SJCBHS, providing the evaluation team with access to extensive client service utilization data previously not available. Additionally, we use conviction data obtained from the San Joaquin County Superior Court manually collected by SJCBHS staff to enable an assessment of Homeward Bound client reconviction within the 12- and 24-month periods following a client's enrollment.

Evaluation of Homeward Bound Outcomes

Outcomes addressed by Quantitative Analysis

The outcomes evaluated in this report follow directly from the goals outlined in the *Goals and Objectives* section of this document and were outlined in detail in Section 4 of the *San Joaquin County Homeward Bound Initiative Evaluation Plan,* beginning on page 25. Those outcomes are listed below:

1) **Improvements in Access and Engagement in Care**
    - **a)** Increase the total number of individuals that complete a full behavioral health assessment at CMC, relative to historical controls.
    - **b)** Increase the total number of individuals receiving behavioral health treatments at CMC, relative to historical controls.
    - **c)** Increase the number and proportion of individuals with mild-to-moderate behavioral health concerns that continue to receive behavioral health treatment 6 months from baseline, relative to historical controls across all services.
2) **Reducing Disparities in Behavioral Healthcare Services Utilization**
    - **a)** Increase the number/proportion of consumers from under-represented groups screened for substance use disorders, relative to historical controls
    - **b)** Increase the number/proportion of consumers from underrepresented groups that engage in community treatment for mild-to-moderate behavioral health concerns, relative to historical controls.
    - **c)** Increase the number/proportion of consumers from underrepresented groups in recovery from substance use disorders, relative to historical controls.
    - **d)** Increase the number/proportion of consumers from underrepresented groups that either remain in CMC services after 6 months, or complete treatment, relative to historical controls.
3) **Reducing criminal justice bookings, convictions, and recidivism**

   a) Reduce the number of individuals incarcerated with mental health disorders, relative to historical control.
   b) Report the number/proportion of those that are either re-arrested, or are booked, charged, or convicted of a new felony or misdemeanor within 90 days following engagement in behavioral health services, delivered as part of the Homeward Bound Initiative.
   c) Report the number/proportion of those treated as part of the Homeward Bound Initiative that recidivate within 12-months of commencing behavioral health treatment.
   d) Report the number/proportion of those treated as part of the Homeward Bound Initiative that recidivate within 24-months of commencing behavioral health treatment.

4) **Delivering High Levels of Consumer and Provider Satisfaction with New Models of Care**
   a) Measure high levels of consumer-reported satisfaction with treatment at ARC.
   b) Measure at least equivalent consumer-reported satisfaction in treatment with those that self-identify as Black/African American or Latino, relative to other racial and ethnic groups.
   c) Measure at least equivalent consumer-reported satisfaction in treatment with those previously convicted of a crime, or are homeless, relative to other consumers.
   d) Measure at least equivalent consumer-reported satisfaction in between those that do and do not report English as their preferred language.

5) **Functional Improvements Following Treatment**
   a) Reduce symptoms of depression and anxiety in those identified as experiencing a mild-to-moderate behavioral health concern at 6 months follow-up, relative to baseline levels.
   b) Report the number/proportion of consumers that are either employed or are enrolled in a job training program at six months follow up.
   c) Increase the number of individuals that are in recovery for a substance use disorder following treatment, relative to historical controls across all services.
   d) Report the number/proportion of individuals that remain in stable housing for at least one month at the six months follow up point.

Based on the available data, we are able to address items 1-3 and 5a in this Year 3 Evaluation Report. Ongoing data collection efforts, along with the addition of more data sources, will provide data necessary for addressing item 4, as well as the remaining objectives in item 5.

Preliminary Outcomes Performance

Improvements in Access and Engagement in Care

As of May 2020, 748 individuals have either been referred or self-referred to receive services as part of the Homeward Bound Initiative, an increase of 303 clients (+68%) from May 2019. **Figure 4** shows the number of new referrals each month since August 2018, the first month of available data. On average, Homeward Bound has received about 34 new referrals per month since August 2018, with monthly referrals increasing at about 5% per month over that period. Assuming the number of new referrals continues to grow 5% per month on average, we project that CMC will receive nearly 100 referrals per month and almost 2,600 referrals total by June 2022.

Figure 4: Number of New Clients Enrolled in Homeward Bound

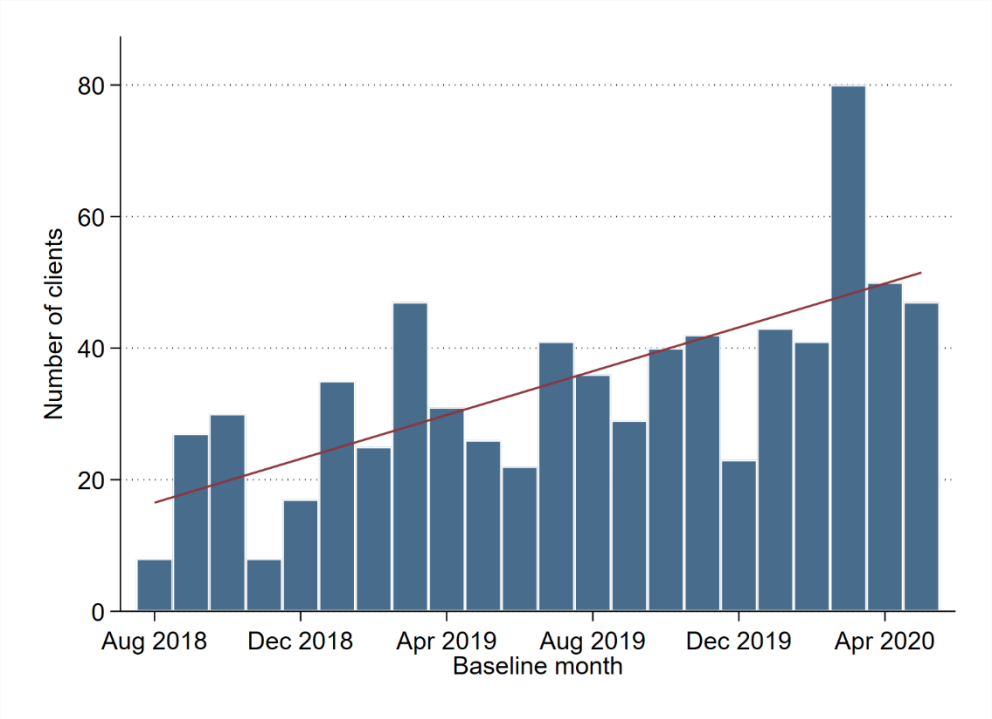
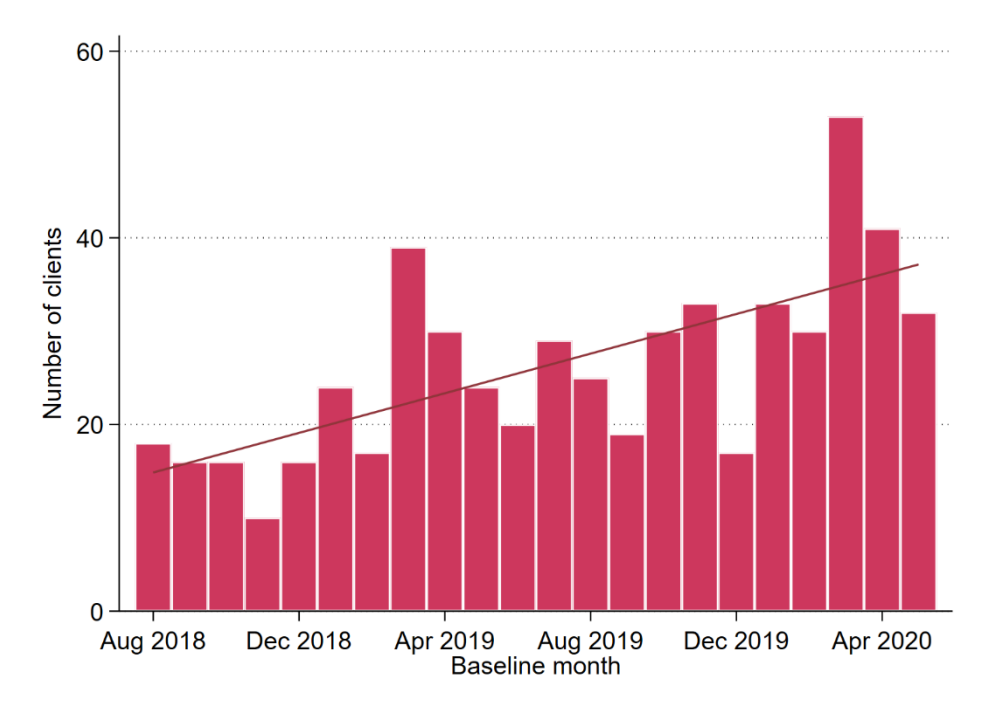


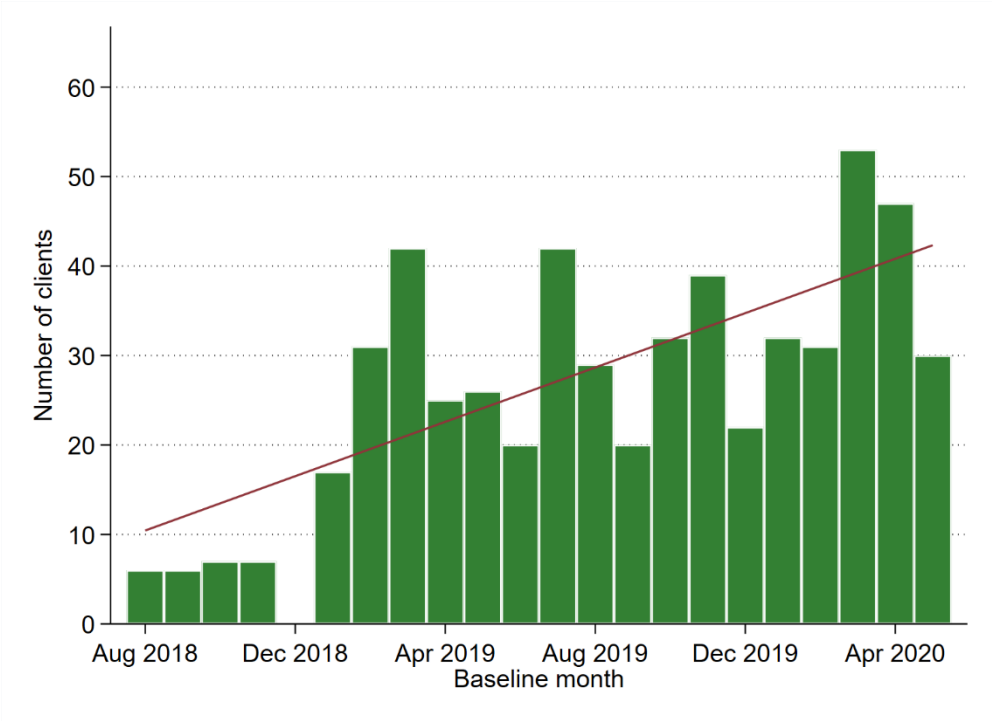
Figure 5 shows the number of clients completing behavioral health assessments each month since August 2018. CMC completed 554 behavioral health assessments between August 2018 and May 2020, a retention rate of approximately 75%. Throughout the program, CMC has completed about 10 behavioral health assessments per month. However, monthly behavioral health assessments have averaged about 38 per month since January 2020.

Figure 5: Number of Clients Completing Behavioral Health Assessments



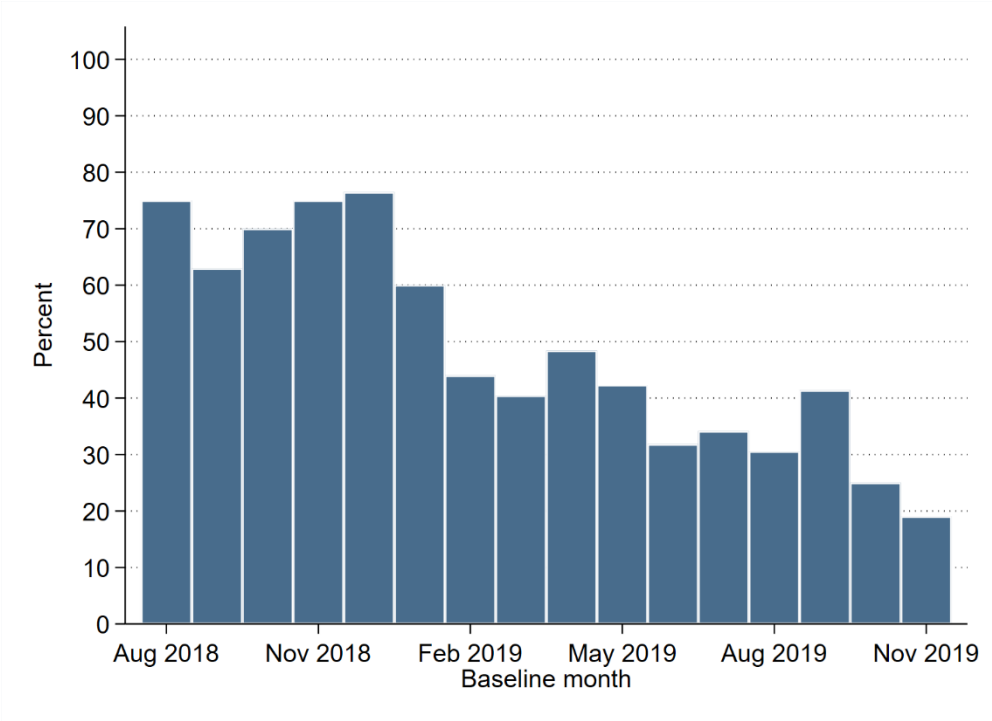
The number of clients engaged in SUD counseling each month since August 2018 is presented in **Figure 6.** By the end of May 2020, CMC enrolled 568 clients in SUD counseling, an average of about 23 clients per month. Since January 2020, however, CMC has enrolled approximately 39 patients per month in SUD counseling. Additionally, CMC has significantly improved clients' wait between assessment and starting SUD counseling, with the average wait time dropping from about 3 months before January 2018 to a few weeks by May 2020. We are unable to evaluate the transition time in units shorter than months because we only observe calendar months.

Figure 6: Number of Clients Receiving SUD Counseling



The evaluation team assessed the number and proportion of clients in SUD counseling at least six months from baseline. The share of clients still in SUD counseling after six months is shown in **Figure 7**. While the proportion of clients continuing SUD counseling was at or above 60% in the first six months, the fraction of clients remaining in SUD counseling fell steadily to below 20% by November 2019. The number of individuals in SUD counseling at least six months has also fallen from a high of 21 in January 2019 to just 8 in November 2019 (although the lowest was 5 clients in November 2018).

Figure 7: Share of Clients in SUD Counseling at Least 6 Months



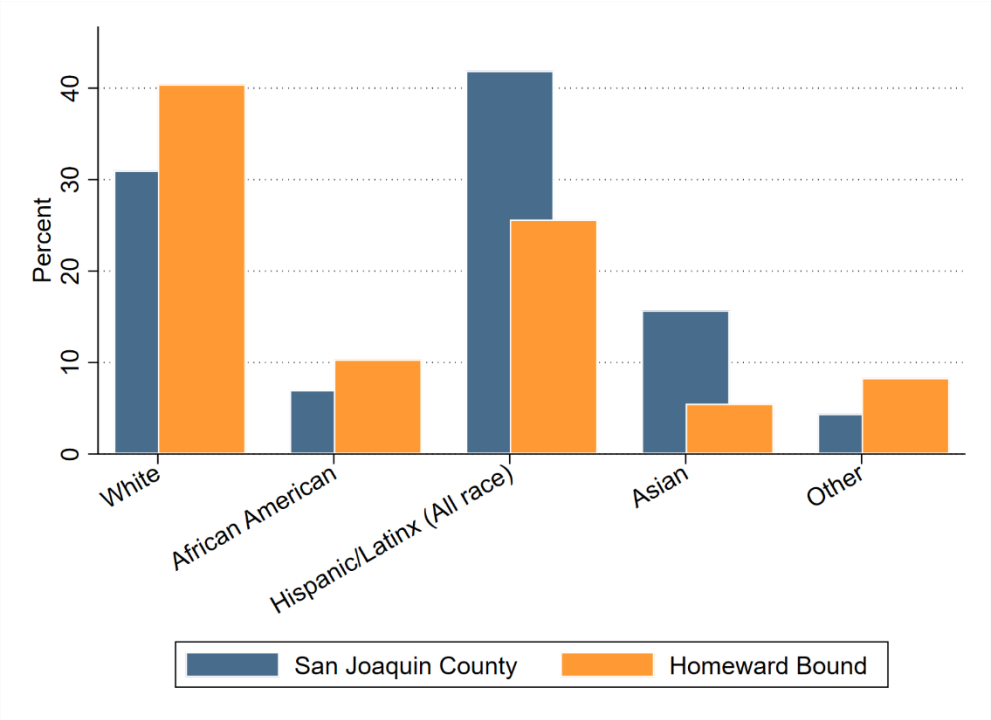
The share of clients remaining in mental health treatment for at least six months has been consistently lower than those in SUD counseling for at least six months, hovering between 20% and 30% from August 2018 to November 2019. For both mental health treatment and SUD counseling we only report data prior to December 2019 to avoid including clients who enrolled for fewer than six months before May 1, 2020.

Service Utilization in Underserved Populations

Race and ethnicity of clients assessed and treated by the Homeward Bound Initiative was analyzed across a variety of dimensions. **Figure 8** provides data on race and ethnicity of all clients assessed compared to the rate of each group within the population of San Joaquin County. 301 clients identified as White, making up 40.4% of all Homeward Bound clients. 191

clients identified as being of Hispanic/Latinx ethnicity, 25.6% of clients. Clients identifying as Black/African American comprised 10.3% of clients, 5.5% of clients identified as Asian, and 8.3% of clients identified with another minority group. About 9% of clients did not report their race or ethnicity. Individuals identifying as Hispanic/Latinx ethnicity made up about 26.5% of new referrals on average monthly, but this share declined from a peak of 37% in November 2019 to 15% in May 2020.

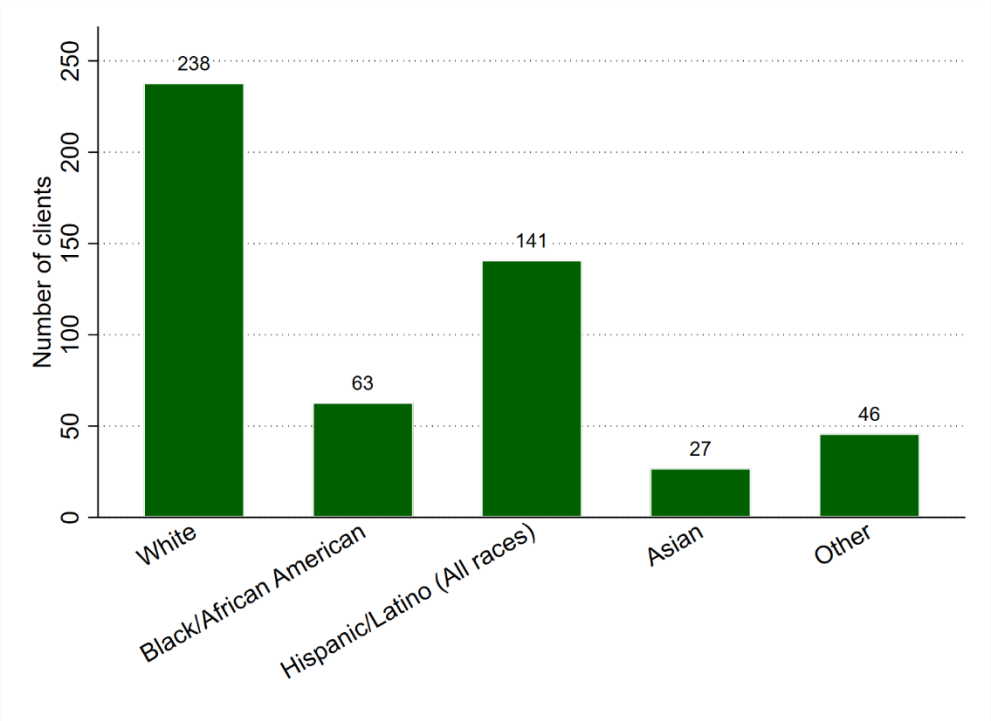
Figure 8: Race and Ethnicity of Clients Who Received An Assessment



Historically underserved populations remain under-represented relative to their population share in San Joaquin County. The population of San Joaquin county Hispanic/Latino individuals was 752,660 in 2018 according to the American Community Survey (U.S. Census Bureau, 2019), of which 41.9% identified as of Hispanic/Latinx ethnicity, 7% identified themselves as African American, 31% as White, 15.7% as Asian, while 4.4% identify as a member of another minority group. The greatest dispairty among groups remains between White and Hispanic/Latinx – Hispanic/Latinx individuals are underrepresented relative to White individuals despite making up a larger portion of the population, while nationwide these groups tend to have similar rates of met SUD treatment needs (Mulvaney-Day et al., 2012). The over-represented treatment rate of African Americans and under-represented treatment rate of Asian individuals in Homeward Bound is consistent with the overall rate of met SUD treatment needs for these groups nationwide.

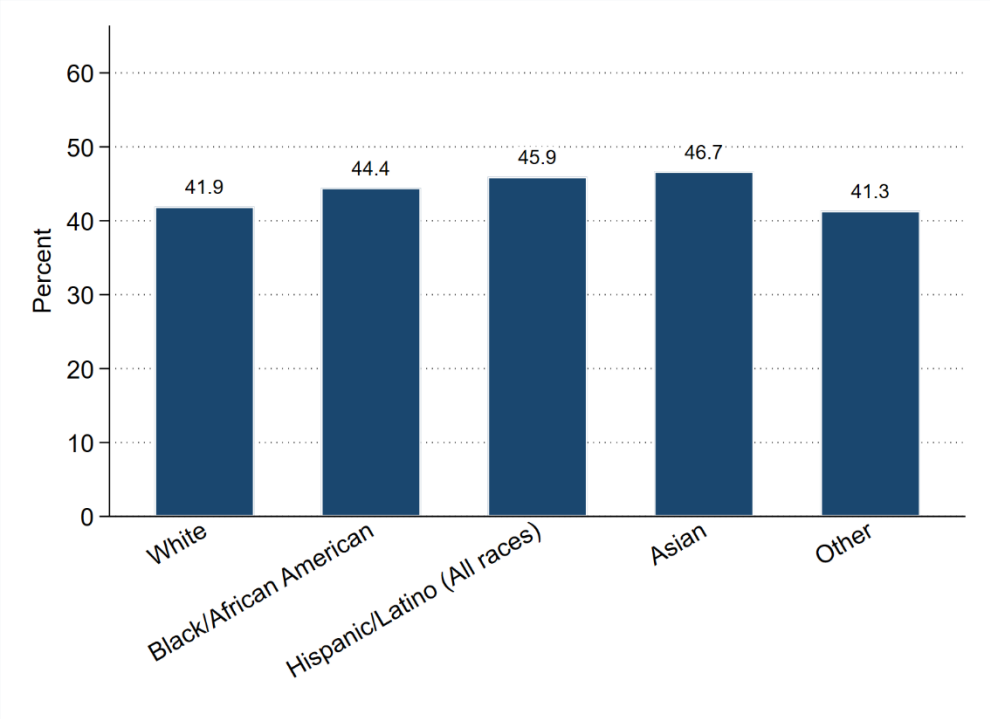
Figure 9 shows the race and ethnicity of Homeward Bound clients receiving substance use disorder counseling, which closely mirrors the overall demographics by race and ethnicity of Homeward Bound clients. For clients enrolled in SUD counseling, about 41% identified as White, 25% identify as of Hispanic/Latinx ethnicity, 11% identify as Black/African American, 5% identify as Asian, and 8% as another minority group. The demographics of clients who received mental health treatment is quite similar: 41% identified as White, 26% identified as of Hispanic/Latinx ethnicity, 10% identified as African American, 6% identified as Asian, and 8% as another minority group.

Figure 9: Race and Ethnicity of Clients Receiving SUD Counseling



Engagement in mental health treatment or SUD counseling for at least six months was almost uniform across race and ethnicity groups, as shown in **Figure 10** for SUD counseling. Across all racial and ethnic groups, approximately 45% of clients receiving SUD counseling engaged for at least six months, while about 30% of clients in each race and ethnicity group receiving mental health treatment were engaged at least six months. Hence, while underserved groups are still under-represented among Homeward Bound clients relative to the population, long-term engagement in treatment and counseling does not differ substantially by race and ethnicity.

Figure 10: Engagement in SUD Counseling for At Least Six Months by Race and Ethnicity

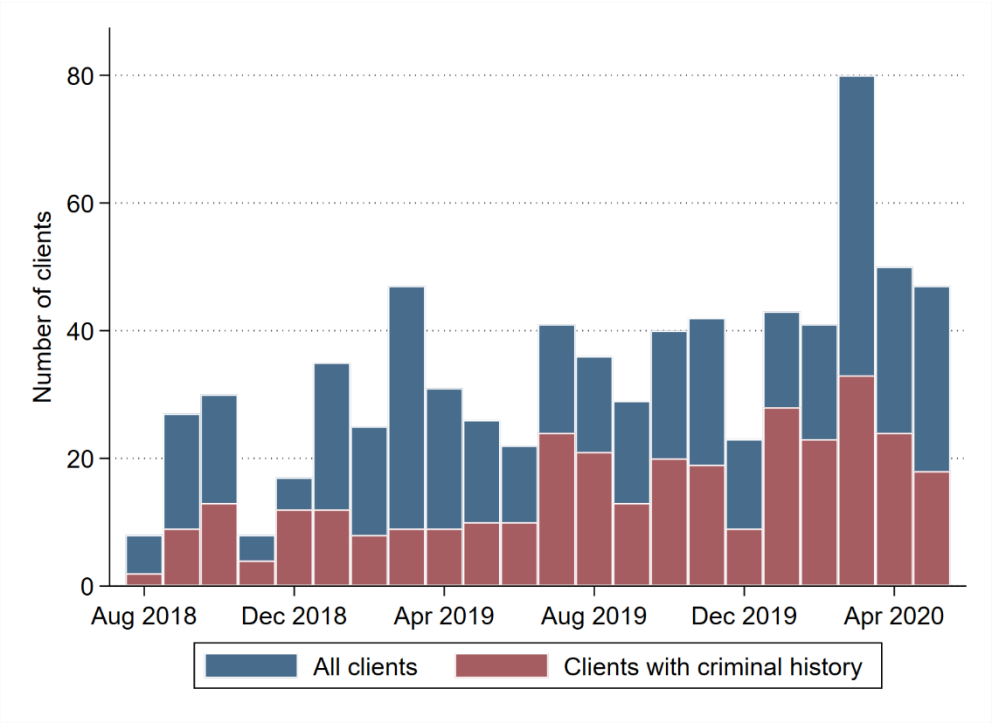


Reducing Criminal Justice Convictions

Identification of clients with a criminal justice history who were reconvicted of a crime within 12- and 24-months of enrollment in Homeward Bound was possible because SJCBHS staff manually collected data from San Joaquin County Superior Court's public-facing Criminal Records Database. In this section, we examine changes in clients with and without a criminal justice history over time, the overall reconviction rate in both the 12- and 24-month periods, and compare the reconviction rate among clients engaged in mental health treatment or SUD counseling for at least six months to those engaged for fewer than six months.

Figure 11 shows the number of referred clients per month with a criminal justice history as a fraction of all monthly referrals. Referrals of clients with a criminal justice history are increasing over time as the number of referrals has increased over time. While the number of referred clients with a criminal justice history has increased over time, the fraction of newly referred clients with a criminal justice history has remained relatively stable – about 1 in 3 referred clients each month.

Figure 11: Number of Referred Clients with and without a Criminal Justice History



Of the clients with a criminal justice history, some fraction have been reconvicted at some point within 12 and 24 months of enrollment; the 12-month conviction rate by month of enrollment is shown in **Figure 12**. The 12-month reconviction rate increased from 12% for those enrolled in January 2019 to 25% for those enrolled in March 2019. No clients enrolled in May 2019 had been reconvicted of a crime, though this may reflect a lag in the collection of conviction records. The 24-month conviction rate follows a similar trend – increasing from 20% for those enrolled in January 2019 to 29% for those enrolled in March 2019. Unfortunately, data is not available for those clients enrolled before January 2019 due to data limitations, or after May 2019 because the 12 month period had not ended for those clients when data was collected.

Figure 12: Reconviction Rate for the 12-Months Following Enrollment

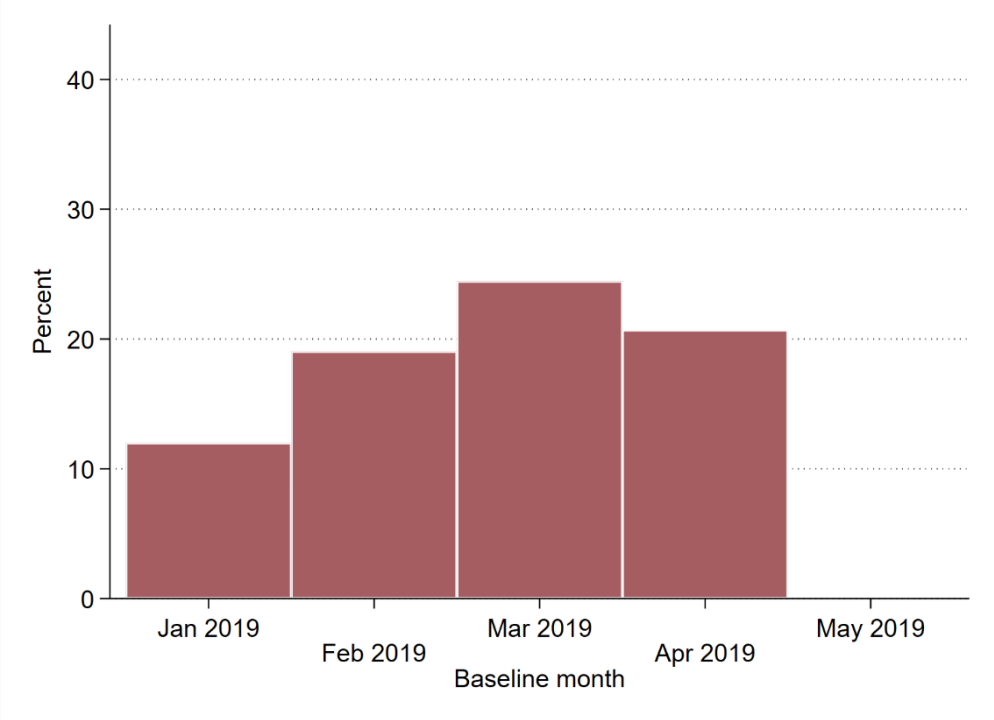
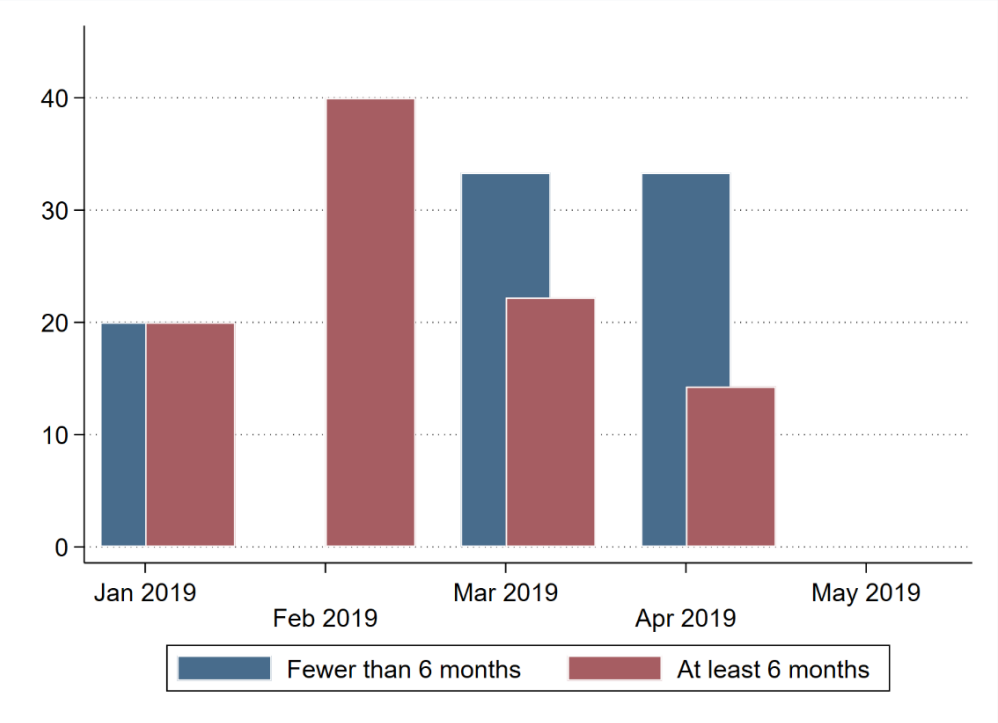


Figure 13 shows a comparison of reconviction rates between clients engaged in SUD counseling for at least six months and those engaged for fewer than six months. In all enrollment months with data for both groups, the reconviction rate for clients engaged for at least six months is at most the same as those engaged fewer than six months, but is significantly lower for clients enrolled in later months – nearly 20 percentage points lower among clients enrolled in April 2019. A similar comparison among clients in mental health treatment shows a slightly different picture – the rate of reconviction among clients engaged for at least six months was higher than those engaged for fewer than six months for those clients enrolled in January and February 2019, but was then significantly lower in later enrollment months. It is worth noting that while 40% of clients with criminal history and in SUD counseling at least 6 months who enrolled in February 2019 were reconvicted within 24 months of enrollment, all those individuals engaged in SUD counseling for at least six months. Therefore, the rate among those in SUD counseling fewer than six months is zero because all of them were engaged long-term.

Figure 13: Reconviction Rate of Clients Enrolled in SUD Counseling

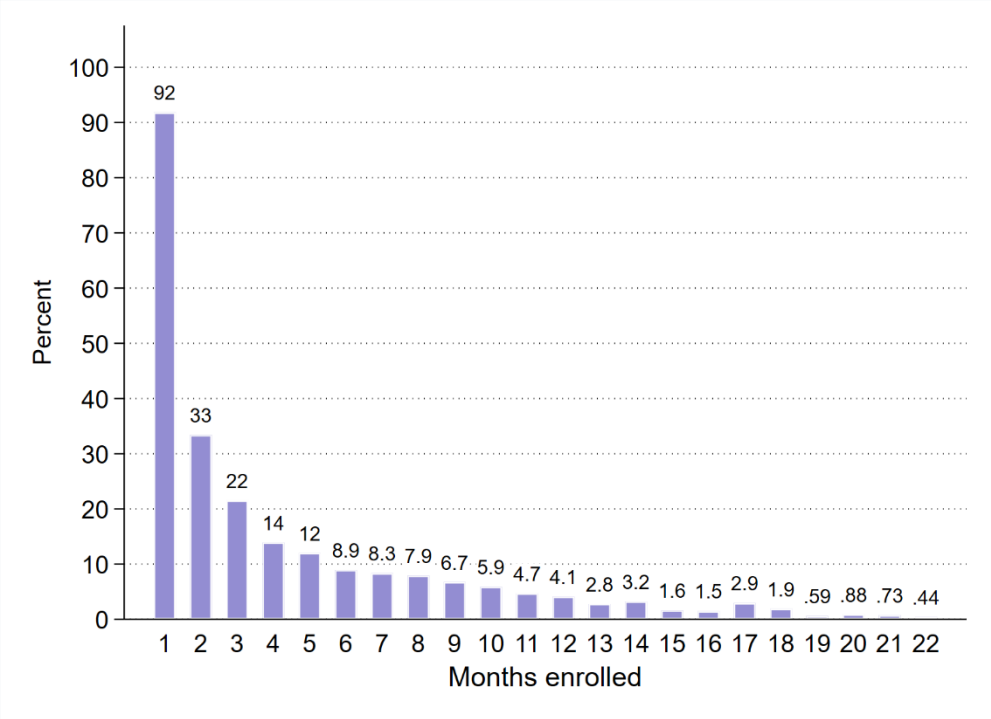


Functional Improvements Following Treatment for Depression

The client-level data collected from CMC allows for the examination of changes in symptoms of depression in clients with mild-to-moderate depression based on longitudinal observations of multiple PHQ-9 assessments per patient throughout treatment and/or counseling.

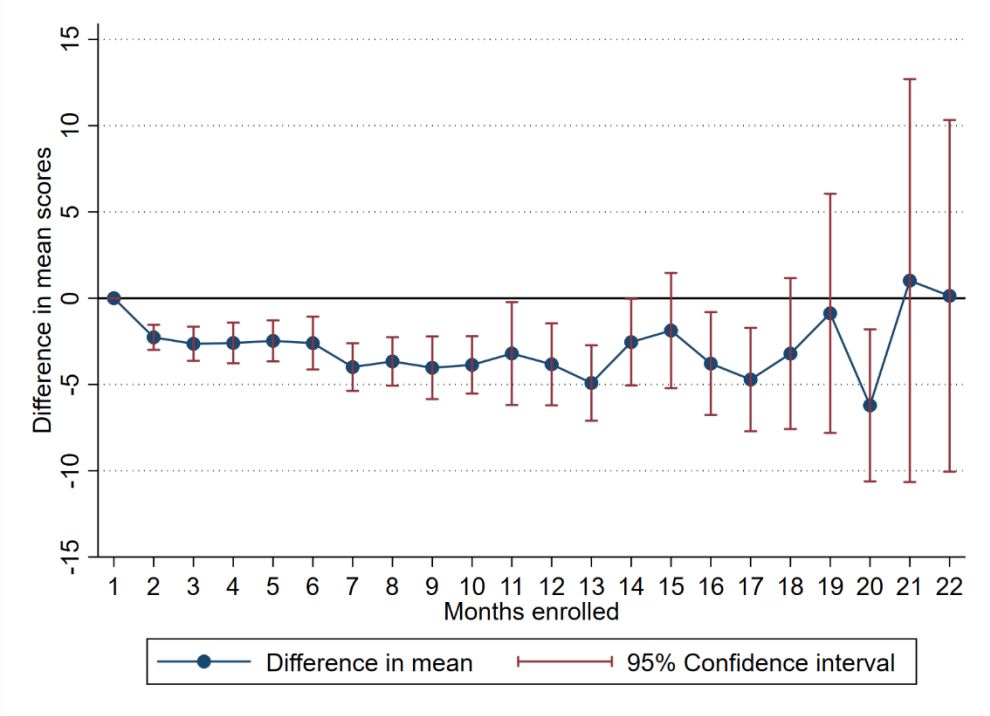
About 40% of referred clients completed only one PHQ-9, while some filled out as many as 13. On average, clients completed 2 PHQ-9s throughout their period of engagement, and about 25% of clients completed more than 3 PHQ-9s. PHQ-9s were given at irregular intervals; **Figure 14** shows the number of PHQ-9s filled out in each month of enrollment, where a client's baseline month is Month 1.

Figure 14: Proportion of Clients Completing a PHQ-9 in Each Month of Enrollment



The irregular nature of PHQ-9 data collection presents challenges when evaluating the effect of the Homeward Bound Initiative on clients with symptoms of mild-to-moderate depression: if PHQ-9s after baseline were only administered when a client's symptoms worsen, then we can only analyze PHQ-9 data in those clients who did not improve, giving the false appearance that the Homeward Bound Initiative is leading to worsening symptoms of depression. However, because 60% of clients completed at least two PHQ-9s, we can apply a fixed effects panel regression to control for client-specific characteristics that do not change over time but are correlated with PHQ-9 scores, such as differences in how engaged clients are in their treatment. We also control for clients entering mental health treatment and SUD counseling separately. We use this technique to estimate the change in mean PHQ-9 scores, relative to the baseline mean, over time for clients enrolled in Homeward Bound. **Figure 15** shows mean PHQ-9 scores in each month enrolled since baseline relative to mean PHQ-9 scores in Month 1.

Figure 15: Change in Mean PHQ-9 Score by Months Enrolled



Mean PHQ-9 scores become increasingly variable because the number of PHQ-9 scores in each month drops quickly, from 228 in month 2 to 46 in month 9 and just 3 in month 22. However, there are enough scores to estimate means with precision in the first 6 months. Due to data limitations, we cannot conclude longer enrollment in Homeward Bound causes lower PHQ-9 scores, but we can conclude longer enrollment in Homeward Bound is correlated with lower PHQ-9 scores compared to a baseline score.

Goals and Objectives Achieved

In the 12 months since the two-year evaluation report, CMC, SJCBHS, and community partners have continued their progress meeting early goals and objectives. Analysis of preliminary client-level data is consistent with these findings, and early conclusions suggest the Homeward Bound Initiative has also made promising strides toward meeting primary objectives for client

outcomes concerning access to and engagement in care, improving racial and ethnic inequities in service utilization, reducing client reconviction, and functional improvements following treatment.

CMC continues to see an increasing number of referrals each month. CMC averaged 33 referrals per month during 2019 but averaged 52 per month during the first half of 2020. It is too early to assess how the ongoing Coronavirus Disease 2019 (COVID-19) pandemic will affect monthly referrals, but early results suggest referrals may continue to increase. Increasing monthly referrals has translated to an increase in behavioral health assessments and clients engaged in SUD counseling. In an average month, 75% of referrals completed a behavioral health assessment, and 80% entered SUD counseling. CMC continues to successfully transition new referrals into treatment, counseling, or both. Additionally, CMC has significantly reduced the wait time to enter SUD counseling over the past 12 months, from an average delay of 3 months to within the same month they were referred. Long-term engagement in mental health treatment and SUD counseling remains a challenge, however.

The share of clients remaining in SUD counseling for at least six months has fallen steadily from 75% in January 2019 to less than 20% in November 2019, while engagement in mental health treatment at least six months has remained consistently at 20%-30% between August 2018 and November 2019.

CMC has continued progress toward increasing the number of referrals of people from underserved populations such as Black/African American people and people of Hispanic/Latinx ethnicity. 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.

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 results from the analysis of conviction records are still preliminary, and great care should be taken when interpreting the limited data collected so far. There is sufficient data to generate preliminary conclusions for clients with a criminal justice history in the context of CMC engagement, and to generate important reference points for future evaluation analyses. However, it is too early to determine the level of success the Homeward Bound Initiative has achieved at reducing reconviction rates among clients referred to the CMC.

Preliminary data shows clients meeting Proposition 47 eligibility requirements continue to be a significant share of monthly referrals, and increasingly so through the first half of 2020. The 12-

month conviction rate increased from 12% among clients referred in January 2019 to 25% of those referred in March 2019, though it should be noted that this increase represents a change from 5 reconvicted clients to 13 – small numbers relative to total monthly referrals. The number of clients analyzed remains relatively small, so it is difficult to interpret the data at this early stage. Analysis of clients with criminal justice history and engaged in mental health treatment or SUD counseling for at least six months shows promise. Overall, 12-month and 24-month reconviction rates are lower among clients engaged for at least six months compared to those engaged for fewer than six months.

The client-level data provided to the evaluation team by CMC contains longitudinal data consisting of repeated PHQ-9 scores for about 60% of all clients referred to CMC, of which about 42% completed three or more PHQ-9s. We use this data in a preliminary analysis of Homeward Bound's progress at achieving functional improvements following treatment for clients with mild-to-moderate symptoms of depression. Other than 92% of clients receiving a PHQ-9 during their baseline month, the PHQ-9 does not appear to be repeated at regular intervals for any clients – many clients completed a second PHQ-9 in their second month while others do not complete a second PHQ-9 until 7 or 8 months after their baseline month. This potentially poses a problem when evaluating Homeward Bound for functional improvements following treatment if clients are more likely to fill out subsequent PHQ-9s when their symptoms escalate as opposed to repeated PHQ-9s being administered regardless of client symptoms. After adjusting for this challenge with the data, we found that mean PHQ-9 scores declined relative to baseline PHQ-9 scores with statistically significant differences out to 11 months post-enrollment, although estimates become highly variable in later months because the sample sizes become quite small. There is promising evidence that CMC is achieving functional improvements following treatment, but it is still too early in data collection to make strong conclusions.

Future evaluation reports will continue to reassess these and other client-level outcomes as more client-level data become available and the quality of the data continues to improve over time.

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San Joaquin Behavioral Health Services
Progressive Housing Initiative

Deliverable 8: Annual Report

Executive Summary

Background

The Progressive Housing Initiative is an innovative, shared-housing approach to addressing homelessness, drawing from Housing First principles. The program has been delivered through a collaboration between Stockton Self-Help Housing and San Joaquin County Behavioral Health Services. Contrary to many alternatives in the San Joaquin County area, Progressive Housing adopts a low barrier to entry model; abstinence from substances is not a requirement to receiving housing. By utilizing such an approach, the primary aim of the Progressive Housing Initiative is to provide stable housing to individuals at high risk or experiencing homelessness who experience severe and chronic mental illness and may have a substance use disorder. Once housed, guests/tenants are offered a range of recovery-oriented behavioral health services, tailored to their readiness to engage in such care. To support recovery, as guests/tenants engage in services, they progress through the system and are moved into homes with other guests/tenants at a similar stage in their own recovery, until the point of graduation where they are ready to transition into private housing. Overall, the initiative aims to provide services to highly vulnerable unserved or underserved individuals in the San Joaquin County area and help to address the urgent unmet needs of those experiencing homelessness in Stockton and the surrounding areas.

Major Findings

As of June 2021, Stockton Self Help Housing has successfully met its original proposal target of 16 homes. Recruitment has been well above original projections, which is likely to be attributable to the rapid expansion of the program, the successful referral pathway into the system, and the higher-than-expected guest/tenant turnover (75.2%). However, COVID-19 and the subsequent shelter-in-place mandate has had a significant impact on behavioral health service delivery, leading to reduced housing capacity, greater restrictions around entry and exits from the homes, and significant disruption to behavioral healthcare delivery. This includes therapy groups, skills training classes, and home visits either being halted, substantially reduced, or shifted to remote delivery. These challenges are a likely factor contributing to the high guest/tenant dropout rate.

More positively, the demographic profile of the guests/tenants served appears highly representative of the homeless population of San Joaquin County, indicating the program has been successful at engaging historically underserved groups. Additionally, many of the clients reported experiencing chronic homelessness over multiple episodes, complex behavioral health and substance use disorder needs, and high levels of functional impairment spanning multiple

domains, indicating the project is successfully engaging individuals the program was originally designed to serve. Finally, client satisfaction with care was remarkably high, despite the impact of COVID-19 on care delivery.

Conclusions

The findings indicate that the Progressive Housing Initiative met the original target of securing 18 homes in the Stockton area, and is successfully engaging a diverse and representative sample of homeless individuals with complex substance use and mental health needs. Additionally, guests/tenants report being highly satisfied with the services that they receive. This is notable, given the significant disruptions to service delivery brought on by the pandemic.

Due to the lack of follow-up data, a comprehensive review of changes in functional or vocational outcomes could not be conducted. Consequently, this will be the focus of future deliverables, as more data become available. Finally, guest/tenant dropout from the program remains high. Going forwards, program dropout should be explored in more detail as COVID-19 response develops over time.

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Project Description

San Joaquin County is experiencing an extreme housing shortage, resulting in high rates of homelessness. The 2019 Point-in-Time survey found 2,629 homeless individuals residing in San Joaquin County; 1,558 of those individuals were unsheltered (San Joaquin Continuum of Care, 2019). Additionally, 34% of the unsheltered population in San Joaquin County self-reported having a mental health issue and 59% reported substance misuse. This is problematic, given that many existing programs available in San Joaquin County adopt a high barrier to entry model, meaning individuals are required to be sober prior to obtaining housing, and can face eviction for relapsing. These zero-tolerance policies for drug and alcohol use make finding and maintaining housing a difficult task for individuals with co-occurring mental health and substance use disorders (SUD).

In response to the growing need for affordable, low barrier housing for individuals with serious mental illness (SMI) who may also have SUD, San Joaquin County Behavioral Health Services (SJCBHS) developed the Progressive Housing Innovation project. This new housing service is being delivered in a partnership between SJCBHS and Stockton Self-Help Housing (SSHH). SSHH is a subsidiary of Sacramento Self-Help Housing that assists persons who are homeless or at risk of becoming homeless to find and retain stable and affordable housing, operating in the Stockton area.

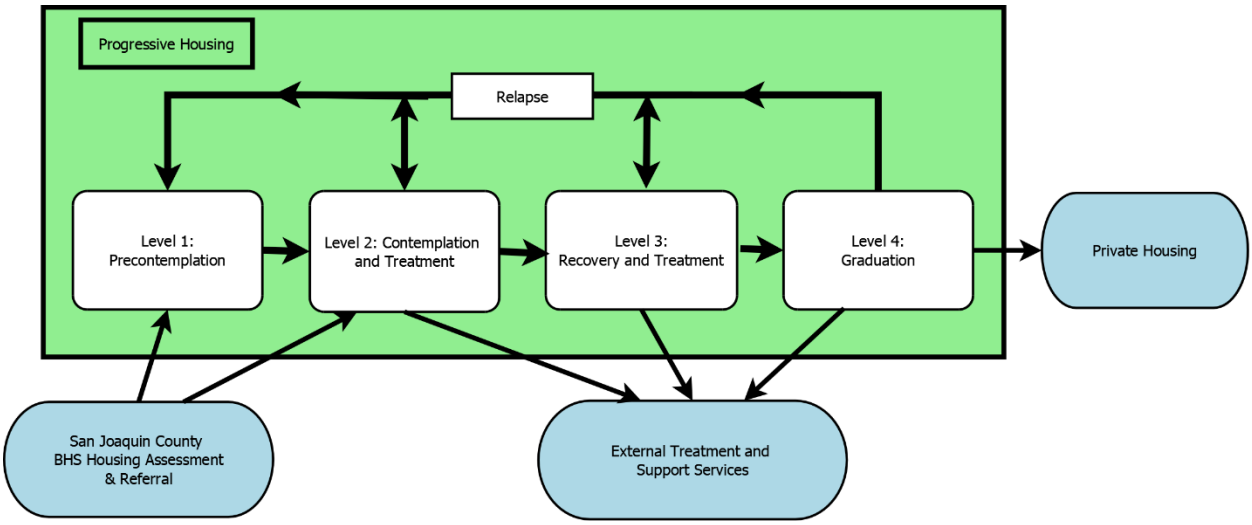
The Progressive Housing Initiative is an adaptation of the Housing First model. Housing First is a validated clinical and housing intervention that focuses on non-contingent permanent housing, autonomy, and community-based supports (Tsemberis, 2012; Stefancic & Tsemberis, 2007). This model does not require abstinence upon entry, stating that drug rehabilitation should be a part of individual's treatment rather than a precursor to other interventions (Pearson, et al., 2009; Stefancic & Tsemberis, 2007; Tsemberis, Gulcur, Nakae, 2004).

Literature on how to implement Housing First programs are scarce. Nelson and colleagues (2013) noted that having partnerships with government agencies, landlord associations, and different services was pivotal to implementing a Housing First program in Canada. However, they still faced barriers with lack of available, affordable housing. This is an issue particularly acute in California, the highest housing prices in the US, and vacancy rates well below the US average (Public Policy Institute of California, 2018). The Progressive Housing Initiative intends to address this significant issue by adapting the traditional single-occupancy Housing First model and implement it in single-family homes where multiple individuals can be housed together.

Housing First approaches have robust evidence supporting their effectiveness at securing long-term housing (Brown, Vaclavik, Watson, & Wilka, 2017; Aubry, et al., 2016; Stefancic &

Tsemberis, 2007), however, there are mixed results on their effectiveness in recovery from SUD (Groton, 2013; Padgett, Stanhope, Henwood, & Stefancic, 2011; Gulcur, Stefancic, Shinn, Tsemberis, & Fischer, 2003). The Progressive Housing Initiative intends to remedy the mixed results in recovery by implementing a hierarchical structure of housing levels based on tenants' recovery status. Tenants enrolled in program services will be placed in a group house that corresponds with their recovery level. Each house is staffed by a resident house manager, called the "house leader," who has lived experience of recovery. The model for the Housing First initiative is presented in Figure 1. The program is designed to stabilize a person's living situation, while also providing supportive services on site within a shared housing environment.

Figure 1. Progressive Housing Conceptual Model



In the first level, clients are provided with a place to stay as a guest while they complete the assessment process and decide if they are ready to participate in treatment. At this stage, guests will undergo a clinical psychosocial assessment to determine diagnosis, develop care plans, and initiate referrals to appropriate treatment. Additionally, they receive frequent site visits by an outreach worker to encourage participation in the program. In the second level, the clients' status changes from "guest" to "tenant," and they are placed in a new home with a higher level of independence and expectations. In this home, tenants are expected to take their own medications, perform household chores, attend house meetings, and create/abide by house rules. A SJCBHS clinician attends house meetings once a month to listen to any emerging issues and help the house leader brainstorm response strategies. At this level, tenants are assigned a housing case manager to help them create a pathway to permanent housing. SJCBHS

also provides weekly home visits by a clinician to conduct medication support services, run treatment groups, conduct outreach, and provide transportation to various other support centers. At level three, tenants contribute a portion of their income to monthly household expenses and are expected to develop a plan to obtain permanent housing. At this stage, SJCBHS provides weekly home visits from recovery coaches, facilitates independent living skills classes, and provides transportation to other centers. Finally, at level four, the tenant resides in independent housing without a house leader. The tenant's goals at this stage are to maintain housing for over a year, attend 90% of routine scheduled appointments, be medication adherent, and have 0-1 crisis visits per year. The tenant characteristics, housing services offered, and the range of treatments available to guests/tenants at each level of the Progressive Housing Initiative are presented in Table 1.

The Progressive Housing Innovation Project is anticipated to have two major outcomes: 1) increased access to mental health services amongst unserved and underserved populations, and 2) improved recovery outcomes for program tenants.

Table 1: Chart of Progressive Housing Program Services

	Guest/Tenant Characteristics	**Housing Services**	**Treatment Services**
Level 1: ***Precontemplation*** Pre/Post Assessment Process	The guest is suspected of having a mental health concern, and has been referred by a health navigator, outreach worker, or service provider for assessment.	Guests are provided with a place to stay as a guest while they complete the assessment process and determine if they are ready to participate in treatment interventions.	Regular engagement by outreach workers to encourage program participation. A clinical psychosocial assessment is made to determine diagnosis, initial case plan, and referrals to treatment.
Level 2: ***Contemplation and Treatment*** Sober Living and Treatment Engagement and Linkage to	Tenants have been assessed as having SMI and have been referred for treatment interventions. Tenants will be referred to a contemplation house or a sober living house. Tenants may be moved from one	Tenants are placed in a shared housing environment, staffed by a house leader. Tenants are expected to take their own medications, perform household chores, attend house meetings, and	SJCBHS will provide weekly home visits to conduct medication support services for all Tenants. SJCBHS will provide home visits 2-3 times/week by outreach workers to meet individually with Tenants. SJCBHS will provide transportation services for

Routine Mental Health Services	type of house to another depending on progress, and tenant needs. Tenants enroll in MediCal, obtain Supplemental Security Income (SSI), and may have a representative payee appointed. Tenants will have a goal of exiting the treatment house within 12-18 months.	create/abide by house rules. SJCBHS Clinician will attend a house meeting monthly to listen to any emerging issues and help house leader brainstorm responses strategies, as needed. Tenants are assigned a housing case manager to help them create a pathway to permanent housing plan.	household members to behavioral health services on regular days and times at least 2 times/week. SJCBHS staff will conduct regular home visits to meet individually with Tenants and/or conduct treatment groups.
<u>Level 3:</u> ***Recovery and Treatment*** Stabilization and Recovery Support Services	Tenant is stabilized and participating successfully in routine mental health treatment services. Tenants are utilizing extant community resources and have more independent living skills.	Tenants elect to participate in a shared housing environment, with a portion of income contributing to monthly household expenses. Tenants have a plan to obtain permanent housing and are working to establish the appropriate documentation for housing vouchers and rental applications.	SJCBHS will provide weekly home visits by recovery coaches to meet individually with Tenants. SJCBHS will provide transportation services for household members to Wellness Center, BHS, and Gibson Center* on regular days and times at least 2 times/week. SJCBHS will refer Tenants to Independent Living Skills classes in preparation for graduation to independent living.
<u>Level 4:</u> ***Graduation*** Independent, permanent housing	Tenant is stable in routine treatment services. Tenant assumes responsibilities for paying a portion of the rent through SSI.	Tenant obtains independent housing. Goals: House is no longer supported by a house leader.	Tenant is stable in treatment. Goals: Tenant attends 90% of routine scheduled appointments, is adherent to medication and treatment

	Goal – Tenant obtains tenant rights and responsibilities	Tenant pays rent from SSI or other income. Tenant maintains residence for at least 1 year	Tenant has no more than one crisis visit in a year

*drop-in socialization center providing health and wellness classes, online zoom classes, consumer empowerment groups, job readiness and vocational services, and local transportation services to SJCBHS

Project Aims and Objectives

The aims and objectives for the project are based on the original Mental Health Services Oversight and Accountability Commission (MHSOAC) innovation proposal and were previously detailed in the Progressive Housing Evaluation Plan (Deliverable 3). These include:

Project Aim 1. Improve outcomes related to housing retention, engagement in treatment, and functional outcomes.

- Increase access to housing and housing retention for homeless and housing insecure individuals that experience co-occurring mental illnesses and SUD.
- Increase engagement in behavioral health services for individuals who experience co-occurring housing insecurity and/or homelessness and ongoing behavioral health concerns.
- Increase functional and recovery outcomes for individuals who experience co-occurring housing insecurity and/or homelessness and ongoing behavioral health concerns.

Project Aim 2. Determine costs associated with implementing housing for individuals with severe mental illnesses and substance use disorders.

- Determine the costs associated with opening Progressive Housing homes
- Deliver Progressive Housing homes at a lower cost to alternative housing solutions for equivalent populations.

Project Aim 3. Deliver housing over a shorter timescale than other housing solutions for individuals with equivalent needs.

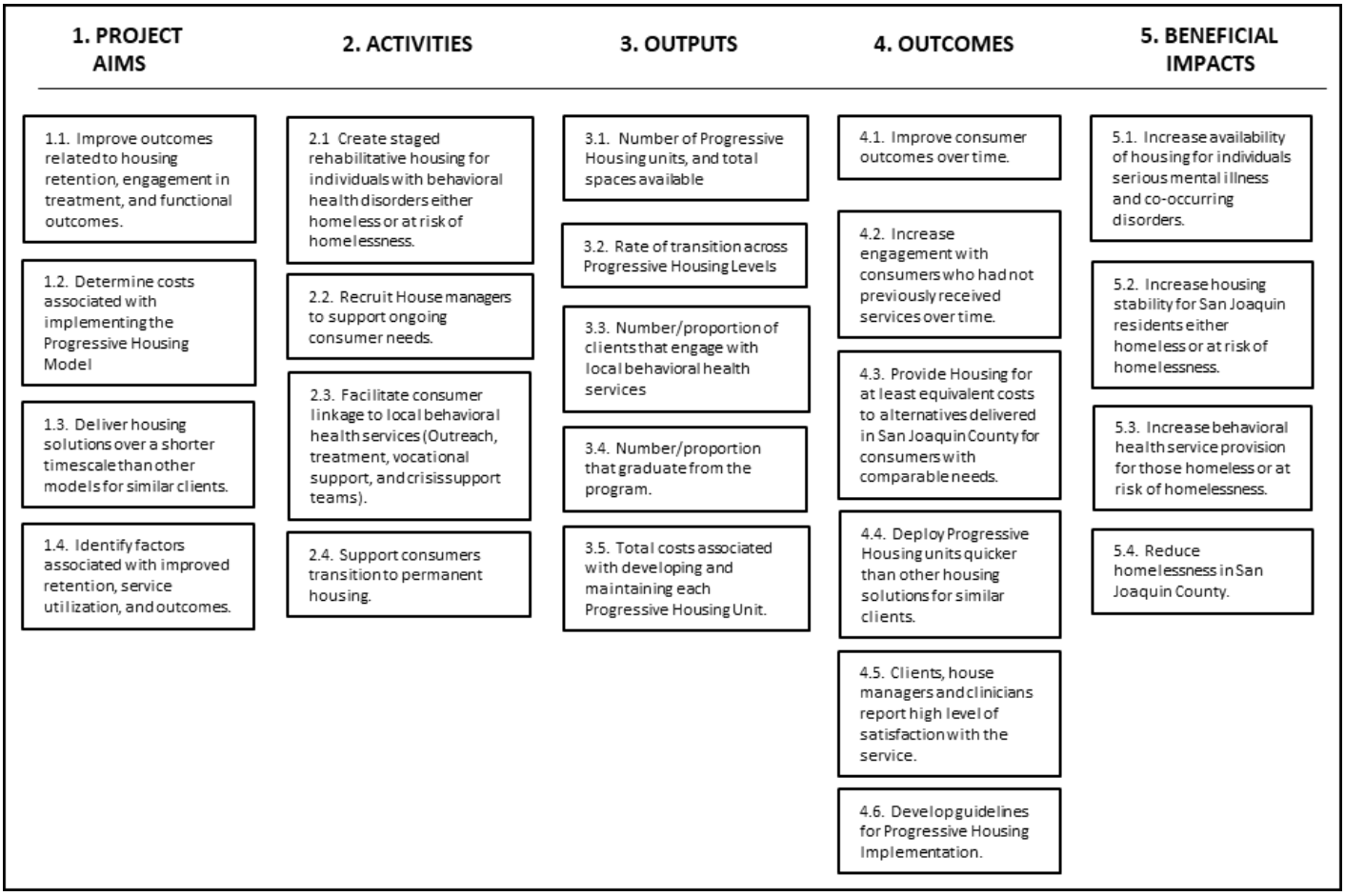
- Determine the mean startup time of Progressive Housing homes from site identification to opening.
- Deliver Progressive Housing homes over a shorter timescale than alternative housing solutions for equivalent populations.

Project Aim 4. Identify factors associated with improved retention, service utilization, and outcomes.

- Identify barriers and facilitators to successful project implementation
- Explore guest/tenant, house leader, and provider experiences of delivering and receiving care as part of the Progressive Housing Initiative
- Explore consumer-level factors associated with improved outcomes.

Logic Model

Figure 2: Logic Model of the Progressive Housing Initiative



Deliverable Scope as it relates to the Logic Model

The aim of this deliverable is to address the outputs and outcomes specified in the logic model. This includes: 3.1 - capacity building, 3.2 - transitions between housing levels, 3.3 - engagement with services. Housing graduation (Output 3.4) will be explored in later deliverables when more tenants have had the opportunity to graduate.

With regards to outcomes, in this report, we will present preliminary findings regarding improving functioning and recovery outcomes (4.1), guest/tenant engagement amongst those previously unserved (4.2), and guest/tenant satisfaction with services (4.5). Startup times relative to other housing models have been explored in a previous deliverable (Deliverable 7),

as has the qualitative exploration of guest/tenant and staff experiences of delivering or receiving care (outcome 4.5), and a review of the barriers and facilitators to implementation of the Progressive Housing approach (outcome 4.6) (Deliverable 5).

Methods

Study Design

In the current deliverable, a mixed-methods approach was adopted. Qualitative semi-structured interviews were conducted with SSHH and SJCBHS leadership to explore the impact of coronavirus disease -2019 (COVID-19) on program implementation, and how this in turn has potentially impacted program outcomes. To explore program expansion, guest/tenant characteristics, housing level transition rates, and program outcomes, a longitudinal survey study of data collected both at SSHH and SJCBHS was conducted.

With regards to the quantitative data utilized in the current report, this represents the basis of all subsequent analyses that will take place going forward, where new guests/tenants will be added as they enter the Progressive Housing program over time. In the early years of the project, these data will be utilized to conduct the formative evaluation of the project. In the final year of the evaluation (Year 5), the dataset will be finalized and used to conduct the summative evaluation.

Target Population

The target population for the Progressive Housing Initiative includes adults (18 years and older) who have a SMI and who are experiencing housing insecurity in San Joaquin County. Notably, actively using substances was not considered an exclusion criterion for program eligibility, contrary to many housing programs in the area. SJCBHS has identified the target population for services as the following:

- Underserved Individuals: Identified consumers with SMI who do not have a stable place to live, or cannot maintain successfully in available housing options due to recovery challenges (e.g., emotional dysregulation, substance use disorders), and as a result are so poorly served they are at grave risk of becoming chronically homeless.

  Unserved Individuals: Homeless individuals with SMI who remain undiagnosed or are not successfully engaged by SJCBHS. An estimated 34% of the homeless individuals in San Joaquin County may meet this criterion based on self-reports of “having a mental

health problem" amongst homeless, unsheltered individuals during the County's annual Point-in-Time Count (San Joaquin Continuum of Care, 2019).

In the formative evaluation of the Progressive Housing Initiative, all guests/tenants who have received services under this program from July 2018 to May 2021 were included in the analysis.

Data Collection Procedures

In the current formative evaluation of the Progressive Housing Initiative, qualitative data was obtained by conducting interviews with SSHH and SJCBHS leadership. The quantitative data collected by SSHH included both housing-level and guest/tenant-level data. With regards to the housing-level data, the SSHH Program Manager collected information regarding the identification, contract initiation, and eventual leasing of each home, enabling the evaluation team to track the expansion of the program over time. SSHH-held guest/tenant-level data were obtained via the Homeless Management Information System (HMIS) intake form. At the point of intake into the Progressive Housing program, each potential guest/tenant completed an assessment with a member of SSHH staff. During this assessment, the full HMIS assessment is completed. Upon completion of the intake assessment, a SSHH case manager uses the assessment form to enter data into a Progressive Housing Evaluation data collection sheet. These data include demographic information, details about past episodes of homelessness, prior service utilization, government assistance, health needs, and vocational information.

The data collected by SJCBHS providers comes from two sources. All data collected at program intake is collected via the Progressive Housing program data collection tool (See Appendix I). This includes basic demographic information, prior service utilization, clinical diagnosis, information around benefits and documentation, the baseline Adult Needs and Strengths Assessment (ANSA), and the Client Satisfaction Questionnaire (CSQ-8). Once the assessment is completed, these data are added to the SJCBHS Progressive Housing Data Log. Next, longitudinal data including subsequent changes in benefits/documentation, annual ANSA assessments, and CSQ-8 scores, in addition to any changes in housing status across the duration of the program are then added to the log by SJCBHS staff as more data is collected.

In order to link the two datasets, providers at SSHH assign guests/tenants a unique ID number following completion of the intake assessment, which is then communicated to their SJCBHS partners. This number is then added to the appropriate case within the SJCBHS Progressive Housing Data Log. These datasets are periodically sent to the evaluation team, who then link cases using the shared unique ID.

Measures

In the current deliverable the Adult Needs and Strengths Assessment (ANSA; Lyons, et 2013) the Client Assessment Questionnaire (CSQ-8; Larsen et al., 1979), and modified version of the Housing First Fidelity Scale (Gilmer et al., 2013) measures were used.

The Adult Needs and Strengths Assessment (ANSA)

The Adult Needs and Strengths Assessment (ANSA; Lyons, 2013) is an assessment tool designed to support clinical decision-making and monitor outcomes in behavioral health. The ANSA is validated for use in SUD populations (Allen and Olson, 2015). Across four core domains (life functioning, strengths, behavioral health needs, and risk behaviors), providers rate various dimensions based on a 4-point scale, with a higher score indicating greater severity of need. For this project, senior leadership at SJCBHS determined that nine items of the ANSA in particular represented domains where changes over time were anticipated to occur because of the Progressive Housing intervention. As a result, these nine domains were captured at both the intake assessment, and then annually until the point of discharge from the program. At each time point, a trained SJCBHS clinician conducted the assessment. The nine domains include impairments related to the guest's/tenant's residential stability, their living situation, substance use, social functioning, self-care, sleep, transport needs around care, physical health, and criminal behavior.

One significant limitation of the tool as an outcome measure relates to the fact that a score of '1' can relate to both to a current, and historical need, limiting the ability of the tool to capture change over time. In order to address this, in the current evaluation, all guest/tenant responses were dichotomized to indicate whether at the point of assessment the individual does or does not present with at least a moderate degree of need, as indicated by a score of '2' or higher.

Client Satisfaction Questionnaire (CSQ-8)

The Client Satisfaction Questionnaire – 8 (CSQ-8; Larsen et al., 1979) is an 8-item Likert questionnaire where responders rate each item from 1-4, with a higher score representing greater satisfaction with treatment. Items include questions such as "Have the services you received helped you to deal more effectively with your problems?" and "How would you rate the quality of service you have received?". The full scale is presented in Appendix II. The CSQ-8 has been extensively used in various healthcare settings and has been validated for use in SUD populations (Wilde and Henriks, 2005).

Housing First Fidelity Assessment Scale

An adapted 16-item self-report version of the Housing First Fidelity Scale (Gilmer et al., 2013) was used to explore the fidelity of the Progressive Housing Model to Housing First principles. The 16 items were presented in a two-factor model: one covering the program's approach to housing, separation of housing and services, and service philosophy, and the other related to service array and team structure (Gilmer et al., 2013). Items include questions such as "What is the program's approach to substance use among clients," and "How often do program staff meet to plan and review services for clients?" The full scale is presented in Appendix III.

Analysis Plan

The current analysis addresses five key areas which include:

1) The impact of COVID-19 on the implementation of the Progressive Housing Initiative, and outcomes
2) A review of service expansion and guest/tenant recruitment into the program
3) The guest/tenant characteristics of the sample served
4) Guest/tenant program retention and transition through the program levels
5) Client/tenant level outcomes and satisfaction with services

To explore the impact of COVID-19 on Progressive Housing implementation and outcomes, semi-structured qualitative interviews were conducted with SSHH and SJCBHS leadership with the results presented in a narrative summary. To explore service expansion and recruitment, the first part of the analysis utilized program-level data collected by SSHH that detailed the date the lease of each home was signed, and the date each home was opened for guests/tenants. Simple summary statistics were used to explore the expansion of services over time, and the rate of expansion. The total number of clients served to date, along with the rate of recruitment over time was explored using summary statistics utilizing guest/tenant-level data collected by SSHH.

To explore guest/tenant characteristics, a detailed summary was conducted using quantitative data collected by SSHH at the HMIS baseline assessment. The areas of interest included guest/tenant sociodemographic information, prior housing status and behavioral health service utilization, baseline sources of income, clinical presentation, educational and vocational health needs, and physical and behavioral health needs. Sociodemographic information was compared to the sociodemographic data of the sheltered and unsheltered homeless population of San

Joaquin County, as detailed in the 2019 Point-In-Time survey (San Joaquin County Continuum of Care, 2019).

An evaluation of program retention and transition through the program levels was conducted using the longitudinal survey data collected by SJCBHS. Summary statistics were used to calculate the proportion of clients that either progressed or regressed across the housing levels, and the mean number of moves that guests/tenants experience during their time in the Progressive Housing Initiative.

In the final part of the analysis, changes in functional impairment were evaluated utilizing the ANSA baseline and follow-up assessment scores, conducted by SJCBHS staff. At each timepoint, the proportion of clients that scored above and below a score of '2' moderate impairment for each item was examined. To evaluate the impact of Progressive Housing on vocational and educational outcomes, the proportion of clients that returned to either work or school/college were reported over each timepoint. Finally, to explore client satisfaction with services, item-level and CSQ-total mean scores were examined both at the baseline stage, and at six-months follow up.

All quantitative analysis was conducted utilizing the statistical software package STATA 14 (StataCorp, 2015).

Results

Structure of Progressive Housing as it relates to Housing First Principles

The Progressive Housing Initiative is a novel intervention based on the principles of the Housing First approach (Tsemberis, 2012). The overlap between the two is important because Housing First is a validated intervention for individuals with co-occurring SMI and SUD. To determine the extent to which the Progressive Housing Initiative adheres to Housing First principles, a Housing First Fidelity Survey was completed by the Progressive Housing Program Director on June 3, 2021 (Gilmer, et al., 2013; see Appendix III).

The Housing First Fidelity Survey was developed by Gilmer et al. (2013). It originally encompassed 46 items across five domains: housing process and structure, separation of housing and services, service philosophy, service array, and team structure. In the current study, a reduced, 16-item version of the tool was used, comprising two factors. The results of the Progressive Housing Initiative's Housing First Fidelity Survey are presented below.

Factor 1 encompasses three domains: housing process and structure, separation of housing and services, and service philosophy. The Progressive Housing model deviated from the Housing First model most noticeably under housing process and structure. In Housing First, under ideal conditions participants reside in individual, affordable, permanent, scattered-site housing,

where participants take up around 15% of a standard apartment complex (Gilmer, et al., 2013). In the Progressive Housing Initiative, guests/tenants are housed in single-occupancy homes with a group of other guests/tenants and a house leader in each home. They do align, however, in the fact that both the Progressive Housing Initiative and Housing First house individuals in standard residential spaces, as opposed to supported housing environments.

Both the Housing First and the Progressive Housing models are low barrier, meaning participants do not have to achieve abstinence, symptom stability, or compliance with medication to enter the program. Instead, they need to meet the responsibility of a standard lease. Services and housing are separate in both models. Housing is provided, contingency-free, and then participants have the option to be connected to services, as desired. The only difference is guests/tenants of the Progressive Housing Initiative must first spend a period in transitional housing before entering the program fully.

The service philosophy between the Progressive Housing Initiative and the Housing First model is quite similar with a few notable differences. In both models, clients with SMI are not required to take medication or participate in treatment, nor are clients with SUD required to participate in substance use treatment. Similarly, clients provide input around what additional external services they would like to receive. The key differences are, in the Progressive Housing Initiative, guests/tenants do not have input on their housing services, such as what their house level is in the progression of the program, the location of their housing, and which tenants also reside with them. Moreover, while abstinence from alcohol and/or drugs is not required off premises, it is required in the homes in order to mitigate the impact on other guests/tenants. Housing First clients are not required to abstain from alcohol and or drugs in or out of their residence and their housing services are less changeable (i.e., no levels, no housemates).

Factor two encompasses two domains, service array and team structure. Housing First programs offer a myriad of services, including SUD treatment, employment, educational, volunteer, general medical, and social integration services (Gilmer et al., 2013). The Progressive Housing program partners with SJCBHS to offer SUD treatment, employment, educational, and volunteer services. However, the Progressive Housing provision of services have been significantly impacted from COVID-19, with most services halted for several months.

Both Housing First and Progressive Housing models have frequent, regular, staff meetings in which teams meet for multiple functions. The Progressive Housing model specifically uses team meetings to review guest/tenant goals, discuss need for proactive contact to prevent future crises, and review previous staff assignments and follow through.

Structure of Progressive Housing as it Relates to Housing First Principles Summary

The Progressive Housing model aligns with most of the validated interventions and program structures of Housing First. The most notable difference is the shift from single-tenant occupancy in apartment complexes to group occupancy in single family homes. This shift also impacts the model's ability to allow substance use indoors, as it would impact other members of the program. This initiative could prove to be an expansion of Housing First to be more inclusive to suburban and rural areas that have fewer available single occupancy apartments.

Impact of COVID-19 on the Implementation of the Progressive Housing Initiative

The most significant factor affecting the progress of the Progressive Housing Innovation Project has been the COVID-19 pandemic and the resulting shelter-in-place order that began in March 2020. The evaluation team has conducted multiple interviews with leadership at SJCBHS and SSHH to assess the impact the pandemic has had on both the implementation and evaluation of the program. The findings from the first set of interviews were reported in Deliverable 6. To record the long term impact of COVID-19, a second set of semi-structured interviews took place on April 27, 2021 (SSHH) and April 30, 2021 (SJCBHS), over a year after the initial shelter-in-place order. A summary of the interviews is detailed below.

The Effect of COVID-19 on the SJCBHS delivery of Services to Progressive Housing Guests/Tenants

SJCBHS described three layers of services that were originally available to Progressive Housing guests/tenants (*see Figure 3*). The first layer includes the SJCBHS Housing Services team that provides treatment (i.e., therapy groups, case management, etc.) directly in the Progressive Housing homes. The second layer is the greater SJCBHS team that provides more generalized behavioral healthcare. Finally, the third layer is community resources such as Alcoholics Anonymous (AA), and organizations that provide services such as skills training and vocational support.

Figure 3: Levels of Care for Individuals in the Progressive Housing Initiative

In the initial stages of the shelter-in-place order, all services across three levels were halted. This period lasted roughly from March 2020 until June 2020. In June 2020, in-house services (i.e., layer 1) resumed through telehealth, using tablets provided by SSHH. Additionally, tenants had the option to resume their regular behavioral health services (i.e., layer 2), but most opted out due to lack of privacy in the homes. The service team struggled to keep in contact with tenants who did not have a personal cell phone. The Progressive Housing landlines are located either in the house leader's bedroom or in the common area, impeding the tenant's ability to make and receive private calls. Therefore, from June 2020 to August 2020, most tenants had only minimal contact with service providers.

In August 2020, more services returned. SJCBHS resumed going into the field once a week, the Independent Living Skills (ILS) program resumed services using telehealth on SSHH provided tablets, and multiple community services (layer 3) re-opened using telehealth. At this time, only individual services were available as leadership was still problem-solving ways to maintain confidentiality in telehealth group settings.

In October 2020, SJCBHS resumed face-to-face contact with tenants, enabling case management, individualized treatment, linkage, transportation, and broader support. Significantly, due to social distancing requirements, group treatments were still not available to tenants. Additionally, house leader meetings ended in October due to clinical staff turnover, given they had no one to facilitate the meetings. As a result, the daily house leader

reports have had an influx of complaints and suggestions to remove tenants from homes since they did not have the clinical support to aid in problem-solving and identification of what behaviors may be symptoms that need clinical intervention versus what behaviors require disciplinary action (i.e. eviction, demotion, etc.). A new clinician was hired to take over the house leader meetings as of May 2021, and so the expectation is that this issue should improve going forward.

Overall, in the past year, the Progressive Housing program has not been running as intended due to challenges posed by the COVID-19 pandemic. Therefore, guest/tenant outcomes have been impacted by both the unintended lapse in services, and the increase in stress resulting from living in a pandemic. Leaders of SJCBHS elaborated that we should expect to see a higher dropout rate, substance relapse, decompensation, staff turnover, and higher hospitalization rates in the data from the onset of the shelter-in-place order until May 2021. Additionally, there was minimal movement between the levels to minimize tenant exposure to possible infection. Additional barriers to level advancement included loss of employment with limited options for new jobs, the inability to obtain documents (i.e., birth certificate, social security card, etc.) due to lack of transportation and online access, and therefore the inability to apply for SSI. Without an income, tenants were unable to advance to Level 3. SJCBHS has changed its approach to handling rule violations during this time to be a more tiered approach since tenants have less support. When a tenant would normally be evicted, staff has been reaching out and working with tenants to acknowledge the issue and form an agreement with SSHH.

The Effect of COVID-19 on SSHH Delivery of Services to Progressive Housing Guests/Tenants

From the onset of the stay-at-home order in early March 2020 through September 2020, there was very little movement of tenants between homes to limit the possible spread of COVID-19. Operation staff were no longer permitted in homes, and houses were required to repurpose one of the bedrooms as an isolation room for any tenant who was experiencing COVID-19 symptoms, or who left the house for upwards of 24 hours. This change resulted in a significant reduction in the overall capacity of the program. In June 2020, a Level 3 house opened for Level 2 graduates, and in October of 2020, movement between the houses began to normalize. In January 2021, entry homes were implemented for tenants to isolate for 4-7 days before they join the program. Since March 2020, only one tenant has tested positive for COVID-19.

SSHH focused its efforts on keeping the homes safe, resourceful, and entertaining, to promote tenants staying inside. In November 2020, they bought tablets for tenants to resume services with SJCBHS and have access to resources. Tablets were originally delivered before services and then picked up at the end of each service, but that became laborious for staff. Now house

leaders are responsible for tablets to ensure their safe keeping. They also provided every home with a smart TV, games, and books.

Around the holiday season, tenants and house leaders were not permitted to see their families in order to maintain quarantine regulations. Instead, they were gifted food rewards (i.e., meal delivery services, etc.), and new furniture in the homes to show SSHH's appreciation and to make tenants and house leaders comfortable. Eventually, they loosened the no-visitation rules and required isolation upon return. Notably, even with these extra expenses, the budget was not drastically altered. The only factor that exceeded the budget noticeably was the utility bills.

In recent months, new tenants have been experiencing more severe mental health symptoms than in previous months. The cause is unknown, but one factor could be the pandemic contributing to mental stress and the need for housing in populations that otherwise would not have sought help. This increase in guest/tenant symptom severity has led the SSHH team to reevaluate their screening method. Ultimately, they want to promote housing first, but also need to take into consideration the individual's fit in the program and their potential impact on other tenants' recovery. At this point, SSHH has never turned away a referred guest/tenant.

There has been an increase in drug use in the houses during the pandemic. Staff have noted that they think the increased use is due to boredom from staying inside. Additionally, individuals who are in earlier stages of their recovery have been dropping out at a higher rate during the pandemic. Staff noted that individuals in active addiction have a harder time staying in the homes. Most resources that individuals would use as coping mechanisms have been shut down, making it increasingly difficult to sit at home with minimal distraction.

Overall, SSHH was able to successfully house tenants as intended, so the pandemic has not altered their ability to provide their proposed service. However, the pandemic has had an impact on the Progressive Housing Initiative's plan at large, limiting services, coping mechanisms, and adding unprecedented stress.

Based on the perspectives of both SSHH and SJCBHS leadership, the substantial upheaval to the implementation of the Progressive Housing Initiative is likely to have caused major disruptions to proposed processes and outcomes. This includes the dropout rate, the rate of engagement in services, the rate and proportion of clients that successfully transition through the stages, client recovery outcomes, and potentially client satisfaction with services. That being the case, it is important to interpret the reported findings within the context of these unprecedented experiences that guests/tenants, house leaders, and providers have had to endure. Additionally, it is reasonable to assume that the metrics used to evaluate the success of the program may improve as the pandemic subsides and the operation of the program can occur in a manner more consistent with the original proposal.

Capacity Building: Expansion of the Progressive Housing Initiative

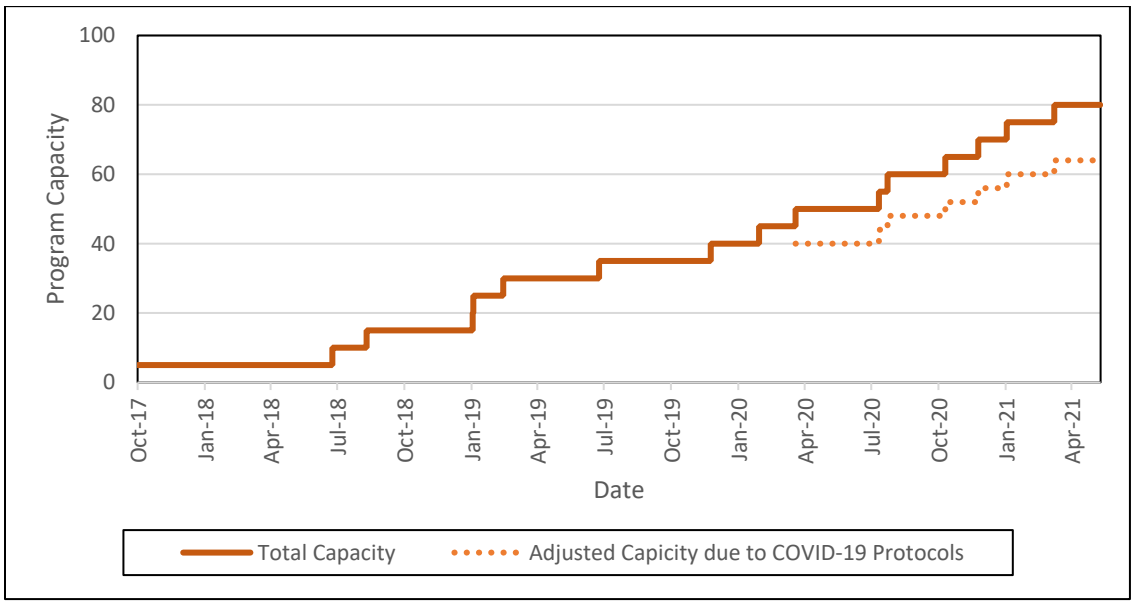
Between July 2018 and May 2021, 16 Progressive Housing homes had been leased and made available to guests/tenants. The rate of home leases and openings are presented in Table 2. The completion of 16 homes meets the original proposal of 12-18 homes being in operation at this stage of the project, as detailed in the MHSOAC proposal. More recently, the plan was to extend this to 18 homes, however a severe housing shortage in the Stockton rental market has led to substantial cost increases that could not be accommodated in the original budget. Notably, SSHH has achieved this milestone despite significant challenges in purchasing and renovating the homes due to the pandemic. To achieve this target, the rate of openings increased after January 2020, despite these challenges. From 07/18/2018 – 12/16/2019, a home opened every 86.3 days, whereas, from 2/20/2020 – 3/30/2021, a home opened every 58.8 days. In line with the expansion of the homes leased, the capacity of the program has increased substantially over time (see Figure 4). At present, the program has capacity for 80 clients, although this figure has temporarily been reduced to 64 to allow for an isolation room in accordance with COVID-19 protocols.

Table 2: Timeline of Progressive Housing Home Openings

	Date of Leasing Agreement	Occupancy Date
Home 1*	10/23/2017	10/23/2017
Home 2	07/18/2018	07/16/2018
Home 3	12/10/2018	09/01/2018
Home 4	12/11/2018	01/24/2019
Home 5	06/01/2018	01/25/2019
Home 6	01/21/2019	03/07/2019
Home 7	06/01/2019	07/16/2019
Home 8	11/01/2019	12/16/2019
Home 9	02/25/2020	02/20/2020
Home 10	01/06/2020	04/10/2020
Home 11	06/18/2020	08/02/2020
Home 12	06/30/2020	08/14/2020
Home 13	09/17/2020	11/01/2020
Home 14	11/01/2020	12/16/2020
Home 15	12/28/2020	1/24/2021
Home 16	03/02/2021	3/30/2021

*Prior SSHH residence re-designated as Progressive Home at project initiation

Figure 4: Expansion of Progressive Housing Initiative Over Time



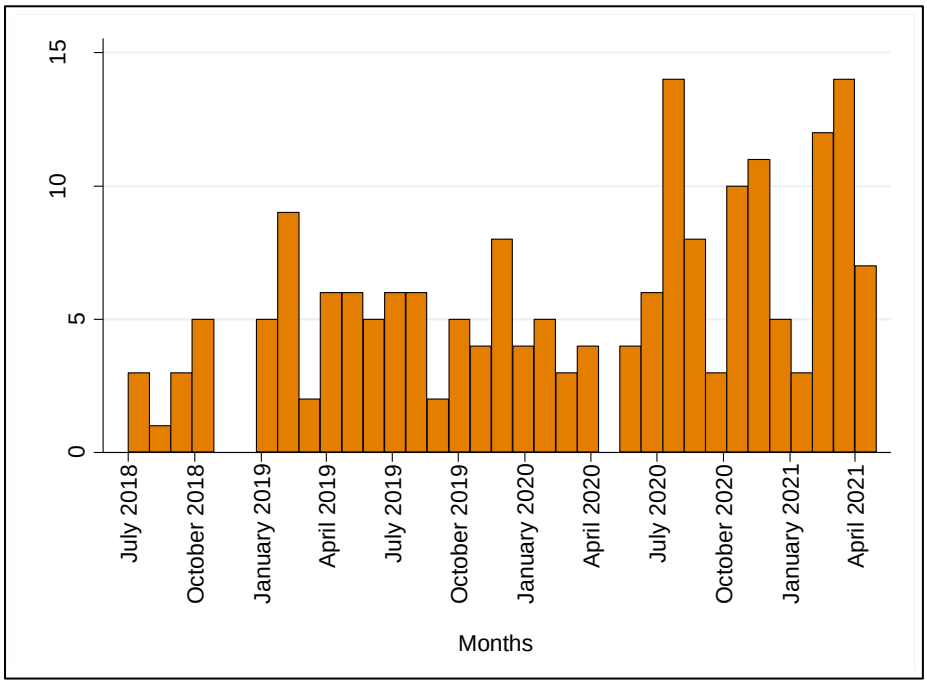
Tenant Recruitment and Rate of Entry into the program

As of May 2021, 193 clients have enrolled in the Progressive Housing program. The rate of client enrollment over time is presented in Figure 5. This significantly exceeds the original target of 90-100 clients, as detailed in the proposal. Additionally, the rate of enrollment has substantially increased over time. Between July 2018 and January 2020, 80 clients entered the program, at a rate of 4.4 clients a month. From February 2020 – May 2021, this rate increased to 7.5 clients per month. Future projections are challenging given the pandemic and other factors, but if this monthly rate is maintained, this could equate to approximately 328 clients by the end of the project period in December 2022.

The substantially higher client enrollment rate than originally projected is likely attributable to multiple factors. One relates to the fact that SSHH and the Progressive Housing Initiative has been successful at opening homes at a rate at the top end of projections, meaning more spaces have been available earlier. However, an important factor is the much higher than anticipated client turnover rate, which has been identified in previous reports, and will be explored further in the current deliverable. Possible reasons for this high turnover have been detailed both above and in previous deliverables (see Deliverables 5 and 6). These include the significant functional impairments that enrollees report, COVID-19 leading to significant reductions in the range of services available, and the challenges of living in the group home environment. Regardless, the fact that the program can fill vacant spots quickly highlights the very high need

for such services in the region. Additionally, it highlights the effectiveness of the referral pathway into the program.

Figure 5: Rate of Entry into the Progressive Housing Program over Time.



Expansion and Capacity Building Summary

The findings indicate the SSHH and the Progressive Housing Initiative have been highly successful at implementing the expansion of the program, despite the challenges experienced by the pandemic. With 16 homes opened and an additional two close to completion, the program is on track to meet the top end of the total number of homes detailed in the original MHSOAC proposal. To achieve this target, SSHH was successful at increasing the rate of home openings over time, despite the pandemic and the challenging home rental environment currently evident across Stockton. Additionally, the program has been highly successful at recruiting guests/tenants into the program, highlighting both the clear need for such a program in the area and the success of the referral pathway into the program. However, the very high recruitment rate is also indicative of the higher turnover rate, which was identified in previous reports, and based on the testimony of SSHH and SJCBHS leadership has been an increasing challenge since the pandemic. In future deliverables, guest/tenant retention will be further

explored to see if this improves once the pandemic subsides and clients have greater access to the full range of supports and services as originally conceived.

Progressive Housing Guest/Tenant Characteristics

As part of this deliverable, the guest/tenant characteristics including their sociodemographic information, prior housing status and behavioral health service utilization, sources of income, clinical presentation, educational and vocational health needs, and physical and behavioral health needs were explored. These data are important for multiple reasons. First, a significant component of the project relates to increasing access and availability of services for individuals who have historically been unserved or underserved by programs. Consequently, ensuring the population served adequately reflects the population in need is critical. Second, such data is important to document and understand the needs of the population served, which is important to support programs and providers to better meet those needs. Third, understanding guest/tenant characteristics is highly informative to identifying which outcomes may represent the most important indicators of program success. Finally, this contextual information can be critical to interpreting many of the outcomes that will be explored in this and future deliverables.

Guest/Tenant Demographics Relative to the Unsheltered Homeless Population of San Joaquin

The demographics of guests/tenants in the Progressive Housing program are presented in Table 3. In total, 35.9% of guests/tenants identified as female, 63.0% male, and non-binary and transgender participants each made up 0.5% of the sample. Regarding ethnicity, 28.7% percent of guests/tenants reported being Hispanic/Latinx. Regarding race, 26.26% of guests/tenants identified as Black or African American, 49.2% identified as White, 5.6% identified as Native Hawaiian or other Pacific Islander, 2.2% identified as Native American or Alaskan Native, and 15.1% identified as more than one race. 5.7% of guests/tenants reported having a veteran status. Notably, almost all guests/tenants had Medi-Cal or Medicare insurance coverage when they entered the program (96.9%).

The Progressive Housing demographics are consistent with figures reported for unsheltered individuals included in the San Joaquin 2019 Point in Time Count (San Joaquin Continuum of Care, 2019). In this report, 63.1% of unsheltered homeless individuals were male, 36.7% female; 5% identified as military veterans; 30.8% were Hispanic/Latinx; 69.6% were White, 26.5% Black/African American, 2.4% were Asian, 1.1% American Indian/Alaskan Native, and 1.8% Native Hawaiian/Pacific Islander. In particular, the proportion of Black/African American

individuals, Hispanic/Latinx individuals, and the proportion of military veterans were almost identical between the Point-in-Time Count and the Progressive Housing Initiative. These findings further support early reports that the program has been successful at engaging historically underserved racial and ethnic minority groups, in addition to military veterans.

It is also notable that most guests/tenants entered the program with Medi-Cal or Medicare insurance coverage, given one aim of the project was to increase Medi-Cal enrollment for those who did not have existing insurance. These findings suggest that either enrollment in Medi-Cal is much higher than anticipated amongst this population, or the program is not effectively engaging those that do not have Medi-Cal insurance. If it is the latter, additional outreach and engagement efforts may be necessary to further facilitate access to services. Regardless, with the very high proportion of guests/tenants already enrolled in Medi-Cal or Medicare at baseline, evaluating the effectiveness of the program in enrolling clients is unlikely to be appropriate, due to ceiling effects.

Table 3: Demographic Breakdown of Sample

Variable	N	%
Age (N=, mean, Std)	41.8	12.4
Gender (n = 192)		
Male	121	63.02
Female	69	35.94
Non-binary	1	0.52
Transgender	1	0.52
Race (n = 179)		
Black / African American	47	26.26
White	88	49.16
Native Hawaiian/Pacific Islander	10	5.59
Native American or Alaskan Native	4	2.23
More than one race	27	15.08
Guest/tenant refused	2	1.12
Guest/tenant doesn't know	1	0.56
Ethnicity (n = 192)		
Non-Hispanic, non-Latinx	136	70.83
Hispanic / Latinx	55	28.65
Guest/tenant refused	1	0.52
Veteran status (n = 191)		
No	180	94.24
Yes	11	5.76
Medi-Cal / Medicare Insurance Coverage (n = 192)		
No	5	2.6
Yes	186	96.88
Guest/tenant refused	1	0.52

Guest/tenant baseline housing status is presented in Table 4. Over three-quarters of the sample reported being homeless at baseline (77.1%) while 15.1% were at imminent risk of homelessness. Immediately prior to the assessment, most slept either in a place not meant for habitation (for example, a car, tent, or abandoned building), or in emergency or transitional housing (27.8% and 37.2% respectively). More than half (54.2%) had experienced homelessness for over a year and similarly, over half (52.4%) had experienced multiple episodes of homelessness.

These findings highlight the chronicity and severity of homelessness that many of the guests/tenants experienced prior to engaging with the Progressive Housing Initiative. Additionally, this indicates Progressive Housing is successfully providing services to individuals

the program was originally designed to serve, namely individuals with prolonged and repeated episodes of homelessness.

Table 4: Prior Housing Status

Variable	n	%
Housing status at entry (n = 192)		
Homeless	148	77.08
Imminent risk of homelessness	29	15.1
At-risk of homelessness	10	5.21
Stable housing	5	2.6
Where Guest/tenant Slept Last Night (n = 191)		
Place not meant for habitation	53	27.75
Emergency shelter / transitional Housing	71	37.17
Family / friend's house	24	12.57
Hotel / motel without voucher	7	3.66
Long term care program or facility	12	6.28
Jail / prison	3	1.57
SUD treatment center	10	5.24
Foster care group home	1	0.52
Guest/tenant rental with subsidy / residential project	7	3.66
Guest/tenant rental, no subsidy	3	1.57
Number of times homeless (n = 191)		
1 time	83	43.46
2 times	29	15.18
3 times	25	13.09
4 + times	46	24.08
Guest/tenant doesn't know	8	4.19
Homelessness duration (n = 192)		
≤ 12 months	80	41.67
> 12 months	104	54.17
Guest/tenant doesn’t know	8	4.17

Guest/tenant sources of income are presented in Table 5. In total, 44.0% of participants had no source of cash income through work or benefits, and only seven individuals (3.8%) reported some form of employment. Notably, amongst those that did receive some form of income, for most (74.1%) this was received exclusively in the form of social security income. Given the importance of securing some form of cash income to both progress through the Progressive

Housing levels and for client recovery, significant client support in this area is likely needed. The impact of such support as the pandemic subsides will be evaluated in future deliverables.

Table 5: Guest/Tenant Sources of Income at baseline

Variable		N	%
Cash income (n = 191)			
	No	84	43.98
	Yes	106	55.5
	Guest/tenant refused	1	0.52
Sources of Income (n = 184)			
	Supplemental Security Income (SSI) / Social Security Disability Insurance (SSDI) / Social Security (SSA)	80	43.47
	Temporary Assistance for Needy Families (TANF) / CalWorks / General Assistance Program (GA)	7	3.80
	Unemployment Insurance	5	2.72
	Pension	1	0.54
	Employment	7	3.8
	Other	1	0.54
	More than one	7	3.8
	N/A	76	41.3
Non-cash benefits (n = 191)			
	No	71	37.17
	Yes	119	62.3
	Guest/tenant refused	1	0.52

Clinical Presentation of the Sample

The clinical presentation of the Progressive Housing Initiative's guests/tenants is presented in Table 6. Almost three-quarters of guests/tenants met the criteria for a substance use disorder at baseline (73.4%), and 95% reported using drugs or alcohol at the point of entry into the program. The most frequently used drug was amphetamine/methamphetamine, with 44.2% of guests/tenants reporting using the drug either alone or in combination with other substances, such as alcohol, cannabis, and/or heroin.

The most frequent primary mental health diagnoses were psychotic disorders (54.2%) and affective disorders (29.6%). In three cases no diagnosis was confirmed, either because they left the program before a final determination was made, or the final diagnosis was still in the process of being confirmed at the baseline stage.

Consistent with the 2020 report, the clinical presentation of the sample confirms that the program is providing services to the target population, namely individuals with SMI and substance use disorders that would lead to significant barriers to housing in other models.

Table 6: Clinical Presentation of the Sample

Variable	N	%
Substance use (n = 161)		
Amphetamine/methamphetamine	60	37.27
Alcohol	33	20.50
Cannabis	39	24.22
Heroin	3	1.86
Cocaine / crack cocaine	3	1.86
Ecstasy	1	0.62
Benzodiazepine	1	0.62
Methamphetamine and alcohol	5	3.11
Methamphetamine, cannabis, and alcohol	4	2.48
Heroin and methamphetamines	2	1.24
Cannabis and Alcohol	2	1.24
None reported	8	4.97
Diagnosed with Substance Use Disorder (SUD) (n = 188)		
No	50	26.6
Yes	138	73.4
Primary Diagnosis (n = 179)		
Psychotic disorder	97	54.19
Affective disorder	53	29.61
Anxiety disorder	23	12.85
Personality disorder	1	0.56
Conduct disorder	1	0.56
Substance use disorder	1	0.56
No Diagnosis	3	1.68

Guest/tenant Educational, Vocational, and Health Needs

The educational and vocational needs of guests/tenants at baseline are presented in Table 7. Almost all of the sample (94.79%) reported being unemployed at baseline, and of those, most were not actively seeking job opportunities (91.71%).

Education may represent a significant barrier to employment. Over one-third (34.1%) reported not having a high school diploma or GED equivalent. Only 10.1% reported completing some form of a post-secondary school course. Additionally, only four guests/tenants reported being in some form of education or training at baseline.

Almost all guests/tenants reported being unemployed and not in education at the point of entry into the program, and over one-third did not have a high school diploma or GED equivalent. This highlights the clear need for vocational and educational support amongst clients who enter the Progressive Housing program. However, providing support in this area has been challenging during the pandemic, given local supported employment and education program were halted, and few organizations were seeking employees. The clear need in this area highlights the importance of engaging guests/tenants back into vocational and educational support programs once programs are re-opened.

Table 7: Educational and Vocational health needs

Variable	N	%
Highest Educational Level Completed (n = 179)		
≤ 8th grade	8	4.47
9-12th grade, no diploma	53	29.61
High school diploma	81	45.25
GED	16	8.94
Post-secondary school	18	10.06
Guest/tenant refused/Didn't know	3	1.68
Enrolled in School (n = 192)		
No	187	97.4
Yes	4	2.08
Guest/tenant refused	1	0.52
Employed (n = 192)		
No	182	94.79
Yes	9	4.69
Guest/tenant refused	1	0.52
If employed, type of employment (n = 9)		
Temporary	1	11.11
Permanent	7	77.78
Guest/tenant doesn't know	1	11.11
If not employed, seeking employment? (n = 181)		
No	166	91.71
Yes	15	8.29
Vocational or apprenticeship program (n = 191)		
No	188	98.43
Yes	1	0.52
Guest/tenant refused	1	0.52
N/A	1	0.52

The developmental and physical health needs of guests/tenants at baseline are presented in Table 8. There is a high prevalence of physical disability (31.41%) and chronic health conditions (43.46%) amongst this population, however, most are receiving at least some form of services for these health concerns (80.0% and 80.72% respectively).

A lower proportion of guests/tenants (27.08%) were diagnosed with a developmental disability. However, relative to other conditions, a lower proportion of those diagnosed with a developmental disability were receiving services at baseline (65.38%).

Overall, this data indicates relatively high developmental and physical health needs for this population. While most guests/tenants are receiving services for these conditions, some are not, particularly those with developmental disabilities. Consequently, the Progressive Housing Initiative team needs to connect guests/tenants with services in cases where support is required but they are not yet receiving services.

Table 8: Developmental and Physical Health Needs

Variable	N	%
Physical disability (n = 191)		
No	130	68.06
Yes	60	31.41
Guest/tenant refused	1	0.52
Receiving services for physical disability (n = 60)		
No	12	20
Yes	48	80
Chronic health condition (n = 191)		
No	106	55.5
Yes	83	43.46
Guest/tenant refused	1	0.52
Guest/tenant doesn't know	1	0.52
Receiving services for chronic health condition (n = 83)		
No	16	19.28
Yes	67	80.72
Developmental disability (n = 192)		
No	134	69.79
Yes	52	27.08
Guest/tenant refused	3	1.56
Guest/tenant doesn't know	3	1.56
Receiving services for developmental disability (n = 52)		
No	17	32.69
Yes	34	65.38
Guest/tenant doesn't know	1	1.92

Guests'/tenants' utilization of SJCBHS services at baseline is presented in Table 9. Almost all guests/tenants had received some form of services from SJCBHS in the past (91.85%). Due to limitations in the data, it is not clear what proportion of these guests/tenants were actively engaged in behavioral health services immediately prior to receiving Progressive Housing services, and who may have previously received care but have long since disengaged. Additionally, the number and proportion of homeless individuals who had never received SJCBHS is also unknown, meaning it is unclear how effective the program is at engaging such individuals. Regardless, these findings do indicate that the program is not engaging many clients who have never previously received SJCBHS services.

Importantly, at the point of assessment very few guests/tenants were actively receiving treatment for substance use disorders either from SJCBHS (4.65%), or other community organizations or groups such as AA or NA (6.82%). This indicates that while the program may

not be effective at engaging clients who have never received SJCBHS services, the program has been highly effective at engaging individuals not actively involved in SUD treatment. These findings indicate that the Progressive Housing Initiative may represent one important pathway to facilitating access to SUD care for homeless individuals residing in San Joaquin County.

Table 9: San Joaquin County Behavioral Health Service Utilization at Baseline

Variable		N	%
Have ever received SJCBHS services (n = 184)			
	No	15	8.15
	Yes	169	91.85
Engaged in SUD care at baseline (n = 43)			
	No	41	95.35
	Yes	2	4.65
Engaged in SUD maintenance support at baseline (i.e., AA, NA meetings) (n = 44)			
	No	41	93.18
	Yes	3	6.82

Progressive Housing Guest/Tenant Characteristics Summary

Overall, the guests/tenants who have received Progressive Housing services to date appear to be highly representative of the San Joaquin County homeless population, as recorded in the 2019 Point-in-Time Survey. The findings indicate the program has been successful at engaging guests/tenants across different genders, races, and ethnic groups. Additionally, the program appears to be successfully engaging military veterans, which is important given the commitment by SSHH to support those who had previously served in the military.

These data provide a comprehensive summary of guest/tenant needs as they enter the program. For example, almost all guests/tenants reported either not being in education or employment, highlighting this as a key area for outcome evaluation and emphasizing the importance of vocational support services that were originally embedded within the program. Additionally, many clients reported experiencing a range of chronic physical and developmental health needs. Encouragingly, the majority reported already experiencing support in these areas, although some did not, particularly with regards to developmental disabilities. Guests/tenants also reported significant mental health and substance use disorder needs, highlighting the success in engaging the target population, and the broad and complex array of needs that those served present upon entry into the program.

Notably, during the baseline assessment, almost all clients reported that they already had either Medi-Cal or Medicare insurance. While this is encouraging, if enrollment rates at baseline above 90% persist, then evaluating how effective Progressive Housing is at facilitating health insurance enrollment as originally proposed would not be considered appropriate due to ceiling effects. Medicare and Medi-Cal enrollment rates will be continued to be explored in future deliverables.

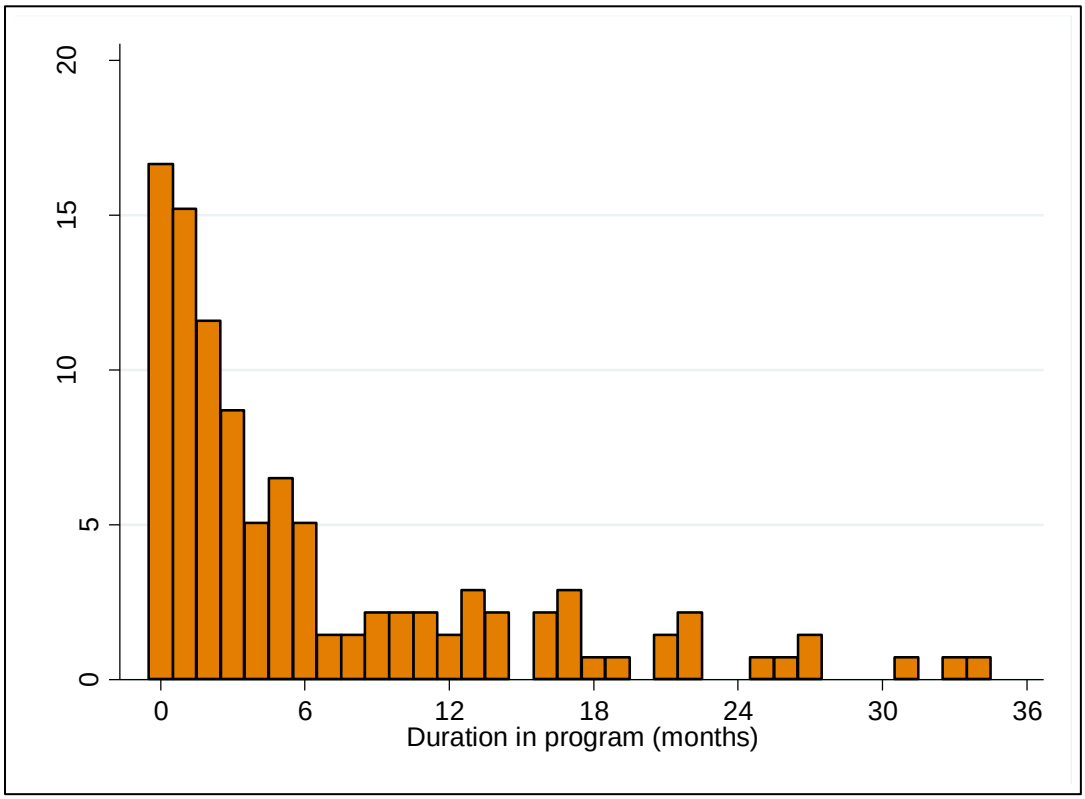
Progressive Housing Stage Program Retention and Transitions

Program Retention

In total, 193 unique guests/tenants have received Progressive Housing services. As of May 2021, 48 guests/tenants currently reside in a Progressive Housing home, representing 24.8% of the total enrolled. Of these, 33.3% of guests/tenants have been in the program one month or less, while seven guests/tenants have received housing for at least 18 months. In total, 24 guests/tenants currently reside in a Level 1 home, 19 guests/tenants in a Level 2 home, and 5 guests/tenants in a Level 3 or higher home.

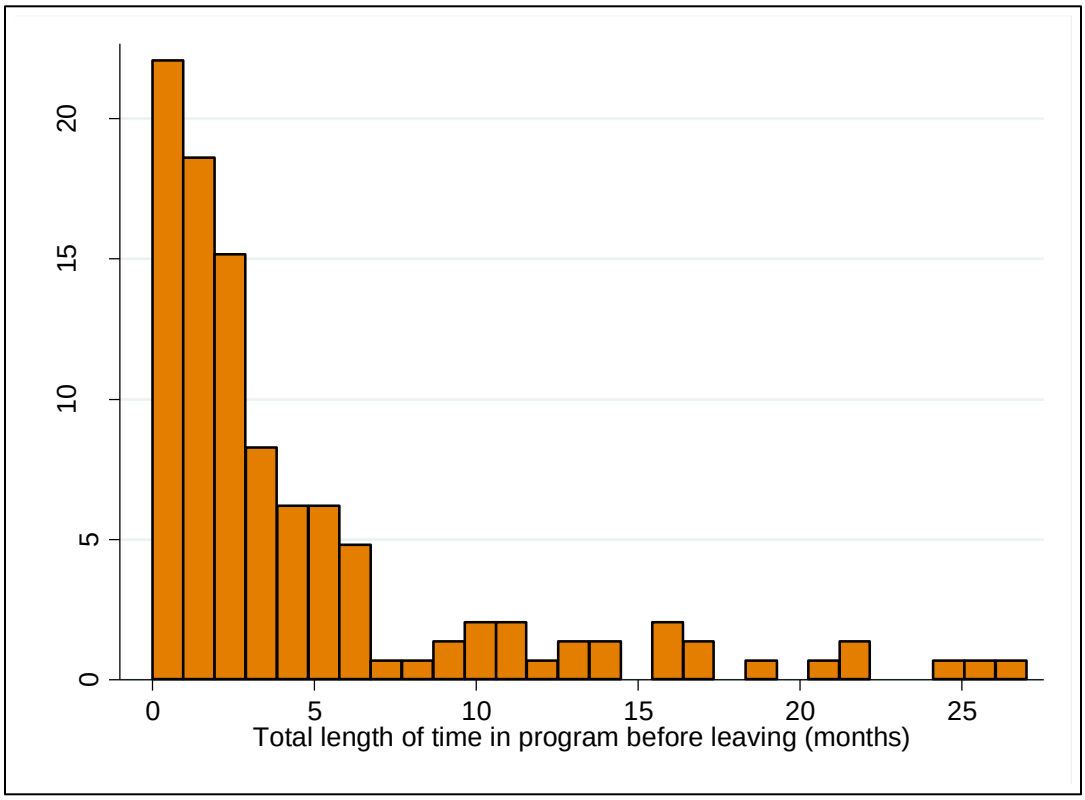
Of the 138 guests/tenants housed between July 2018 and November 2020, the median total duration of time spent in Progressive Housing is 3 months (Interquartile Range (IQR) 1 – 10). Overall, this figure is slightly lower than the time reported in the Year 2 report (median = 5 months, IQR 2 – 11), which, given the additional challenges detailed in the SSHH and SJCBHS manager interviews, is to be expected. The distribution of the guest/tenant length of stay amongst this sample is presented in Figure 6. In future deliverables, the duration of time spent in the program will be explored again to see if this metric increases as services started to become more available as the pandemic subsides.

Figure 6: Duration Guests/Tenants have Remained in the Progressive Housing Project who Enrolled Between July 2018 – November 2020



Among the 145 guests/tenants that have dropped out of the program, the median duration of the time spent in the program is 2 months (IQR 1 – 5). The distribution of tenant length of stay amongst guests/tenants that leave is presented in Figure 7. Consistent with the findings from the Year 2 report, the data indicates that when clients leave prematurely, they are more likely to do so in the first three months of entry into the program (55.9% of the sample).

Figure 7: Duration Guests/Tenants Remained in the Progressive Housing Program Before Leaving the Service



Of the 146 guests/tenants that have elected to leave the program since July 2018, 9 have returned. While there is insufficient data to draw strong conclusions, the data suggests that returning guests/tenants may stay in the program longer on their return, relative to their first admission. In the first round, guests/tenants stayed a mean length of 1.8 months (Std Dev=1.6), while during their second stay the mean length of stay was 3.2 months (std dev= 3.03) with three still in the program, two of which have been in the program 7 and 8 months, respectively.

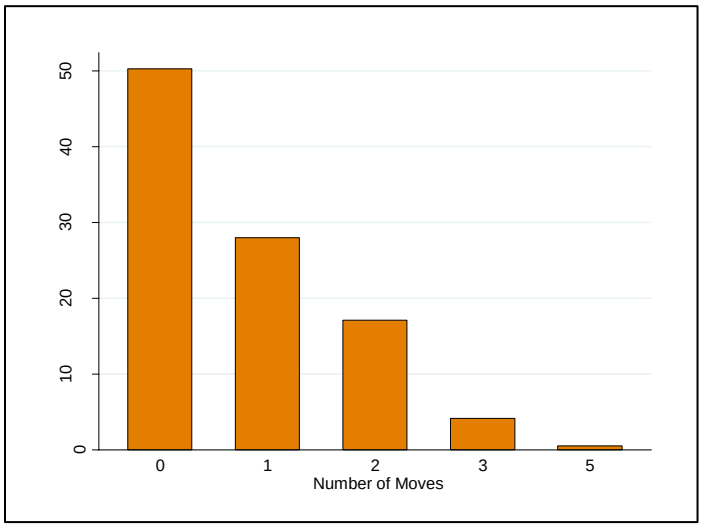
Transitions between Houses

From July 2018 – May 2021, 93 guests/tenants (48.2%) moved a total of 139 times between Progressive Housing homes. As expected, given the expansion of the program, the total number and the proportion of clients that have moved is higher than the figures reported in the 2020 report. However, the volume of movement between the homes is still relatively low. The total number of moves experienced by guests/tenants is presented in Figure 8. In total, 81.4% of

guests/tenants experienced either one or no moves, 14.5% experienced two moves, 3.6% experienced three moves, and one guest/tenant (0.5%) has moved a total of five times.

Of the 139 moves, 49 (35.3%) were lateral moves, where the guest/tenant moved from one house to another at the same level; 76 (54.7%) moved to a higher-level home; and 14 (10.1%) moved to a lower-level Progressive Housing home. Relative to the Year 2 report, moves to a lower level were still relatively infrequent, while lateral moves significantly increased. Part of this increase in lateral moves may be attributable due to COVID-19 protocols, where a series of re-organizations were necessary to accommodate the quarantine rooms required in each Progressive Housing home. Consistent with the findings in the Year 2 report, the relatively small proportion of clients that move to a lower level suggest that the program is not promoting most guests/tenants before they are ready to do so.

Figure 8: Number of Moves between Homes Made by Guests/Tenants involve in the Progressive Housing Program



Guest/Tenant Graduation between Levels

Of the 179 guests/tenants that have entered the Progressive Housing system at a Level 1 home, 95 (53.1%) left the program before graduating to a Level 2 home, 64 (35.8%) graduated to a higher-level home, and 20 (11.2%) are still in a Level 1 home.

In total, 68 guests/tenants have resided in a Level 2 home. Of those, the first time that they reached that level, 12 (17.7%) moved to a Level 1 home, 7 (10.3%) graduated to a Level 3 home, 32 (47.1%) left the program at Level 2, and 12 (17.7%) remain in a Level 2 home.

Of the 14 guests/tenants that have resided in a Level 3 home, three (21.4%) have left the program at this level, four (28.6%) moved to a lower level, five (35.7%) are still in a Level 3 home, and two (14.3%) have graduated to a Level 4 home.

Progressive Housing Stage Transitions and Program Retention Summary

Consistent with the Year 2 report, the high dropout rate from the program remains notable. Of the 193 individuals who originally joined the program, 75.2% have since left. This figure is higher than the 64% dropout rate reported in the Year 2 report. At least part of this increase may be attributable to the substantial impact of COVID-19 on program delivery and shelter-in-place protocols. Given most of the dropout (55.9%) appears to occur within the first three months of program engagement, additional support during this period may be critical to improving program retention.

Otherwise, client/tenant transition between the Progressive Housing levels appears to remain on track. While an increase in lateral moves was evident during the past 12 months, likely due to COVID-19 related re-organization, most moves (54.7%) were to a higher-level home. This indicates that guests/tenants are progressing through the Progressive Housing system of care as proposed. Notably, no one has graduated from level 4 to date. Analysis of graduation rates will be explored in future deliverables.

Progressive Housing Outcomes

Impact of Progressive Housing on Functional Outcomes

The number and proportion of clients that experienced moderate or severe functional impairment across selected domains over time is presented in Table 10. To date, 133 guests/tenants completed a baseline assessment, 13 completed an assessment at the 6-month follow-up, and seven clients completed a 12-month follow-up assessment. Given the current paucity of follow-up data, firm conclusions concerning how functional outcomes may change over time during care cannot be drawn. However, we expect to have more follow-up data available for future deliverables, which may permit a more comprehensive review of functional improvements over time.

At the baseline stage, a significant proportion of the sample reported at least moderate impairments in their residential stability and housing situation (79.7% and 75.2%, respectively). This again supports the conclusion that the program is currently providing services to the targeted population.

Regarding other areas of impairment, 40.9% of guests/tenants reported at least moderate impairments due to substance use, 30.8% in social functioning, 11.6% in self-care, 22% reported moderate impairments in sleep, 24.1% required significant support to manage appointments, 11.3% reported significant physical or medical issues, and 3.7% reported impairments related to criminal justice involvement. Overall, these findings point to the range of complex needs and impairments that Progressive Housing guests/tenants experience.

Table 10: Proportion of tenants that experience at least moderate levels of impairment across selected domains over time

ANSA Item	Baseline (n=133)		6-month follow up (n=13)		12-month follow up (n=7)	
	N	%	N	%	N	%
Residential Stability	106	79.7	6	46.2	2	28.6
Living Situation	100	75.2	5	38.5	2	28.6
Substance Use*	54	40.9	1	7.7	2	28.6
Social Functioning	41	30.8	7	53.9	3	42.9
Self-Care	22	11.6	1	7.7	3	42.9
Sleep*	29	22.0	3	23.1	3	42.9
Transport Support	32	24.1	2	15.4	3	42.9
Physical Medical	15	11.3	7	53.9	3	42.9
Criminal Justice Involvement**	5	3.7	0	0	0	0

*n=132 at baseline; **=n=136 at baseline

Of the 7 clients that completed a 12-month ANSA assessment, 6 also completed a baseline assessment. The data for these six clients are presented in Table 11. Overall, there appears to be minimal variation across the two time points in most domains. The one exception is social functioning, where no clients reported having at least moderate levels of impairment in social functioning at the baseline stage, while three guests/tenants (50%) reported at least moderate impairment at the 12-month follow-up. A possible reason for the increase in social functioning deficits could be due to guests'/tenants' requirement to be in more social situations, given the group housing model, making challenges more evident. However, due to limited follow-up data it is unclear if this finding is meaningful. Regardless, this will be explored in future deliverables when more data is available.

Table 11: Reported Impairments amongst Clients with Baseline and 12-month Follow-up Data.

ANSA Item	Baseline (n=6)		6-month follow up (n=6)	
	N	%	N	%
Residential Stability	3	50.0%	2	33.3%
Living Situation	3	50.0%	2	33.3%
Substance Use*	1	20.0%	2	33.3%
Social Functioning	0	0.0%	3	50.0%
Self-Care	3	50.0%	3	50.0%
Sleep	2	33.3%	3	50.0%
Transport Support	2	33.3%	3	50.0%
Physical Medical	0	0.0%	1	25.0%
Criminal Behavior	0	0.0%	0	0

*n=5 at baseline.

Guest/Tenant Return to Employment or Education

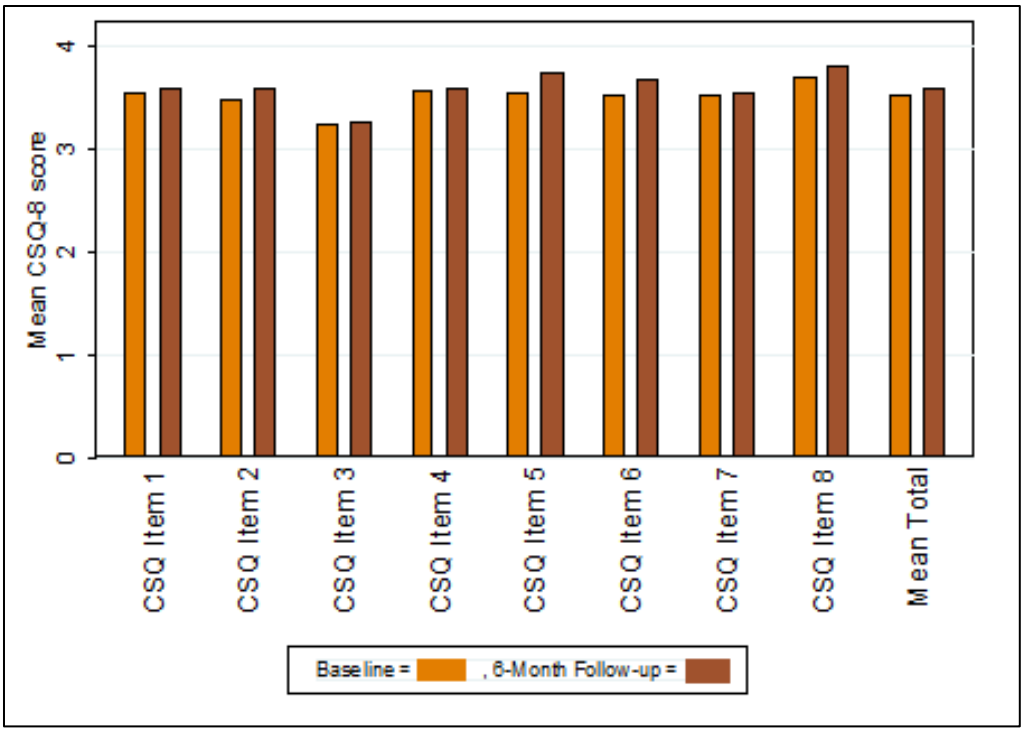
In addition to assessing functional impairment, the rate at which guests/tenants returned to school or work over time was also explored. Amongst 16 guests/tenants surveyed at the 6-month follow-up stage, 15 guests/tenants were still not enrolled in school, and one guest/tenant was continuing their education which they started prior to engaging in Progressive Housing services. At the 12-month follow-up stage, all five guests/tenants surveyed did not enroll in higher education. Regarding employment, all 16 guests/tenants surveyed at the six-month stage, and all five at the 12-month stage, reported not being actively employed. Overall, these preliminary findings suggest that Progressive Housing has not facilitated engagement in work or continuing education. However, this proposed component of the Progressive Housing Initiative was substantially impacted by the pandemic, limiting job opportunities, the ability to attend educational courses/colleges, and halting vocational courses designed to support guests/tenants in this endeavor. Consequently, the lack of impact in this domain is to be expected. In future deliverables, this will be explored further as more data becomes available, and the pandemic subsides, enabling more opportunities for education and employment and greater services to facilitate such engagement.

Guest/Tenant Satisfaction

The CSQ-8 was administered at the baseline stage and at six month follow-ups to gauge guests/tenants' satisfaction with the Progressive Housing Initiative. Findings from both time points are presented in Figure 9. At baseline (n = 47), Guest/tenant overall satisfaction of the

Progressive Housing Initiative was found to be extremely high (M = 3.51, SD = 0.50). Additionally, clients reported high levels of satisfaction on every item. At six months, while data was only available for a small subsample of the population (n=15), this very high level of satisfaction was maintained. Overall, this appears to indicate that clients receiving services are very positive about Progressive Housing services. It is important to note, however, that this data only includes guests/tenants that are currently in the program. Satisfaction cannot be determined for individuals who have left the program, which limited our ability to ascertain how satisfied guests/tenants of the program are as a whole.

Figure 9: Guests/tenants Satisfaction with Progressive Housing Services at Baseline and Six Months Follow up.



Program Outcomes Summary

Overall, clients are reporting substantial impairments in functioning across a key range of outcomes, and almost all are unemployed and not in education at program entry. At present, it is unclear if the significant disruption in services due to COVID-19 has had a detrimental impact on outcomes. Additionally, there is relatively little follow-up data available, meaning no firm conclusions regarding the longitudinal course of these key outcomes can be drawn. However, in the available data, minimal changes were evident. In future deliverables, how functional

impairments and vocational outcomes change over time will explored as more follow-up data becomes available and the impact of COVID-19 subsides. In such a scenario, comparisons between times when services were and were not impacted by COVID-19 may allow for modeling to determine what the impact of these disruptions may be.

Regarding client satisfaction, the available data indicates that Progressive Housing guests/tenants are highly positive about the services they receive, both at the point of program entry and six months into the program. This finding is particularly positive given the backdrop of COVID-19 where clients have experienced a significant reduction in services available to guests/tenants, and stricter controls around reduced visitation and isolation protocols.

Discussion

Over the past 24 months, SSHH, in collaboration with SJCBHS, have met several of the primary goals and objectives around the implementation of the Progressive Housing Project. First, by leasing 16 properties the program has successfully met its target as detailed in the original MHSOAC proposal. Significantly, this is despite the substantial challenges brought on by the COVID-19 pandemic and a challenging rental market in Stockton. Additionally, the program has successfully recruited a substantially higher number of clients than originally proposed.

Consistent with earlier reports, the Progressive Housing Initiative appears to be highly successful at engaging and providing services to Black/African American and Hispanic/Latinx individuals who are historically underserved in community behavioral health settings (California Pan-Ethnic Health Network, 2015). The racial and ethnic breakdown of the current Progressive Housing sample is broadly consistent with the demographic distribution of the unsheltered homeless detailed in the 2019 Point in Time survey of the unsheltered homeless (San Joaquin Continuum of Care, 2019). Additionally, the Progressive Housing Initiative has also been successful at recruiting a representative sample of homeless military veterans into the program, which is important given SSHH's commitment to end local homelessness among veterans (https://www.stocktonselfhelp.org/what-we-do).

Consistent with the qualitative data collected prior to COVID-19 (see Deliverable 5), the data indicates that guests/tenants engaged in the Progressive Housing Initiative are highly satisfied with the services they receive. These high levels of satisfaction are evident both at entry into the program and after six months of receiving services. Encouragingly, there was no evidence of a reduction of satisfaction with the program with the onset of COVID-19, despite it causing a substantial reduction in available services and restrictions around home visitations. While the reasons for satisfaction remaining so high was not explored quantitatively, one factor for this may be the increase in social events hosted by SSHH and efforts to further renovate the homes

to offset the challenges experienced as detailed in the interviews. However, it is important to note that satisfaction was only measured for clients currently enrolled in the program. It may be that dissatisfied clients dropped out of the program.

Consistent with the Year 2 report, the baseline guest-/tenant-level data indicates that the program is continuing to be successful at engaging individuals from the target population. This includes individuals with SMI who have experienced multiple episodes of chronic homelessness. Additionally, all clients reported some combination of active substance use disorders and multiple areas of significant need to maintain functioning. Almost all the guests/tenants included individuals who had already been seen by SJCBHS previously, so it is unclear how successful the program has been at engaging "unserved individuals" (i.e., those who have not received any form of behavioral healthcare). However, almost no guests/tenants were actively engaged in any form of substance use counseling at the point of program engagement, indicating that the Progressive Housing Initiative could represent an important pathway to engaging guests/tenants in appropriate care.

Regarding challenges to the implementation of the program, it is important to highlight the very high dropout rate from the Progressive Housing Initiative, particularly when compared to other Housing First models. In this program, 76% of the 193 guests/tenants who have engaged in the service have since left. This is higher than the dropout reported in the Year 2 report (64%) and much higher than other Housing First programs that have reported dropout as low as 16% at a similar stage of the implementation process (i.e., Stefancic & Tsemberis, 2007). The already high dropout is likely to have been exacerbated by the additional challenges caused by COVID-19. In future deliverables, the dropout rate will be explored further to see if it declines if the impact of COVID subsides.

Conclusion

The findings indicate that the Progressive Housing Initiative is delivering low-barrier housing for San Joaquin County residents with complex needs in a manner broadly consistent with Housing First principles. SSHH has successfully opened 16 homes, meaning they have met the timeline originally outlined in the MHSOAC proposal. Additionally, clients who are receiving services report being highly satisfied with the care that they receive, despite the additional restrictions and reductions in services available due to COVID-19. Consistent with the findings from the Year 2 report, the program has been highly successful at engaging a representative sample of the San Joaquin homeless population, including a representative proportion number of females, Black and African Americans, Hispanic/Latinx's, and military veterans. Finally, the program is successfully engaging clients who report experiencing complex behavioral health

needs, significant functional impairment, and have experienced chronic homelessness that the program was designed to serve.

Due to the lack of follow-up data, a comprehensive review of changes in functional or vocational outcomes could not be conducted. Consequently, this will be the focus of future deliverables, as more data becomes available. Additionally, further work will be conducted to examine the higher than anticipated dropout rate, and factors that may lead to guests/tenants electing to leave Progressive Housing. Going forward, program dropout will be explored in more detail as COVID-19 subsides and a greater range of services become available again to Progressive Housing guests/tenants.

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Appendix I: SJCBHS Baseline Data Collection Tool

Progressive Housing Program Data Collection Tool (6/25/20)

INTERVIEWER: Statements/questions in bold text below are questions and/or verbal prompts that should be used as close to verbatim as reasonably possible. *Unless otherwise noted, all questions pertain to the individual's status at the time of interview.*

1) Unique Identifier (Number provided only upon placement at SSHH house): _____

2) Housing Start Date (Date individual is actually placed at a SSHH house): _____

3) **What is your full name?**: _____

4) BHS Medical Record # (if applicable): _____

5) Case Manager (if applicable): _____

6) **What is your age?**: _____

7) **Are you currently participating in any type of educational or vocational support program to help you with school or get a job**?

   YES __ NO ___

   If "YES": Month and year (best estimate is okay) participation in education or vocational support program began:

   _____/00/_____

8) **Are you currently participating in any type of substance use disorder (SUD) treatment?**

   YES ___ NO ___

   If "YES", Month and year (best estimate is okay) SUD treatment participation began:

   _____/00/_____

9) **Do you currently have or have you ever been given a substance use disorder diagnosis?**

YES ___ NO ___

If "YES", **If you can recall, what was your most recent substance use disorder diagnosis was?** Enter stated primary diagnosis below:

_____

If "NO" or the individual cannot recall, verify in CG. If history is present, take the primary substance use disorder SUD diagnosis from the following sources, in the order listed:

a. Most recent CG psychiatrist note
b. Most recent Adult Assessment
c. Most recent Crisis Screening

If "NO" or the individual does not know or is unable to recall, but a substance use disorder diagnosis is suspected and there is no information from one of the sources above, enter "F19.00, Unspecified Other (or Unknown) Substance-Related Disorder"

10) If individual has a history of or is currently using substances, **"What's your drug or substance of choice?"** Alternate question if individual has a difficult time answering: "**If all the substances you've ever used were on a table in front of you, and you could only choose one, which one would you choose?"** _____

11) **Are you currently or have you ever participated in outpatient mental health services before?** Participation is defined as opened to BHS Outpatient Case Management services and having attended at least one psychiatric appointment. If services were provided in SJC, verify in CG before completing. If outside of County, rely on individual's self-report:

YES ___ NO ___

If "YES": Month and year of opening to BHS Outpatient Case Management services. If services were provided in SJC, verify in CG before completing. If outside of County, best estimate is okay:

_____**/00/**_____

12) **Do you currently have a BHS Case Manager**? Verify in CG, if needed.

YES ___ NO ___

If "YES", **Do you know which program?** _____(Staff member: if individual is unsure, verify in CG, and/or consult with a Supervisor or Manager. Please note that not all programs qualify as BHS Case Management services.)

13) **Do you currently have, or have you ever been given a mental health diagnosis?**
YES ___ NO ___

If "YES": **If you can recall, what your most recent mental health diagnosis was?** Enter stated diagnosis/diagnoses below:

_____

If "NO" or the individual cannot recall, verify in CG. If history is present, take the primary mental health diagnosis from the following sources, in the order listed:

a. Most recent CG psychiatrist note
b. Most recent Adult Assessment
c. Most recent Crisis Screening

If "NO" or the individual does not know or is unable to recall, but a mental health diagnosis is suspected and there is no information from one of the sources above, or if services were in another County, enter: "R69, Diagnosis Deferred"

14) **Do you currently have Medi-Cal benefits?** YES __ NO ___

If "YES", **Do you have your Medi-Cal card with you, or can you remember what year you first received Medi-Cal benefits?** If the individual can remember the year, but not the month, help them narrow it down by asking if they recall what season it was (i.e. winter, spring, summer, fall). The best estimate is better than nothing.

Month and year (best estimate is okay) Medi-Cal Benefits began:
_____/00/_____

15) **Do you currently have reasonably easy access to these documents? If you don't, this will <u>not</u> affect your ability to participate in the Progressive Housing program:**

a. IDENTITY: **A birth certificate, paycheck, driver license, U.S. passport, U.S. military ID, school records, State ID, or Indian Native Tribal documents?**
YES _ NO___

b. SOCIAL SECURITY NUMBER: **A social security card, Medicare card, or Award Letter? YES _ NO___**

c. IMMIGRATION STATUS: **If applicable, Immigration and Naturalization Service documents to verify your immigration status?**

YES _ NO___

d. RESIDENCE: **A California driver's license or Identification Card, utility bill, rent receipt, mortgage receipt, check stub, any official document showing a California address to provide your state residency?**

YES ___ NO____

e. INCOME: **Recent pay stubs, a signed statement from an employer, a copy of tax returns, or bank statements?**
YES _ NO___

f. UNEARNED INCOME: **A recent Cost-Of-Living Increase Notice or Award Letter from Social Security, a current bank statement and copy of a current Social Security check, or a statement signed by a person who has provided you with unearned income? YES _ NO___**

g. RESOURCES: **If you have assets such as a checking or savings account, life insurance policy, trust, or other property, do you have documents that prove their value?**
N/A __ YES ___ NO ___

POINT OF FIRST CONTACT CANSA ITEMS

Unless otherwise noted, base your ratings on the 30 days prior to interview. For each item, circle the number of one response item that best captures the individual's status and/or history, as appropriate.

"The following section involves answering some questions that give us an idea of what areas of life you might be struggling in, and how, should you participate in it, the Progressive Housing Program might best support you."

1) CRIMINAL/DELINQUENT BEHAVIOR

Within the last 30 days, even if you weren't caught or arrested, have you engaged in any behavior that could have resulted in police involvement or arrest? Have you ever been arrested?

0 No evidence of any needs. No evidence or no history of criminal/delinquent behavior.

1 Requires monitoring, watchful waiting, or preventive action. This may have been a risk behavior in the past. History or suspicion of criminal/delinquent behavior, but none in the recent past. Status offenses would generally be rated here.

2 Action or intervention is required to ensure the identified need is addressed. Currently engaged in criminal/delinquent behavior (e.g., vandalism, shoplifting, etc.) that puts individual at risk.

3 Intensive and/or immediate action is required to address the need or risk behavior. Serious recent acts of delinquent activity that place others at risk of significant loss or injury, or place individual at risk of adult sanctions. Examples include car theft, residential burglary, and gang involvement.

2) SUBSTANCE USE

Have you or anyone else ever had concerns about your own alcohol or substance use? Have you ever been arrested or hospitalized due to anything related to your alcohol or substance use? Have you ever participated in a recovery program for drugs or alcohol?

0 No current need; no need for action or intervention. Individual has no notable substance use difficulties at the present time.

1 Identified need requires monitoring, watchful waiting, or preventive activities. Individual has substance use problems that occasionally interfere with daily life (e.g., intoxication, loss of money, reduced work/school performance, parental concern). History of substance use problems without evidence of current problems related to use is rated here.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with individual's functioning. Individual has a substance use problem that consistently interferes with the ability to function optimally, but does not completely preclude functioning in an unstructured setting.

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Individual has a substance use problem that represents complications to functional issues that may result in danger to self, public safety issues, or the need for detoxification of the individual.

3) RESIDENTIAL STABILITY

What is your current living situation? How many times have you moved in the last year?

0 No current need; no need for action or intervention. Individual has stable housing for the foreseeable future.

1 Identified need requires monitoring, watchful waiting, or preventive activities. Individual has relatively stable housing, but has either involuntarily moved in the past three months or there are indications housing problems could arise at some point within the next three months.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with individual's functioning. Individual has moved multiple times in the past year. Housing is unstable.

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Individual has experienced periods of homelessness in the past six months.

4) SOCIAL FUNCTIONING (INTERVIEWER: Do you feel that the individual can act appropriately in social settings?)

Would you say that you get along with others easily, or do you find yourself frequently having disagreements, or getting into arguments with others?

0 No current need; no need for action or intervention. No evidence of problems and/or individual has developmentally appropriate social functioning.

1 Identified need requires monitoring, watchful waiting, or preventive activities. There is a history or suspicion of problems in social relationships. Individual is having some difficulty interacting with others and building and/or maintaining relationships.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with functioning. Individual is having some problems with social relationships that interfere with functioning in other life domains.

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Individual is experiencing significant disruptions in social relationships. Individual may have no friends, have constant conflict in relations with others, or have maladaptive relationships with others. The quality of the individual's social relationships presents imminent danger to the individual's safety, health, and/or development.

5) SLEEP

About how many hours do you sleep each night? Do you have trouble falling asleep, staying asleep, or waking up early? Do you often find yourself sleepy during the day?

0 No current need; no need for action or intervention. Individual gets a full night's sleep each night.

1 Identified need requires monitoring, watchful waiting, or preventive activities. Individual has some problems sleeping. Generally, individual gets a full night's

sleep but at least once a week problems arise. This may include occasionally awakening, bed wetting, or having nightmares.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with individual's functioning. Individual is having problems with sleep. Sleep is often disrupted and individual seldom obtains a full night of sleep.

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Individual is generally sleep deprived. Sleeping is almost always difficult and the individual is not able to get a full night's sleep.

6) ACTIVITIES OF DAILY LIVING (INTERVIEWER: Does the individual appear to be able to take care of themselves?)

How do you get the basic things you need, such as food, clothing, and hygiene supplies? Are you able to cook your own meals and clean your own living area? Do you have any difficulty with toileting, including making it to the restroom on time or cleaning up after yourself if you aren't able to?

0 No current need; no need for action or intervention. No evidence of problems with activities of daily living. The individual is fully independent across these areas, as developmentally appropriate.

1 Identified need requires monitoring, watchful waiting, or preventive activities. Mild problems with activities of daily living. The individual is generally good with such activity, but may require some verbal prompting or support to complete some specific developmentally appropriate activities.

2 Action or intervention is required to ensure that the identified need is addressed; need is interfering with individual's functioning. Moderate problems with activities of daily living. The individual has difficulties with developmentally appropriate activities. For example, they may require assistance (physical prompting) on self-care task or attendant care on a single self-care task (e.g., eating, bathing, dressing, or toileting).

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Severe problems with activities of daily living. The individual requires significant and consistent support to complete developmentally appropriate activities such as eating, bathing, dressing, toileting.

7) TRANSPORTATION

Do you have your own transportation? Do you use public transportation? If not, what keeps you from using public transportation? How do you get to the places you need to go?

0 No current need; no need for action or intervention. Individual has no transportation needs. Individual is able to get to appointments, school/work, activities, etc.

1 Identified need requires monitoring, watchful waiting, or preventive activities. Individual has occasional transportation needs. Individual's difficulties getting to appointments, school/work, activities, etc. do not significantly impact the individual's participation in these activities.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with functioning. Individual has frequent transportation needs – getting to appointments, school/work, activities, etc. – which impact the individual's ability to consistently participate in these activities. The individual needs assistance and access to transportation resources, which may include a special vehicle (such as a bus or modified vehicle).

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Individual has no access to appropriate transportation and is unable to get to appointments, school/work, activities, etc. Individual needs immediate intervention and development of transportation resources, which may include a special vehicle (such as a bus or modified vehicle).

8) LIVING SITUATION (INTERVIEWER): If the individual has been in respite, brief detention/jail, and brief medical and psychiatric hospitalization for the last 30 days, based on current presentation, consider what the individual's behavior would likely have been in a community setting.)

How have you managed your living situation within the last month? What's the most difficult part of how, where, or who you are living with now?

0 No current need; no need for action or intervention. No evidence of problem with functioning in current living environment. Individual and caregivers feel comfortable dealing with issues that come up in day-to-day life.

1 Identified need requires monitoring, watchful waiting, or preventive activities. Individual experiences mild problems with functioning in current living situation. Caregivers express some concern about individual's behavior in living situation, and/or individual and caregiver have some difficulty dealing with issues that arise in daily life.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with individual's functioning. Individual has moderate to severe problems with functioning in current living situation. Individual's difficulties in maintaining appropriate behavior in this setting are creating significant problems for others in the residence. Individual and caregivers have difficulty interacting effectively with each other much of the time.

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Individual has profound problems with functioning in current living situation. Individual is at immediate risk of being removed from living situation due to problematic behaviors.

9) MEDICAL/PHYSICAL

Do you have any medical or health issues that limit your physical abilities? If so, how much would you say these limitations interfere with your ability to do the things you want and need to on a daily basis?

0 No current need; no need for action or intervention. No evidence of medical or physical health problems. Caregiver is generally healthy.

1 Identified need requires monitoring, watchful waiting, or preventive activities. There is a history or suspicion of, and/or caregiver is in recovery from, medical/physical problems.

2 Action or intervention is required to ensure the identified need is addressed; need is interfering with functioning. Caregiver has medical/physical problems that interfere with their capacity to provide care for the individual.

3 Problems are dangerous or disabling; requires immediate and/or intensive action. Caregiver has medical/physical problems that make providing care for the individual impossible at this time.

Appendix II: The Client Satisfaction Questionnaire (CSQ-8)

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much; we really appreciate your help.

Circle your answer:

1. How would you rate the quality of service you have received?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted?

1	2	3	4
No, definitely	No, not really	Yes, generally	Yes definitely

3. To what extent has our program met your needs?

4	3	2	1
Almost all needs met	Most needs met	Only few needs met	No needs met

4. If a friend were in need of similar help, would you recommend our program to him or her?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

5. How satisfied are you with the amount of help you have received?

1	2	3	4
Quite dissatisfied	Mildly dissatisfied	Mostly satisfied	Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?

4	3	2	1
They helped a great deal	Yes, they helped	No, they didn't help	They make things worse

7. In an overall general sense, how satisfied are you with the service you have received?

4	3	2	1
Very satisfied	Mostly satisfied	Mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to our program?

1	2	3	4
No, definitely not	No, I don't think so	Yes, I think so	Yes, definitely

Appendix III: Housing First Fidelity Assessment

Please select the answer choice that best describes the **housing process and structure** that this program offers its participants (Questions 1-2).

1. What percent of participants live in housing that is considered emergency, short-term, transitional, or time limited, in that participants are expected to move when either standardized criteria or individual milestones are met?

0-14% 15-29% 30-44% 45-59% 60-84% 85-100%

2. What percent of participants live in scattered-site permanent supported housing, wherein less than 20% of the units are leased by the program?

0-14% 15-29% 30-44% 45-59% 60-84% 85-100%

Please select the answer choice that best describes **how housing and services are related** in this program (Questions 3-4).

3. What requirements do program participants have to meet in order to gain access to permanent housing? (**choose all that apply**)

Completion of a period of time in transitional housing, outpatient, inpatient, or residential treatment

Sobriety or abstinence from alcohol and/or drugs

Compliance with medication

Psychiatric symptom stability

Willingness to comply with a treatment plan that addresses sobriety, abstinence, and/or medication compliance

Agreeing to face-to-face visits with staff

Meeting responsibilities of a standard lease

4. If yes, which of the following provisions does the lease or agreement contain? (**choose all that apply**)

Provisions regarding adherence to medication, sobriety, and/or a treatment plan

Provisions regarding adherence to program rules such as curfews or overnight guests

Provisions regarding adherence to face-to-face visits with staff

Provisions regarding creating behavioral disturbances with respect to other tenants

Please select the answer choice that best describes the **service philosophy** of this program (Questions 5-8).

5. To what extent do program participants choose the type, sequence, and intensity of services on an ongoing basis?

Services are chosen by the service provider, with little no input from the participant

Participants have some say in choosing, modifying, or refusing services, although program staff determinations usually prevail

Participants have some say in choosing, modifying, or refusing services, although participant preferences usually prevail

Participants have the right to choose, modify, or refuse services and supports at any time, except one face-to-face visit with staff a week

6. What are the requirements for participants with serious mental illness (SMI) to take medication or participate in psychiatric treatment such as attending groups or seeing a psychiatrist?

All participants with SMI are required to take medication and/or participate in treatment

Most participants with SMI are required to take medication and/or participate in treatment, but exceptions are made

Participants with SMI who have not achieved symptom stability are required to take medication and/or participate in treatment

Participants with SMI are not required to take medication and/or participate in treatment

7. What are the requirements for participants with substance abuse (SA) disorders to participate in SA treatment such as inpatient treatment, attending groups, or counseling with a substance use specialist?

All participants with SA disorders, regardless of current use or abstinence, are required to participate in SA treatment

Participants with SA disorders who have not achieved a specified period of abstinence must participate in SA treatment

Participants with SA disorders who are currently actively using substances must participate in SA treatment

Participants with SA disorders are not required to participate in SA treatment

8. What is the program's approach to substance use among participants?

Participants are required to abstain from alcohol and/or drugs at all times

Participants are required to abstain from alcohol and/or drugs while they are in their residence

Participants are not required to abstain from alcohol and/or drugs, but staff work with participants to achieve abstinence

Participants are not required to abstain from alcohol and/or drugs, but staff work with participants to reduce the negative consequences of use and/or utilize appropriate stage matched interventions

Please select the answer choice that best describes the **service array** of this program (Questions 9-14).

9. What types of services, if any, are available to participants who are in need of substance use treatment? (**choose all that apply**)

Substance use treatment services are not available

Systematic and integrated screening and assessment

Interventions tailored to change readiness

Outreach or motivational interviewing CBT, relapse prevention, or other EBP or Promising Practice (e.g. BRITE)

10. What types of services, if any, are available to participants who are interested in paid employment opportunities? (**choose all that apply**)

Employment services are not available

Vocational assessment

Individualized short-term employment (e.g. day labor)

In-house work experience or sheltered work (e.g. Goodwill)

Community based employment

11. What types of services, if any, are available to participants who are interested in education? (**choose all that apply**)

Educational services are not available

Educational assessment

In house education (e.g. literacy remediation)

Adult school, vocational training, trade school / apprenticeship

Supported education in the community (e.g. community college)

12. What types of services, if any, are available to participants who are interested in volunteering? (**choose all that apply**)

Volunteering services are not available

Volunteering capability and interest assessment

Individualized short-term volunteering

In house volunteer experience or sheltered experience

Community based volunteering

13. What types of services, if any, are available to participants who have medical (physical health) issues? (**choose all that apply**)

Medical/physical health services are not available

Screening for medical problems or medication side effects

Managing medication related to physical health

Communicating and coordinating services with other medical providers

Health promotion, prevention, education activities

On-site diagnosis and treatment of physical health conditions

14. What types of social integration services, if any, are available to participants? (**choose all that apply**)?

Social integration services are not available

Basic social skills training (e.g., maintaining eye contact, holding a conversation)

Group recreational/ leisure activities (lunches, sporting events, senior center)

One-on-one support for developing social competencies (e.g., help with empowerment, resolving problems with members of social network, establishing trust)

Services to help support or expand participants' social roles (e.g., employee / volunteer, sibling/ parent / grandparent, neighbor)

Support for activities pertaining to citizenship or civic participation (e.g., help with advocacy, voting, community involvement, faith community involvement)

Please select the answer choice that best describes the **team structure/human resources** of this program (Questions 15-16).

15. How often do program staff meet to plan and review services for participants?

Program staff meet less than one day a month

Program staff meet 1 day per month

Program staff meet 1 day per week

Program staff meet 2-3 days per week

Program staff meet at least 4 days per week

16. To what extent does the program use its team meetings to meet the following functions? (**choose all that apply**)

Conduct a brief, but clinically relevant review of any participants with whom they had contact in the past 24 hours

Conduct a review of the long-term goals of all clients on a regularly scheduled basis

Develop a staff schedule based on participant schedules and emerging needs

Discuss need for proactive contacts to prevent future crises

Review previous staff assignments for follow through

XII. Appendix: Community Planning Documents

2021-22 MHSA Community Meeting Flyer

2021-22 MHSA Consumer/Family Member Focus Groups Flyer

2021-22 MHSA Community Training and Planning Presentation

MHSA Community Meeting Input and Recommendations Form and Results Summary

MHSA Community Planning Stakeholder Demographic Form

MHSA Community Planning Stakeholder Demographic Results Summary

MHSA Consumer & Stakeholder Surveys and Results Summary

2022-23 MHSA Annual Update Public Hearing Presentation to BHB

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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)

The Mental Health Services Act (MHSA) is 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 community meetings to discuss the needs and opportunities to strengthen mental health services in San Joaquin County. These meetings will include training, 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 2022-23 Annual Update of the 2020-23 Three Year Program and Expenditure Plan.

We are counting on your voice to help guide us!

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.

BHS Consortium	BHS Behavioral Health Board	General Town Hall Meeting	Spanish Town Hall Meeting	General Town Hall Meeting
Wednesday, Jan 5 **3 P.M. – 5 P.M.**	**Wednesday, Jan 19** **5 P.M. – 7 P.M.**	**Thursday, Jan 20** **1 P.M. – 3 P.M.**	**Wednesday, Jan 26** **3 P.M. – 5 P.M.**	**Thursday, Jan 27** **10 A.M. – 12 P.M.**
Join Zoom Meeting https://caltelehealth.zoom.us/j/92996120355?pwd=NG0xLzNIWk5Ld3U1OWsrMVp3VlJ1UT09 Phone: 1 669 900 6833 Meeting ID: 929 9612 0355 Passcode: 486601				

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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Behavioral Health Services
A Division of Health Care Services Agency

Tony Vartan, MSW, LCSW, BHS Director

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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 training and 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 2022-23 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 **Thursday, January 6, 2022** **10 A.M. – 12 P.M.**	**Gipson Center** **Thursday, January 13, 2022** **10 A.M. – 12 P.M.**
Join Zoom Meeting https://caltelehealth.zoom.us/j/92996120355?pwd=NG0xLzNIWk5Ld3U1OWsrMVp3VlJ1UT09 Phone: 1 669 900 6833 Meeting ID: 929 9612 0355 Passcode: 486601	

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Welcome to 2021-22 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

1

SAN JOAQUIN COUNTY

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San Joaquin County Behavioral Health Services Mental Health Services Act – Overview and Planning

Community Program Planning for Fiscal Year 2022-2023

2

2

Part 1: Overview of BHS

WELCOME AND INTRODUCTIONS
BHS MISSION, VISION, AND VALUES

SAN JOAQUIN COUNTY

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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.

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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.

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Part 2: Community Training on Mental Health Services Act

OVERVIEW OF MHSA
COMMUNITY INVESTMENT
COMMUNITY

6

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

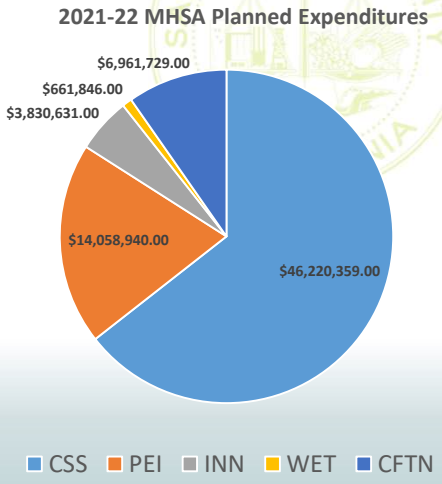
MHSA Core Principles

- **Client/family driven**
- **Cultural competence**
- **Community collaboration**
- **Service integration**
- **Focus on recovery, wellness, and resilience**
- **Serving the unserved and underserved**

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**



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New and Expanded MHSA Programs

2020-21 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)
- FSP High-Risk Transition Team (CSS)
- Community Trauma Services for Adults (PEI)

Program Operations have Begun

2022 New Programs

- Information and Education Campaign (PEI)
- Suicide Prevention in the Community (PEI)
- INNOVATION Project – "Home to Stay" – Intensive Transitional Housing
  - 5 Scattered Houses
  - 16-Bed Modular Building (2023)
  - Engage chronically homeless individuals w/ SMI or Co-Occuring Disorder
    - Deliver culturally relevant, multi-disciplinary services.
    - Deliver culturally responsive support systems

SAN JOAQUIN COUNTY

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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

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Part 4: Planning Discussion

GROUP BRAINSTORM

- What works?
- What needs Improvement?

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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) Community-Defined – underserved, unserved groups
4) Identify key needs and 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/Family Member Focus 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)**

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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

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Angelo Balmaceda
MHSA Coordinator
abalmaceda@sjcbhs.org

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Behavioral Health Services

Stakeholder Community Meeting Feedback Form MHSA Planning 2021-2022

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

Formulario de Comentarios de la Reunión Comunitaria de las Partes Interesadas

Planificación de la MHSA 2021-2022

* 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

MHSA Planning 2021-2022 - Demographics January 2022

Per the State of California guidelines, San Joaquin County must report demographic information on MHSA planning participants. This information will be kept confidential and used for reporting purposes only. Participants may decline to answer these questions.

* 1. Which meeting did you attend?

- ◯ Wednesday, January 5, 2022 3 p.m. - 5 p.m. (BHS Consortium)
- ◯ Thursday, January 6, 2022 10 a.m. - 12 p.m. (Wellness Center)
- ◯ Thursday, January 13, 2022 10 a.m. - 12 p.m. (Gipson Center)
- ◯ Wednesday, January 19, 2022 5 p.m. - 7 p.m. (BHS Behavioral Health Board)
- ◯ Thursday, January 20, 2022 1 p.m. - 3 p.m. (General Town Hall Meeting)
- ◯ Wednesday, January 26, 2022 3 p.m. - 5 p.m. (Spanish Town Hall Meeting)
- ◯ Thursday, January 27, 2022 10 a.m. - 12 p.m. (General Town Hall Meeting)

* 2. Please indicate your age range.

- ☐ Under 18
- ☐ 18-25
- ☐ 26-59
- ☐ 60 and older

* 3. What is your gender identity?

- ◯ Female
- ◯ Male
- ◯ Non-binary
- ◯ Transgender
- ◯ Other (please specify)

* 4. What is your sexual orientation?

- ◯ Heterosexual / Straight
- ◯ LGBTQI
- ◯ Prefer not to answer
- ◯ Other (please specify)

* 5. What is the primary language spoken in your home?

- ◯ English
- ◯ Spanish
- ◯ Other (please specify)

* 6. What is your race or ethnicity?

- ◯ American Indian / Native American / First Nations (including Hawaiian and Alaskan Native)
- ◯ Black / African American
- ◯ Hispanic or Latinx
- ◯ Southeast Asian
- ◯ Other Asian or Pacific Islander
- ◯ White / Caucasian
- ◯ Mixed Race or Other

* 7. Consumer Affiliation (if applicable)

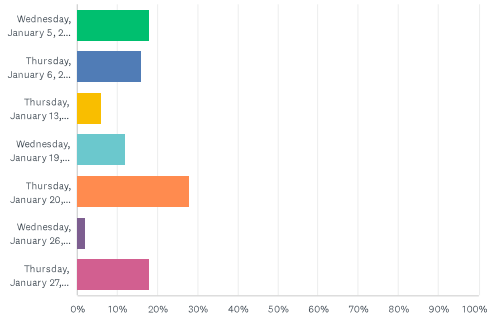
- ☐ Mental health client / Consumer
- ☐ Family member or care giver of a mental health consumer
- ☐ None of the above

* 8. Stakeholder Affiliation (check all that apply)

- [ ] Community Based / Non-Profit Mental Health Services Provider
- [ ] Community Based Organization (Not-Mental Health Services Provider)
- [ ] Advocate
- [ ] Children and Family Service Provider
- [ ] K-12 Education Provider
- [ ] Veterans Services
- [ ] Senior Services
- [ ] Law Enforcement
- [ ] Hospital / Health Care Provider
- [ ] County Mental Health or Substance Abuse Services Staff
- [ ] Other (please specify)

Q1 Which meeting did you attend?

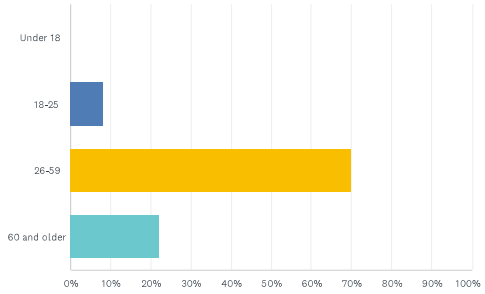
Answered: 50 Skipped: 0



ANSWER CHOICES	RESPONSES	
Wednesday, January 5, 2022 3 p.m. - 5 p.m. (BHS Consortium)	18.00%	9
Thursday, January 6, 2022 10 a.m. - 12 p.m. (Wellness Center)	16.00%	8
Thursday, January 13, 2022 10 a.m. - 12 p.m. (Gipson Center)	6.00%	3
Wednesday, January 19, 2022 5 p.m. - 7 p.m. (BHS Behavioral Health Board)	12.00%	6
Thursday, January 20, 2022 1 p.m. - 3 p.m. (General Town Hall Meeting)	28.00%	14
Wednesday, January 26, 2022 3 p.m. - 5 p.m. (Spanish Town Hall Meeting)	2.00%	1
Thursday, January 27, 2022 10 a.m. - 12 p.m. (General Town Hall Meeting)	18.00%	9
TOTAL		50

Q2 Please indicate your age range.

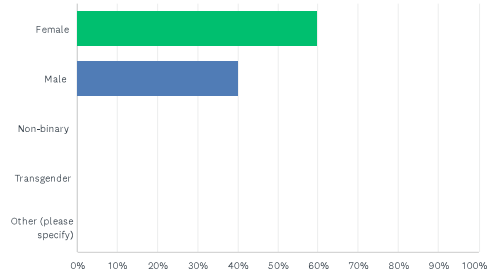
Answered: 50 Skipped: 0



ANSWER CHOICES	RESPONSES	
Under 18	0.00%	0
18-25	8.00%	4
26-59	70.00%	35
60 and older	22.00%	11
Total Respondents: 50		

Q3 What is your gender identity?

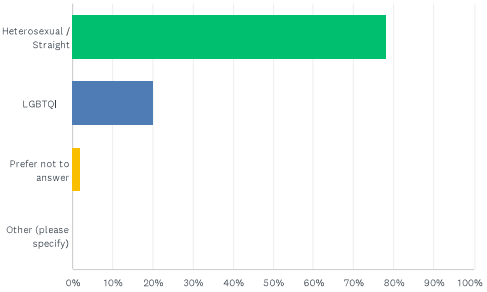
Answered: 50 Skipped: 0



ANSWER CHOICES	RESPONSES	
Female	60.00%	30
Male	40.00%	20
Non-binary	0.00%	0
Transgender	0.00%	0
Other (please specify)	0.00%	0
TOTAL		50

Q4 What is your sexual orientation?

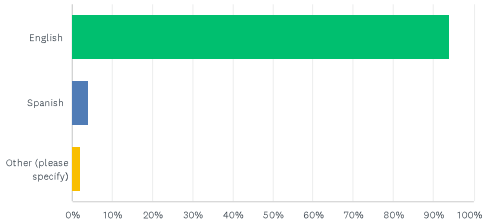
Answered: 50 Skipped: 0



ANSWER CHOICES	RESPONSES	
Heterosexual / Straight	78.00%	39
LGBTQI	20.00%	10
Prefer not to answer	2.00%	1
Other (please specify)	0.00%	0
TOTAL		50

Q5 What is the primary language spoken in your home?

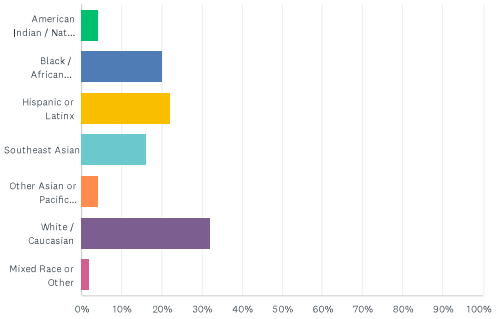
Answered: 50 Skipped: 0



ANSWER CHOICES	RESPONSES	
English	94.00%	47
Spanish	4.00%	2
Other (please specify)	2.00%	1
TOTAL		50

Q6 What is your race or ethnicity?

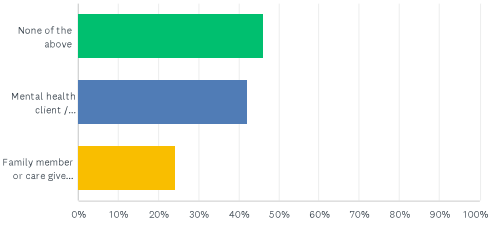
Answered: 50 Skipped: 0



ANSWER CHOICES	RESPONSES	
American Indian / Native American / First Nations (including Hawaiian and Alaskan Native)	4.00%	2
Black / African American	20.00%	10
Hispanic or Latinx	22.00%	11
Southeast Asian	16.00%	8
Other Asian or Pacific Islander	4.00%	2
White / Caucasian	32.00%	16
Mixed Race or Other	2.00%	1
TOTAL		50

Q7 Consumer Affiliation (if applicable)

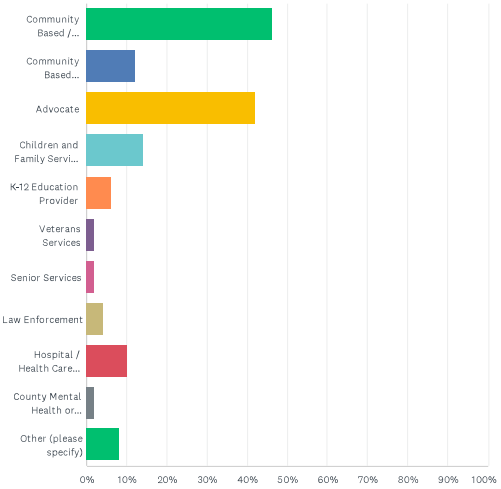
Answered: 50 Skipped: 0



ANSWER CHOICES	RESPONSES	
None of the above	46.00%	23
Mental health client / Consumer	42.00%	21
Family member or care giver of a mental health consumer	24.00%	12
Total Respondents: 50		

Q8 Stakeholder Affiliation (check all that apply)

Answered: 50 Skipped: 0



ANSWER CHOICES	RESPONSES	
Community Based / Non-Profit Mental Health Services Provider	46.00%	23
Community Based Organization (Not-Mental Health Services Provider)	12.00%	6
Advocate	42.00%	21
Children and Family Service Provider	14.00%	7
K-12 Education Provider	6.00%	3
Veterans Services	2.00%	1
Senior Services	2.00%	1
Law Enforcement	4.00%	2
Hospital / Health Care Provider	10.00%	5
County Mental Health or Substance Abuse Services Staff	2.00%	1
Other (please specify)	8.00%	4
Total Respondents: 50		

SAN JOAQUIN COUNTY
Behavioral Health Services

Planificación MHSA 2021-2022 - 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 5 de enero, 3 p.m. - 5 p.m. 2022 (BHS Consortium)
- ◯ Jueves 6 de enero, 10 a.m. - 12 p.m. 2022 (Wellness Center)
- ◯ Jueves 13 de enero, 10 a.m. - 12 p.m. 2022 (Gipson Center)
- ◯ Miércoles 19 de enero, 5 p.m. - 7 p.m. 2022 (BHS Behavioral Health Board)
- ◯ Jueves 20 de enero, 1 p.m. - 3 p.m. 2022 (Sesión General)
- ◯ Miércoles 26 de enero, 3 p.m. - 5 p.m. 2022 (Sesión de español)
- ◯ Jueves 27 de enero, 10 a.m. - 12 p.m. 2022 (Sesión General)

* 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)

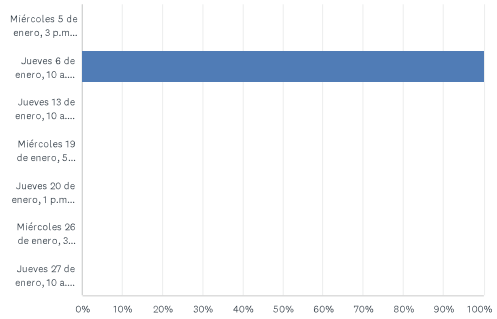
- ☐ Cliente de salud mental / consumidor
- ☐ Familiar de un consumidor de salud mental
- ☐ Ninguna de las anteriores

* 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)

Q1 ¿A qué reunión asististe?

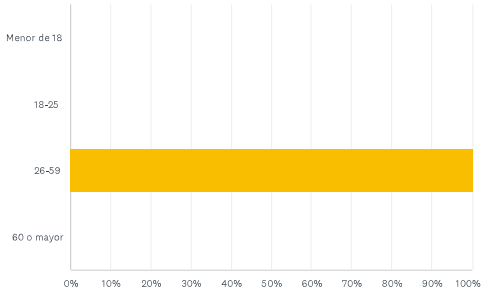
Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Miércoles 5 de enero, 3 p.m. - 5 p.m. 2022 (BHS Consortium)	0.00%	0
Jueves 6 de enero, 10 a.m. - 12 p.m. 2022 (Wellness Center)	100.00%	1
Jueves 13 de enero, 10 a.m. - 12 p.m. 2022 (Gipson Center)	0.00%	0
Miércoles 19 de enero, 5 p.m. - 7 p.m. 2022 (BHS Behavioral Health Board)	0.00%	0
Jueves 20 de enero, 1 p.m. - 3 p.m. 2022 (Sesión General)	0.00%	0
Miércoles 26 de enero, 3 p.m. - 5 p.m. 2022 (Sesión de español)	0.00%	0
Jueves 27 de enero, 10 a.m. - 12 p.m. 2022 (Sesión General)	0.00%	0
TOTAL		1

Q2 Indique su rango de edad

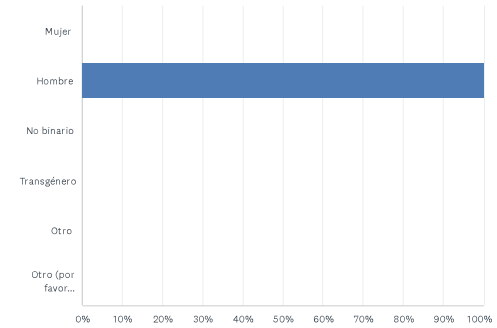
Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Menor de 18	0.00%	0
18-25	0.00%	0
26-59	100.00%	1
60 o mayor	0.00%	0
Total Respondents: 1		

Q3 Indique su género

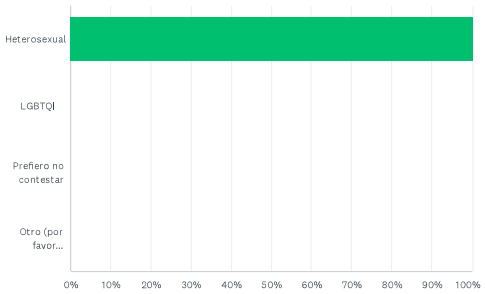
Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Mujer	0.00%	0
Hombre	100.00%	1
No binario	0.00%	0
Transgénero	0.00%	0
Otro	0.00%	0
Otro (por favor especifique)	0.00%	0
TOTAL		1

Q4 ¿Cuál es su orientación sexual?

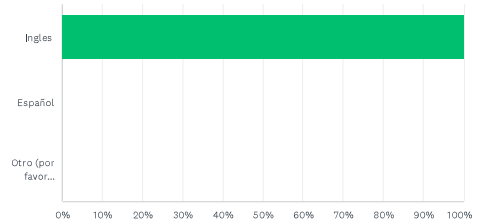
Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Heterosexual	100.00%	1
LGBTQI	0.00%	0
Prefiero no contestar	0.00%	0
Otro (por favor especifique)	0.00%	0
TOTAL		1

Q5 Indique el idioma principal que se habla en su hogar

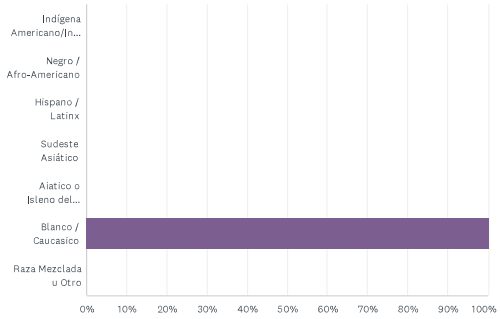
Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Ingles	100.00%	1
Español	0.00%	0
Otro (por favor especifique)	0.00%	0
TOTAL		1

Q6 Indique su raza o etnia

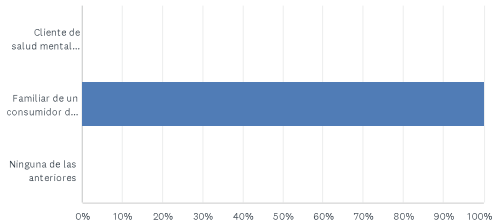
Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Indígena Americano/Indio Americano/Primeras Naciones (incluyendo Hawaiano y Nativo)	0.00%	0
Negro / Afro-Americano	0.00%	0
Hispano / Latinx	0.00%	0
Sudeste Asiático	0.00%	0
Aiatico o Isleno del Pacifico	0.00%	0
Blanco / Caucasico	100.00%	1
Raza Mezclada u Otro	0.00%	0
TOTAL		1

Q7 Afiliación de consumidor (si aplica)

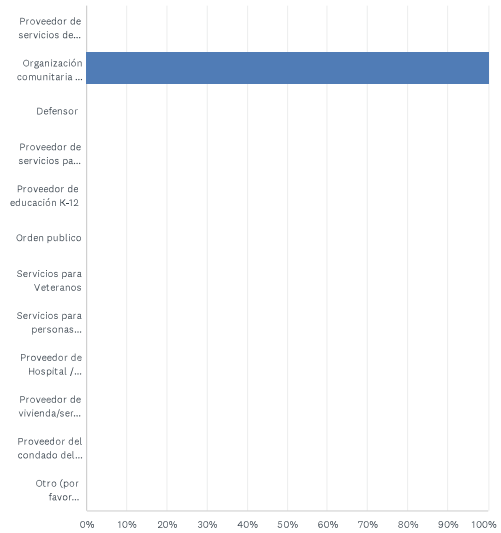
Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Cliente de salud mental / consumidor	0.00%	0
Familiar de un consumidor de salud mental	100.00%	1
Ninguna de las anteriores	0.00%	0
Total Respondents: 1		

Q8 Afiliación de intereses (marque todas las que aplican)

Answered: 1 Skipped: 0



ANSWER CHOICES	RESPONSES	
Proveedor de servicios de salud mental comunitarios / sin fines lucrativos	0.00%	0
Organización comunitaria (no un proveedor de servicios de salud mental)	100.00%	1
Defensor	0.00%	0
Proveedor de servicios para niños y familias	0.00%	0
Proveedor de educación K-12	0.00%	0
Orden publico	0.00%	0
Servicios para Veteranos	0.00%	0
Servicios para personas mayores	0.00%	0
Proveedor de Hospital / cuidado de salud	0.00%	0
Proveedor de vivienda/servicios de vivienda	0.00%	0
Proveedor del condado del departamento de salud mental o de servicios de abuso de sustancias	0.00%	0
Otro (por favor especifique)	0.00%	0
Total Respondents: 1		

SAN JOAQUIN COUNTY
Behavioral Health Services

2021 - 2022 MHSA Consumer & Stakeholder 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 BHS informational materials such as flyers, brochures, or on the website?

Needs Improvement	Fair	Good	Very Good	Excellent
★	★	★	★	★

If "Needs Improvement" was selected: What changes would you like to see?

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
★	★	★	★	★

If "Needs Improvement" was selected: What types of individual or group interventions would you like to see?

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

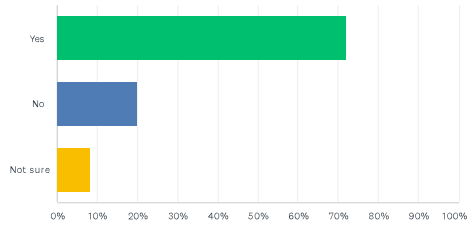
29. What is your sexual orientation?

- ◯ 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?

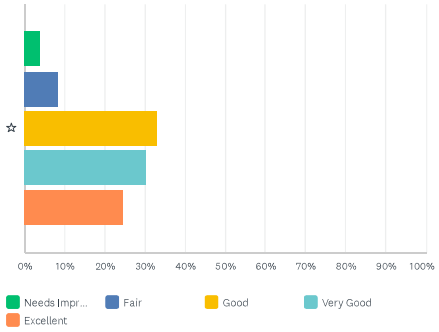
Answered: 371 Skipped: 4



ANSWER CHOICES	RESPONSES	
Yes	71.97%	267
No	19.95%	74
Not sure	8.09%	30
TOTAL		371

Q2 How would you rate the location where our services are provided?

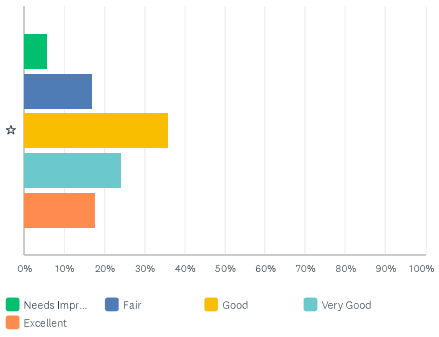
Answered: 374 Skipped: 1



	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	3.74% 14	8.29% 31	33.16% 124	30.21% 113	24.60% 92	374	3.64

Q3 How would you rate BHS informational materials such as flyers, brochures, or on the website?

Answered: 352 Skipped: 23



	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	5.68% 20	16.76% 59	35.80% 126	24.15% 85	17.61% 62	352	3.31

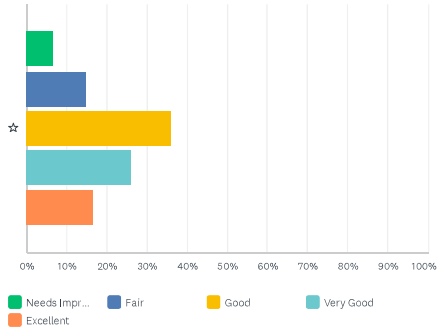
#	IF "NEEDS IMPROVEMENT" WAS SELECTED: WHAT CHANGES WOULD YOU LIKE TO SEE?	DATE
1	Speakers, flyers, brochures. Not everyone has accessed to the internet	3/18/2022 10:34 AM
2	Rules need to be the same for all clients and staff	3/18/2022 10:13 AM
3	See a therapist online	3/17/2022 9:26 AM
4	None	3/16/2022 11:11 AM
5	N/A	3/16/2022 11:10 AM
6	N/A All good.	3/16/2022 10:17 AM
7	Making them more readily available.	3/16/2022 8:56 AM
8	Communication effectiveness during intake process.	3/15/2022 3:48 PM
9	Brochures	3/15/2022 3:22 PM
10	N/A	3/15/2022 3:16 PM
11	Staff and outdoors	3/15/2022 2:11 PM
12	N/A	3/15/2022 1:49 PM
13	More Rooms	3/15/2022 10:12 AM

14	N/A (Never Seen)	3/15/2022 9:26 AM
15	More	3/15/2022 9:19 AM
16	Expansion of more services and location	3/15/2022 8:34 AM
17	Need another location/expansion for more space and services	3/14/2022 4:22 PM
18	More Services in Rural Areas	3/14/2022 4:14 PM
19	N/A	3/14/2022 3:48 PM
20	Have not received	3/14/2022 2:13 PM
21	None	3/14/2022 8:54 AM
22	friendlyer staff	3/11/2022 3:55 PM
23	loseing weight	3/11/2022 3:52 PM
24	Finding the right therapist	3/11/2022 3:33 PM
25	informative TV	3/11/2022 3:20 PM
26	No change now	3/8/2022 3:27 PM
27	N/A	3/8/2022 3:09 PM
28	No	3/4/2022 8:47 AM
29	Mental disability application awareness	3/4/2022 8:46 AM
30	Not sure	3/4/2022 8:00 AM
31	Time management	3/3/2022 2:37 PM
32	Communication socializing	3/3/2022 2:27 PM
33	Don't See any	3/2/2022 1:05 PM
34	None	3/2/2022 1:04 PM
35	Stop helping out identity theft	3/2/2022 8:56 AM
36	More work choices	3/1/2022 4:10 PM
37	More information	3/1/2022 4:07 PM
38	No	3/1/2022 4:02 PM
39	N/A	3/1/2022 3:54 PM
40	Being Accepted	3/1/2022 2:45 PM
41	More parking lots	3/1/2022 1:15 PM
42	N/A	3/1/2022 1:10 PM
43	I haven't seen any	3/1/2022 10:12 AM
44	None	3/1/2022 9:43 AM
45	None	3/1/2022 9:36 AM
46	None	3/1/2022 9:32 AM
47	More information from the Martin Gibson Center	3/1/2022 9:17 AM
48	Help finding own home.	3/1/2022 8:43 AM
49	Get Medication Services	3/1/2022 8:17 AM
50	Never heard of it until cdcc	3/1/2022 8:14 AM
51	Not up to date	2/28/2022 4:18 PM

52	No Brochures and Website is messy	2/28/2022 2:50 PM
53	Better website / No Brochures	2/28/2022 2:48 PM
54	Bad Website	2/28/2022 2:41 PM
55	Website improvement	2/28/2022 1:44 PM
56	The website is outdated and not very user friendly	2/28/2022 1:35 PM
57	It is as is Just Fine	2/28/2022 1:17 PM
58	More	2/28/2022 11:11 AM
59	N/A	2/28/2022 10:27 AM
60	Overhaul of the BHS WEBSITE is NEEDED!!	2/22/2022 11:42 AM

Q4 How would you rate the length of time it takes to get an appointment?

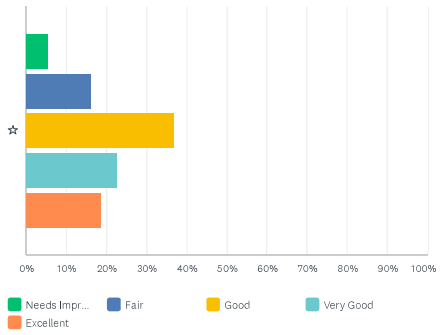
Answered: 366 Skipped: 9



	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	6.56% 24	14.75% 54	36.07% 132	25.96% 95	16.67% 61	366	3.31

Q5 How would you rate the types of individual or group interventions that are offered?

Answered: 358 Skipped: 17



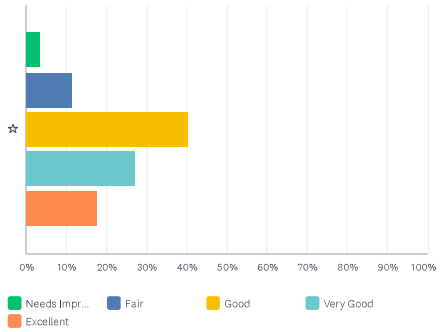
	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	5.59% 20	16.20% 58	36.87% 132	22.63% 81	18.72% 67	358	3.33

#	IF "NEEDS IMPROVEMENT" WAS SELECTED: WHAT TYPES OF INDIVIDUAL OR GROUP INTERVENTIONS WOULD YOU LIKE TO SEE?	DATE
1	Could take a while to make important appt.	3/18/2022 10:13 AM
2	Therapist	3/17/2022 9:26 AM
3	Same	3/16/2022 11:11 AM
4	N/A	3/16/2022 11:10 AM
5	N/A All good.	3/16/2022 10:17 AM
6	Would like to see them at all.	3/16/2022 8:56 AM
7	Yes	3/15/2022 3:22 PM
8	Food Services	3/15/2022 3:16 PM
9	N/A	3/15/2022 10:12 AM
10	N/A (Never Seen)	3/15/2022 9:26 AM
11	Peer	3/15/2022 9:19 AM
12	Faster appointment times and work more with their clients and more intervention services for clients	3/15/2022 8:34 AM

13	Takes too long	3/14/2022 4:34 PM
14	Better response during crisis	3/14/2022 3:52 PM
15	N/A	3/14/2022 3:48 PM
16	Groups	3/14/2022 10:22 AM
17	None	3/14/2022 8:54 AM
18	a focussed brain	3/11/2022 3:52 PM
19	GROUP THERAPY	3/11/2022 3:33 PM
20	No Groups	3/11/2022 3:20 PM
21	I don't know	3/11/2022 2:59 PM
22	Haven't received the counseling that I've signed up for yet	3/11/2022 2:53 PM
23	More supports group / Bx GRP	3/8/2022 3:27 PM
24	N/A	3/8/2022 3:09 PM
25	LGBT Services, Detox services, outreach	3/4/2022 1:19 PM
26	I don't know	3/4/2022 8:47 AM
27	Communications	3/4/2022 8:00 AM
28	Needs more therapy	3/3/2022 3:20 PM
29	Teen WRAP for children BHS youth srv.	3/3/2022 2:40 PM
30	I could run some groups - possibly better	3/3/2022 2:37 PM
31	Socializing Mingling	3/3/2022 2:27 PM
32	None	3/2/2022 1:04 PM
33	If offered resources, I am not deserving only for the identity theftors.	3/2/2022 8:56 AM
34	Symptoms	3/1/2022 4:10 PM
35	No	3/1/2022 4:02 PM
36	N/A	3/1/2022 3:54 PM
37	Behaviorist, More Black Clinicians	3/1/2022 10:12 AM
38	N/A	3/1/2022 9:46 AM
39	None	3/1/2022 9:43 AM
40	None	3/1/2022 9:32 AM
41	Hard to get into the program	2/28/2022 4:18 PM
42	More Time in Psychotherapy therapeutic service focused on the person centered before perscription medication is perscrived in treating substance abuse disorders and mental health diagnosis's	2/28/2022 2:16 PM
43	Lack of staffing makes it difficult to offer individual and group services. Increase staffing	2/28/2022 1:35 PM
44	MORE!!!!	2/28/2022 1:22 PM
45	Whatever is clever Just as is	2/28/2022 1:17 PM
46	DMV Groups How to pass test	2/28/2022 10:32 AM
47	N/A	2/28/2022 10:27 AM

Q6 How would you rate the thoroughness of the services that are provided?

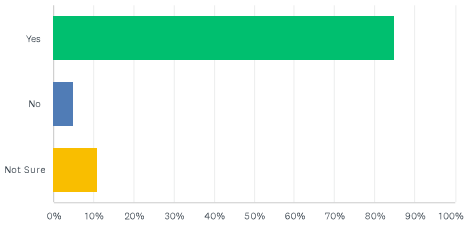
Answered: 343 Skipped: 32



	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	3.50% 12	11.37% 39	40.23% 138	27.11% 93	17.78% 61	343	3.44

Q7 Would you recommend our services to people who need help for a mental health or substance use concern?

Answered: 348 Skipped: 27



ANSWER CHOICES	RESPONSES	
Yes	84.77%	295
No	4.60%	16
Not Sure	10.63%	37
TOTAL		348

Q8 What services or supports need the most improvement and what should BHS do to make them better?

Answered: 132 Skipped: 243

#	RESPONSES	DATE
1	N/A	3/18/2022 10:54 AM
2	More groups and more writing throughout the week.	3/18/2022 10:45 AM
3	More specific service and advertisment.	3/18/2022 10:34 AM
4	None	3/18/2022 10:28 AM
5	Doctors and psychiatrists	3/18/2022 10:15 AM
6	N/A	3/18/2022 10:12 AM
7	Having a therapist phone line	3/17/2022 9:26 AM
8	I'm not receiving therapy because there is a waiting list.	3/16/2022 11:02 AM
9	N/A All good.	3/16/2022 10:17 AM
10	Help Homeless	3/16/2022 9:09 AM
11	More group programs and Jobs like at gipson center	3/15/2022 3:55 PM
12	Based on needs assessment and time at SJBHS, Housing improvement, to help with stabilization of care of patient. (or assisting in placing/placement of safe housing.	3/15/2022 3:48 PM
13	Outdoors or entertainment Taste of food	3/15/2022 2:11 PM
14	Social Security	3/15/2022 2:06 PM
15	My Family	3/15/2022 1:45 PM
16	The talking with the doctor.	3/15/2022 10:12 AM
17	Appointment Scheduling	3/15/2022 9:26 AM
18	Intake	3/15/2022 9:19 AM
19	Peer Support	3/15/2022 9:15 AM
20	Crisis support. Appointments should not be needed for a crisis.	3/15/2022 8:36 AM
21	Then need to focus on the client and pa attention to their needs, staff needs to stop taking amongst each other in front of clients.	3/15/2022 8:34 AM
22	Attentiveness from staff to clients - in all BHS depts and contracted programs.	3/14/2022 4:34 PM
23	Crisis Services more compassionate	3/14/2022 4:27 PM
24	Customer Service	3/14/2022 4:24 PM
25	Need more social skills and talk to consumers with kindness and don't bring their own problems to work.	3/14/2022 4:22 PM
26	More therapy made available more outreach, better referrals.	3/14/2022 4:14 PM
27	More Compassion from case workers	3/14/2022 4:10 PM
28	N/A	3/14/2022 3:48 PM
29	To learn	3/14/2022 3:34 PM
30	M.	3/14/2022 3:23 PM

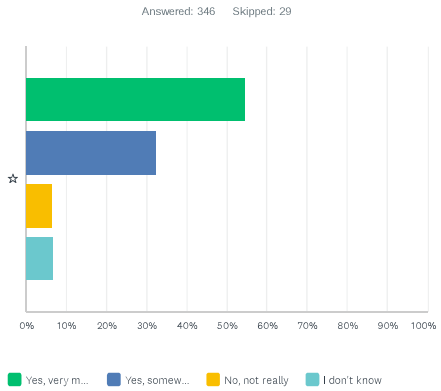
31	Idk	3/14/2022 2:30 PM
32	Not Sure	3/14/2022 2:28 PM
33	None, with who I had interactions with.	3/14/2022 11:06 AM
34	Not sure	3/14/2022 11:03 AM
35	Not sure	3/14/2022 11:00 AM
36	I think there good.	3/14/2022 10:20 AM
37	Nothing	3/14/2022 9:33 AM
38	Nothing, I think services are nice.	3/14/2022 9:01 AM
39	None	3/14/2022 8:54 AM
40	Not sure	3/14/2022 8:49 AM
41	None, they are amazing	3/11/2022 4:10 PM
42	more access to therapist or some one i can talk to about what is bothering me	3/11/2022 4:04 PM
43	I am new so i don't know	3/11/2022 3:55 PM
44	Hope, More Patience	3/11/2022 3:50 PM
45	Therapy	3/11/2022 3:33 PM
46	Cafeteria	3/11/2022 3:20 PM
47	Good	3/11/2022 3:05 PM
48	None	3/11/2022 2:59 PM
49	I'm not sure	3/11/2022 2:55 PM
50	Doctor needs to slow down and not rush through meetings	3/11/2022 2:53 PM
51	Someone to talk to no just listen	3/11/2022 2:48 PM
52	Not Sure	3/11/2022 2:43 PM
53	More freedom in choosing a doctor	3/11/2022 2:40 PM
54	To my knowledge they are all doing fine.	3/11/2022 8:00 AM
55	24hr ER Care	3/11/2022 7:56 AM
56	N/A	3/9/2022 3:29 PM
57	Need additional program to address youth with both intellectual disabilities and mental illness (dual diagnosed)	3/9/2022 2:08 PM
58	None	3/9/2022 1:58 PM
59	I don't know	3/9/2022 12:55 PM
60	None that I can think of. Maybe more availability	3/9/2022 11:14 AM
61	Maybe on timing but besides it's very good	3/9/2022 11:12 AM
62	Physicians way to engrossed in computer work instead of child.	3/9/2022 11:03 AM
63	Drug use / Depression Support	3/8/2022 3:27 PM
64	N/A	3/8/2022 3:09 PM
65	Location, need more services in South County	3/8/2022 2:21 PM
66	Not sure	3/4/2022 1:36 PM
67	Services for trans people	3/4/2022 9:00 AM
68	I don't know	3/4/2022 8:47 AM

69	Psychologist for in-person therapy	3/4/2022 8:46 AM
70	Human courtesy	3/4/2022 8:00 AM
71	More Therapy	3/3/2022 3:20 PM
72	Unknown	3/3/2022 3:11 PM
73	Serve more food	3/3/2022 3:03 PM
74	Check Doctors overall mental health also	3/3/2022 2:52 PM
75	Meetings on time - follow up on paperwork	3/3/2022 2:37 PM
76	Provide Volunteer programs	3/3/2022 2:27 PM
77	Walk through the services so they can find ourselves with the wellness center or even other services	3/3/2022 2:19 PM
78	Pharmacy	3/2/2022 1:57 PM
79	The waiting time for injection appointment are a little long.	3/2/2022 1:23 PM
80	Nothing	3/1/2022 4:13 PM
81	Early relief	3/1/2022 4:10 PM
82	Support groups	3/1/2022 4:07 PM
83	No	3/1/2022 4:02 PM
84	N/A	3/1/2022 3:54 PM
85	More Groups	3/1/2022 3:52 PM
86	Health insurance help	3/1/2022 2:50 PM
87	N/A	3/1/2022 2:41 PM
88	Employment for mentally ill (volunteer activities) Understanding about our potential path of life and reactions	3/1/2022 2:19 PM
89	Mobile Crisis	3/1/2022 1:53 PM
90	Case mngr's tie along with private payeeship	3/1/2022 1:41 PM
91	Hire better people	3/1/2022 1:38 PM
92	Groups	3/1/2022 1:33 PM
93	None	3/1/2022 1:07 PM
94	Psychiatry could be more thorough	3/1/2022 10:55 AM
95	More Psychiatrists so there are more availability for appointments	3/1/2022 10:53 AM
96	More after school appointments	3/1/2022 10:13 AM
97	More Providers; More Availability	3/1/2022 10:12 AM
98	Don't Know	3/1/2022 9:43 AM
99	Don't know	3/1/2022 9:36 AM
100	None	3/1/2022 9:32 AM
101	It's all fine for now	3/1/2022 9:17 AM
102	None	3/1/2022 9:04 AM
103	Nothing	3/1/2022 9:02 AM
104	Appointment Availability	3/1/2022 8:55 AM
105	N/A	3/1/2022 8:49 AM

106	Help Finding own Home	3/1/2022 8:43 AM
107	The Allowance or integration of outside service (Gibson center or library or meetings)	3/1/2022 8:28 AM
108	None	3/1/2022 8:20 AM
109	Get Medication Change	3/1/2022 8:17 AM
110	N/A Helping get meds faster (ie: for others)	3/1/2022 8:14 AM
111	H and I just there time of arrival - pretty much it	3/1/2022 8:08 AM
112	Need more staff and recreation	3/1/2022 8:03 AM
113	Client safety cleanliness, Dr. Appointments / Medications / Food / Improving.	2/28/2022 4:18 PM
114	More TV time: outside visits	2/28/2022 4:10 PM
115	It is all good	2/28/2022 4:06 PM
116	Southside Stockton	2/28/2022 2:50 PM
117	Outreach	2/28/2022 2:48 PM
118	Groups / Classes: Other locations and centers have outreach	2/28/2022 2:45 PM
119	More time and behavioral observations in the clients real environment to ensure proper diagnosis continued care management	2/28/2022 2:16 PM
120	The Homeless population / and Care homes	2/28/2022 1:47 PM
121	Pharmacy	2/28/2022 1:42 PM
122	Connecting ppl to svcs shouldn't be as labor intensify as it feels from department to department. Just having staff available to provide to the support.	2/28/2022 1:35 PM
123	All of it! Hire Staff, Keep Staff, Pay Staff and make people want to stay Put patients first	2/28/2022 1:22 PM
124	Satisfied with service I received .	2/28/2022 11:24 AM
125	Homes for Homeless	2/28/2022 11:11 AM
126	Improve their referral services.	2/28/2022 11:07 AM
127	Psychiatrist appointment due pandemic uses Internet or zoom	2/28/2022 11:03 AM
128	N/A	2/28/2022 10:27 AM
129	Activities / NA / NA	2/28/2022 10:25 AM
130	Locations in South Stockton	2/28/2022 10:02 AM
131	Offer More food More People to team up for deescalation	2/28/2022 9:29 AM
132	BHS needs more Outreach to Underserved Communities - Public is unaware of BHS Services and MHSA Services	2/22/2022 11:42 AM

Q9 From a cultural and linguistic perspective, are the BHS lobby and reception areas friendly and welcoming?

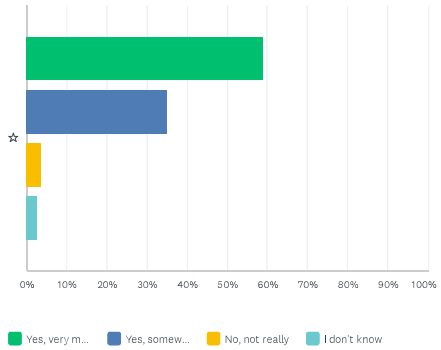
Answered: 346 Skipped: 29



	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	54.62% 189	32.37% 112	6.36% 22	6.65% 23	346	1.65

Q10 Are BHS staff members courteous and professional?

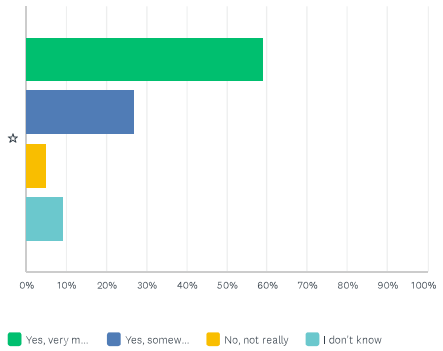
Answered: 345 Skipped: 30



	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	58.84% 203	35.07% 121	3.48% 12	2.61% 9	345	1.50

Q11 Are BHS staff members respectful of your cultural heritage?

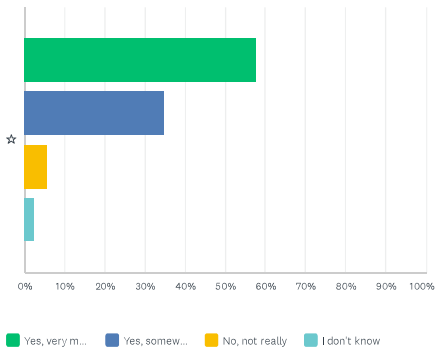
Answered: 346 Skipped: 29



	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	58.96% 204	26.88% 93	4.91% 17	9.25% 32	346	1.64

Q12 Do BHS staff members explain things in a way that you like and understand?

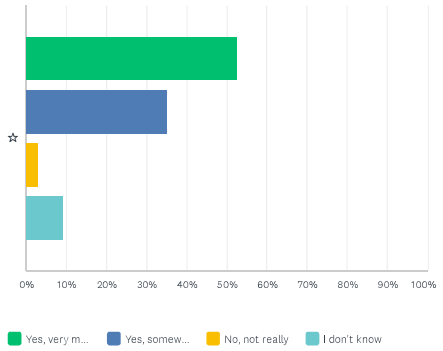
Answered: 346 Skipped: 29



	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	57.51% 199	34.68% 120	5.49% 19	2.31% 8	346	1.53

Q13 Are BHS programs helpful for many different types of people?

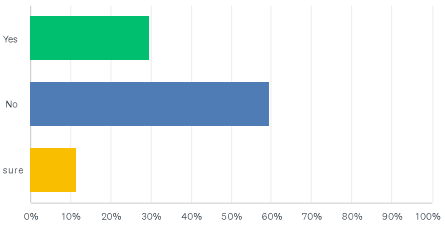
Answered: 347 Skipped: 28



	YES, VERY MUCH SO	YES, SOMEWHAT	NO, NOT REALLY	I DON'T KNOW	TOTAL	WEIGHTED AVERAGE
☆	52.74% 183	35.16% 122	2.88% 10	9.22% 32	347	1.69

Q14 Have you or a family member ever used BHS interpretation services?

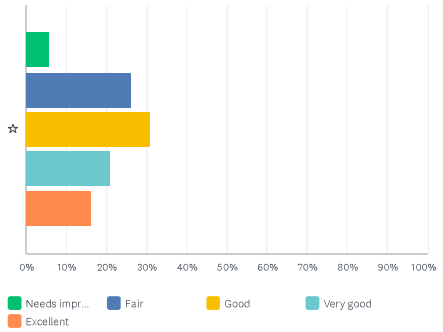
Answered: 347 Skipped: 28



ANSWER CHOICES	RESPONSES	
Yes	29.39%	102
No	59.37%	206
Not sure	11.24%	39
TOTAL		347

Q15 If you've used BHS interpretation services, how would you describe the quality of the interpretation services?

Answered: 172 Skipped: 203



	NEEDS IMPROVEMENT	FAIR	GOOD	VERY GOOD	EXCELLENT	TOTAL	WEIGHTED AVERAGE
☆	5.81% 10	26.16% 45	30.81% 53	20.93% 36	16.28% 28	172	3.16

Q16 What is the MOST important factor that contributes to wellness and recovery?

Answered: 250 Skipped: 125

#	RESPONSES	DATE
1	Groups	3/18/2022 10:56 AM
2	N/A	3/18/2022 10:54 AM
3	The helpfulness to provide	3/18/2022 10:52 AM
4	Attending Groups	3/18/2022 10:50 AM
5	Groups, inpatient services (Program)	3/18/2022 10:45 AM
6	Sobriety	3/18/2022 10:36 AM
7	My Wrap plan	3/18/2022 10:28 AM
8	Honesty	3/18/2022 10:27 AM
9	Rehabilitation and staying away from substances	3/18/2022 10:15 AM
10	Sobriety and Mental Stability	3/18/2022 10:12 AM
11	Able to read what's writen	3/17/2022 9:26 AM
12	Safety	3/17/2022 9:23 AM
13	God	3/17/2022 9:21 AM
14	Treatment , continuing with services	3/17/2022 9:18 AM
15	Taking Medication.	3/16/2022 11:10 AM
16	Routine appointments and Med Checks	3/16/2022 11:08 AM
17	A good psychiatrist and an excellent therapist who provides the skills/tools, and encouragement for seccess	3/16/2022 11:06 AM
18	Support	3/16/2022 11:02 AM
19	Medicine	3/16/2022 10:43 AM
20	Good Helpful and caring people great place to hangout.	3/16/2022 10:17 AM
21	Help homeless with housing	3/16/2022 9:09 AM
22	Ongoing group support.	3/16/2022 8:56 AM
23	Kind people who help and the willingness to get better	3/15/2022 3:55 PM
24	Progress of care, safe housing, good communication, understanding of rights and responsibilities, and voicing our concerns so that there are better future outcomes.	3/15/2022 3:48 PM
25	Entertainment and friendliness	3/15/2022 2:11 PM
26	Suta Math	3/15/2022 2:06 PM
27	Games.	3/15/2022 1:49 PM
28	My Health	3/15/2022 1:45 PM
29	Safety	3/15/2022 1:41 PM
30	Support	3/15/2022 1:14 PM

31	Consistency	3/15/2022 1:13 PM
32	The straight my thought of change	3/15/2022 10:12 AM
33	N/A	3/15/2022 9:26 AM
34	Insurance	3/15/2022 9:23 AM
35	Health	3/15/2022 9:19 AM
36	Time	3/15/2022 9:15 AM
37	Education	3/15/2022 8:42 AM
38	N/A	3/15/2022 8:40 AM
39	Access to services	3/15/2022 8:39 AM
40	Peer support, more respites.	3/15/2022 8:36 AM
41	Housing	3/15/2022 8:34 AM
42	Support from people who care, understand + have been where i'm at (peers)	3/14/2022 4:34 PM
43	Support groups	3/14/2022 4:27 PM
44	Understanding	3/14/2022 4:24 PM
45	Respect, Integrity, Culture respect and human kindness	3/14/2022 4:22 PM
46	Hope - from services providers	3/14/2022 4:14 PM
47	Willingness	3/14/2022 4:10 PM
48	Encouragement	3/14/2022 3:52 PM
49	Peer support	3/14/2022 3:48 PM
50	Sobriety	3/14/2022 3:43 PM
51	Good diet	3/14/2022 3:34 PM
52	Therapy	3/14/2022 3:26 PM
53	Availability of consistent therapy sessions	3/14/2022 3:24 PM
54	M.	3/14/2022 3:23 PM
55	Listen	3/14/2022 2:53 PM
56	Consistent	3/14/2022 2:51 PM
57	Someone to talk to	3/14/2022 2:50 PM
58	Talk to someone	3/14/2022 2:49 PM
59	Sleep	3/14/2022 2:47 PM
60	Talk	3/14/2022 2:30 PM
61	Honest	3/14/2022 2:28 PM
62	Consistency	3/14/2022 2:23 PM
63	Non Judgmental Services	3/14/2022 2:15 PM
64	Quick access to Tx	3/14/2022 2:11 PM
65	Consistency	3/14/2022 11:06 AM
66	Honesty	3/14/2022 11:03 AM
67	Counseling	3/14/2022 11:02 AM
68	Talking about mental issues	3/14/2022 11:00 AM

69	recognizing potential	3/14/2022 10:22 AM
70	Breathing techniques	3/14/2022 9:35 AM
71	Stable living environment	3/14/2022 9:31 AM
72	Making Sure they are safe	3/14/2022 9:06 AM
73	Talking to someone doing something to keep stuff off your mind	3/14/2022 9:01 AM
74	Coping skills	3/14/2022 8:54 AM
75	?	3/14/2022 8:49 AM
76	Communication	3/14/2022 8:47 AM
77	That I can be free from meds	3/11/2022 4:10 PM
78	Communication	3/11/2022 4:04 PM
79	Deep breathes and mindfullness	3/11/2022 4:01 PM
80	They talk to you	3/11/2022 3:57 PM
81	staying on my medications	3/11/2022 3:55 PM
82	To Keep my appointments	3/11/2022 3:54 PM
83	Patience	3/11/2022 3:50 PM
84	Meds: Motivation - Activity	3/11/2022 3:47 PM
85	Getting Help and Being Understood	3/11/2022 3:33 PM
86	Being Helpful	3/11/2022 3:30 PM
87	Getting Better	3/11/2022 3:26 PM
88	My klomipin medication	3/11/2022 3:23 PM
89	Good Help	3/11/2022 3:21 PM
90	Caring People	3/11/2022 3:20 PM
91	Service	3/11/2022 3:18 PM
92	never used interpreter	3/11/2022 3:17 PM
93	don't know	3/11/2022 3:13 PM
94	I won't recover because its neurological every has a.d.d.	3/11/2022 3:12 PM
95	yourself	3/11/2022 3:10 PM
96	Being in open-minded person	3/11/2022 3:07 PM
97	straight	3/11/2022 3:05 PM
98	environment	3/11/2022 3:03 PM
99	To not needing mental health any longer or able to do and function on your own	3/11/2022 3:01 PM
100	Meds	3/11/2022 2:59 PM
101	A Welcoming and Understanding Environment	3/11/2022 2:55 PM
102	love and understanding	3/11/2022 2:53 PM
103	the medicine	3/11/2022 2:50 PM
104	Honesty	3/11/2022 2:48 PM
105	Medicine	3/11/2022 2:44 PM
106	Not Sure	3/11/2022 2:43 PM

107	Relationship with Jesus Christ (an in turn w/ Gof the father, Holy Spirit & Word of God	3/11/2022 2:40 PM
108	Communication	3/11/2022 8:28 AM
109	Desire for wellness and recovery	3/11/2022 8:23 AM
110	Psychological therapy	3/11/2022 8:12 AM
111	Support from family and friends	3/11/2022 8:00 AM
112	Compassion	3/11/2022 7:58 AM
113	Keeping Communication w/ counselor	3/11/2022 7:56 AM
114	Understanding with communication	3/11/2022 7:53 AM
115	To listen to the Children	3/9/2022 3:29 PM
116	For patients to be willing to get better	3/9/2022 2:54 PM
117	Everybody here is cool.	3/9/2022 2:48 PM
118	Healthy enviroment	3/9/2022 2:10 PM
119	Variety of programs that is specific to my needs	3/9/2022 2:08 PM
120	Support	3/9/2022 1:58 PM
121	Understanding	3/9/2022 12:55 PM
122	Medication	3/9/2022 11:25 AM
123	Clases paralos minos	3/9/2022 11:22 AM
124	Strong support system	3/9/2022 11:14 AM
125	Not Sure	3/9/2022 11:12 AM
126	Trust	3/9/2022 11:10 AM
127	Therapy	3/9/2022 11:08 AM
128	The correct help a person can get	3/9/2022 11:06 AM
129	Identifying the issues and putting together a genuine plan (+Meds if needed) Re-Evaluation often!	3/9/2022 11:03 AM
130	Consistancy	3/9/2022 10:57 AM
131	They make sure to keep me posted on new things	3/9/2022 9:13 AM
132	The Kindness	3/9/2022 9:07 AM
133	Taking medicine	3/9/2022 9:05 AM
134	Meds	3/9/2022 9:00 AM
135	Therapy Medication	3/9/2022 8:44 AM
136	Mentally strong. Listen to the therapist in your mind. continue to pray	3/8/2022 3:27 PM
137	N/A	3/8/2022 3:09 PM
138	Location - Meet the individual closer to where they reside	3/8/2022 2:21 PM
139	Being listened to	3/4/2022 1:36 PM
140	Safety	3/4/2022 1:19 PM
141	Peers in the system	3/4/2022 8:54 AM
142	God	3/4/2022 8:49 AM
143	?	3/4/2022 8:47 AM
144	Counsel with Therapist	3/4/2022 8:46 AM

145	What helps me the most that I can get prescriptions filled right there at Mental Health	3/4/2022 8:43 AM
146	Spirituality 12 steps peer support	3/4/2022 8:00 AM
147	Therapy, Medication	3/4/2022 7:57 AM
148	Being able to advocate for yourself and others	3/3/2022 4:11 PM
149	Kindness	3/3/2022 3:22 PM
150	Compliance	3/3/2022 3:20 PM
151	Unknown	3/3/2022 3:11 PM
152	God	3/3/2022 3:09 PM
153	Meetings	3/3/2022 3:07 PM
154	Better health	3/3/2022 3:03 PM
155	Being Help-by recovery coaches.	3/3/2022 2:58 PM
156	Mental Health	3/3/2022 2:52 PM
157	Supprt	3/3/2022 2:40 PM
158	Self-motivation, good diagnosis, drug free (street)	3/3/2022 2:37 PM
159	Staying focus	3/3/2022 2:31 PM
160	Peer Support	3/3/2022 2:29 PM
161	Being positive	3/3/2022 2:27 PM
162	I would say to keep coming and that I attend what I do need in my life.	3/3/2022 2:19 PM
163	Mental Health	3/2/2022 1:57 PM
164	discipline and consistency.	3/2/2022 1:23 PM
165	Clean and sober	3/2/2022 1:18 PM
166	Being Kind	3/1/2022 4:21 PM
167	Conservator Factor	3/1/2022 4:14 PM
168	Good	3/1/2022 4:13 PM
169	Meds	3/1/2022 4:11 PM
170	CBIS	3/1/2022 4:10 PM
171	None.	3/1/2022 4:07 PM
172	Staying Focused	3/1/2022 4:05 PM
173	Med's	3/1/2022 3:54 PM
174	Groups / Job	3/1/2022 3:52 PM
175	Doctor check ups and Meds	3/1/2022 2:50 PM
176	Anger Management Counseling for VMRC Clients	3/1/2022 2:45 PM
177	Relieving Stress	3/1/2022 2:43 PM
178	Meds	3/1/2022 2:41 PM
179	Being sober - right minded willing to be well	3/1/2022 2:19 PM
180	Take medications that your doctor prescribed.	3/1/2022 1:56 PM
181	Help with situation that demand helping out!	3/1/2022 1:53 PM
182	psychiatric medications	3/1/2022 1:41 PM

183	Respect and support	3/1/2022 1:38 PM
184	Housing	3/1/2022 1:35 PM
185	Getting off meds	3/1/2022 1:33 PM
186	I don't know	3/1/2022 1:15 PM
187	Having someone to talk to	3/1/2022 1:12 PM
188	Willingness to recover	3/1/2022 1:10 PM
189	Motivation	3/1/2022 1:07 PM
190	Knowing that there is help when needed.	3/1/2022 1:05 PM
191	A willingness from the patient	3/1/2022 1:04 PM
192	Strong connection with therapist, counselors etc.	3/1/2022 11:01 AM
193	Getting the help you need	3/1/2022 10:56 AM
194	Communication	3/1/2022 10:55 AM
195	Support and understanding	3/1/2022 10:53 AM
196	Support	3/1/2022 10:13 AM
197	Resources	3/1/2022 10:12 AM
198	The Counselors	3/1/2022 10:08 AM
199	Counselors and Therapist that truly care about their patients	3/1/2022 10:06 AM
200	To try and stay healthy	3/1/2022 9:48 AM
201	Injection	3/1/2022 9:46 AM
202	Take Medicine	3/1/2022 9:44 AM
203	Come see Dr. Med	3/1/2022 9:43 AM
204	Take Medicine	3/1/2022 9:40 AM
205	Medication	3/1/2022 9:33 AM
206	Doctor + Meds + Injection	3/1/2022 9:32 AM
207	Medication and Therapy	3/1/2022 9:17 AM
208	Taking Medicine	3/1/2022 9:09 AM
209	Thearapy	3/1/2022 9:07 AM
210	Talking, Exercise, treatment	3/1/2022 9:06 AM
211	None	3/1/2022 9:04 AM
212	Take your Medication	3/1/2022 9:02 AM
213	Taking Medicine	3/1/2022 8:59 AM
214	The want to change for the better	3/1/2022 8:55 AM
215	The Check in and getting appointment area	3/1/2022 8:49 AM
216	Communication	3/1/2022 8:43 AM
217	Housing	3/1/2022 8:28 AM
218	Foundation	3/1/2022 8:20 AM
219	Truly caring for us, about us	3/1/2022 8:17 AM
220	My attitude	3/1/2022 8:14 AM

221	Most important factor that contributes my wellness and recovery is the people in here, we connect like a family	3/1/2022 8:08 AM
222	Trusting Your Higher Power	3/1/2022 8:03 AM
223	Sobriety - Boundaries	3/1/2022 8:00 AM
224	Support Reassurance	2/28/2022 4:18 PM
225	Being Listened to	2/28/2022 4:10 PM
226	Stay in my recovery	2/28/2022 4:06 PM
227	Staff that look like me.	2/28/2022 2:48 PM
228	Being Heard, My concerns and the way i want to take care of my mental health	2/28/2022 2:45 PM
229	Appropriate time and behavioral observations in persons real/natural environment understand the whole person and traumas	2/28/2022 2:16 PM
230	The people and staff that are here for you...	2/28/2022 1:52 PM
231	Doing what you think is best for you.	2/28/2022 1:47 PM
232	Mental Health	2/28/2022 1:42 PM
233	Support	2/28/2022 1:35 PM
234	Participation from client	2/28/2022 1:31 PM
235	Resources	2/28/2022 1:22 PM
236	Participation	2/28/2022 1:19 PM
237	Don't fake it to make it To, Practice what you preach	2/28/2022 1:17 PM
238	Staying busy	2/28/2022 1:11 PM
239	Stay occupied Dont Worry about the past	2/28/2022 11:26 AM
240	Participation / Willingess	2/28/2022 11:24 AM
241	Stay Clean	2/28/2022 11:11 AM
242	Making me worse	2/28/2022 11:09 AM
243	Respect, honesty, understanding, trust, confidentiality, concern	2/28/2022 11:07 AM
244	Behavioral Approach Classes	2/28/2022 11:03 AM
245	Medication	2/28/2022 10:32 AM
246	Individuals	2/28/2022 10:27 AM
247	Strong Mental	2/28/2022 10:25 AM
248	Friendly Staff	2/28/2022 10:02 AM
249	Sleep	2/28/2022 9:36 AM
250	Keeping positive attitude Be aware of surroundings Follow rules	2/28/2022 9:29 AM

Q17 What is the SECOND most important factor that contributes to wellness and recovery?

Answered: 214 Skipped: 161

#	RESPONSES	DATE
1	Support	3/18/2022 10:56 AM
2	N/A	3/18/2022 10:54 AM
3	Recovery and wellness	3/18/2022 10:52 AM
4	Councling	3/18/2022 10:50 AM
5	Support system, sponsor (W.R.A.P.) coping skills	3/18/2022 10:45 AM
6	Willingness	3/18/2022 10:36 AM
7	Soberity	3/18/2022 10:28 AM
8	Open-mindedness	3/18/2022 10:27 AM
9	Sobriety	3/18/2022 10:15 AM
10	Education on Mental illness	3/18/2022 10:12 AM
11	Supportive staff NOT pill pusher	3/17/2022 9:26 AM
12	Medicine	3/17/2022 9:21 AM
13	Continuing the services	3/17/2022 9:18 AM
14	Taking Medication.	3/16/2022 11:10 AM
15	Feeling as though I'm being heard	3/16/2022 11:06 AM
16	Resources	3/16/2022 11:02 AM
17	Dr. Appointments	3/16/2022 10:43 AM
18	The people and staff groups too.	3/16/2022 10:17 AM
19	Food clothing etc.	3/16/2022 9:09 AM
20	Good therapists and counselors	3/15/2022 3:55 PM
21	Staying connected with the BHS staff, educators, learning services	3/15/2022 3:48 PM
22	Friendliness	3/15/2022 2:11 PM
23	None Smoking products	3/15/2022 2:06 PM
24	Staff Team.	3/15/2022 1:49 PM
25	Consentration	3/15/2022 1:45 PM
26	Professionish	3/15/2022 1:41 PM
27	?	3/15/2022 1:14 PM
28	Alertness	3/15/2022 1:13 PM
29	Changing for the family	3/15/2022 10:12 AM
30	N/A	3/15/2022 9:26 AM
31	Good Staff	3/15/2022 9:23 AM

32	Medication	3/15/2022 9:19 AM
33	Courteous	3/15/2022 9:15 AM
34	Doctor Education	3/15/2022 8:42 AM
35	N/A	3/15/2022 8:40 AM
36	Friendly Staff	3/15/2022 8:39 AM
37	Advocacy	3/15/2022 8:36 AM
38	Staying clean and sober	3/15/2022 8:34 AM
39	a clinician who listens + trusts me and takes the time needed to help me.	3/14/2022 4:34 PM
40	Eating healthy/ alot of water	3/14/2022 4:27 PM
41	Experience	3/14/2022 4:24 PM
42	Treat people where they are at in recovery and not where you feel they should be.	3/14/2022 4:22 PM
43	Support	3/14/2022 4:14 PM
44	Open Minded	3/14/2022 4:10 PM
45	Family Support	3/14/2022 3:52 PM
46	Counseling	3/14/2022 3:48 PM
47	Support	3/14/2022 3:43 PM
48	Exercise	3/14/2022 3:34 PM
49	More Therapy	3/14/2022 3:26 PM
50	On.	3/14/2022 3:23 PM
51	Visits / Talk	3/14/2022 2:53 PM
52	Understanding	3/14/2022 2:51 PM
53	Support	3/14/2022 2:50 PM
54	Understand	3/14/2022 2:49 PM
55	Talk	3/14/2022 2:47 PM
56	Listen	3/14/2022 2:30 PM
57	Learn	3/14/2022 2:28 PM
58	Communication	3/14/2022 2:23 PM
59	Acknowledgement	3/14/2022 2:15 PM
60	Empathy	3/14/2022 2:11 PM
61	Detail	3/14/2022 11:06 AM
62	Willingness	3/14/2022 11:00 AM
63	accessibility	3/14/2022 10:22 AM
64	Learning how to control your feelings	3/14/2022 9:35 AM
65	Family connections	3/14/2022 9:31 AM
66	Making sure they have everything they need	3/14/2022 9:06 AM
67	Always talk to someone before doing something	3/14/2022 9:01 AM
68	?	3/14/2022 8:54 AM
69	?	3/14/2022 8:49 AM

70	Everybody working towards the same goals	3/14/2022 8:47 AM
71	Stay drug free and alcohol free	3/11/2022 4:10 PM
72	Self Discipline	3/11/2022 4:04 PM
73	Talk Therapy	3/11/2022 4:01 PM
74	take it day by day	3/11/2022 3:57 PM
75	Keeping your appointments	3/11/2022 3:55 PM
76	Take my prescribed medications	3/11/2022 3:54 PM
77	Love	3/11/2022 3:50 PM
78	Being Understood and Getting Help	3/11/2022 3:33 PM
79	Being Heard	3/11/2022 3:30 PM
80	Getting Better	3/11/2022 3:26 PM
81	loving environment / people	3/11/2022 3:23 PM
82	Structure	3/11/2022 3:20 PM
83	Patient	3/11/2022 3:18 PM
84	water, prescribed meds, making appointment	3/11/2022 3:17 PM
85	peace	3/11/2022 3:12 PM
86	motivation	3/11/2022 3:07 PM
87	support	3/11/2022 3:05 PM
88	consistency	3/11/2022 3:03 PM
89	that you can set up in the morning eat and dress yourself.	3/11/2022 3:01 PM
90	Talking to the Dr.	3/11/2022 2:59 PM
91	Friends that understand your boundaries	3/11/2022 2:55 PM
92	therapy	3/11/2022 2:53 PM
93	Positive Attitude	3/11/2022 2:44 PM
94	Not Sure	3/11/2022 2:43 PM
95	Right therapist/ doctor that listens to your situation/needs	3/11/2022 2:40 PM
96	Home/ Living environment	3/11/2022 8:23 AM
97	Medication	3/11/2022 8:12 AM
98	Continuing to receive help	3/11/2022 8:00 AM
99	Understanding	3/11/2022 7:58 AM
100	Updating coping skills with patient	3/11/2022 7:56 AM
101	Trust	3/11/2022 7:53 AM
102	Letting the children be themself	3/9/2022 3:29 PM
103	A good treatment plan	3/9/2022 2:54 PM
104	Ease of use; accessibility	3/9/2022 2:08 PM
105	Use Coping Skills	3/9/2022 1:58 PM
106	Help/Support	3/9/2022 12:55 PM
107	Counseling	3/9/2022 11:25 AM

108	La comunicacion	3/9/2022 11:22 AM
109	Check up often	3/9/2022 11:14 AM
110	Not Sure	3/9/2022 11:12 AM
111	Consistency	3/9/2022 11:10 AM
112	Positive environment	3/9/2022 11:08 AM
113	Ongoing care	3/9/2022 11:03 AM
114	They are always there when I need to see Doctor	3/9/2022 9:13 AM
115	Understanding	3/9/2022 9:07 AM
116	Take my meds	3/9/2022 9:00 AM
117	Mentally Stable	3/9/2022 8:44 AM
118	Listen to yourself, what being said	3/8/2022 3:27 PM
119	N/A	3/8/2022 3:09 PM
120	Staying clean	3/4/2022 1:36 PM
121	Respect, Availability	3/4/2022 1:19 PM
122	Counseling	3/4/2022 8:49 AM
123	?	3/4/2022 8:47 AM
124	Medication / Mental Health	3/4/2022 8:46 AM
125	The doctors are good.	3/4/2022 8:43 AM
126	Friendships peer support	3/4/2022 8:00 AM
127	Finding things to keep me busy	3/4/2022 7:57 AM
128	Resiliency	3/3/2022 4:11 PM
129	Hope	3/3/2022 3:22 PM
130	Going to my doctor when there's a problem	3/3/2022 3:20 PM
131	Unknown	3/3/2022 3:11 PM
132	Self	3/3/2022 3:09 PM
133	Foodbank	3/3/2022 3:07 PM
134	Mental	3/3/2022 3:03 PM
135	Housing	3/3/2022 2:52 PM
136	Listening Ear	3/3/2022 2:40 PM
137	Good diagnosis	3/3/2022 2:37 PM
138	By sharing	3/3/2022 2:31 PM
139	Groups	3/3/2022 2:29 PM
140	Achieve goals that are desired.	3/3/2022 2:27 PM
141	My problems in programs that I need help with in present and future and all others that I need.	3/3/2022 2:19 PM
142	Doctor	3/2/2022 1:57 PM
143	To be Initiative	3/2/2022 1:23 PM
144	Trust	3/2/2022 1:18 PM
145	Continue taking medicine	3/1/2022 4:21 PM

146	N/A	3/1/2022 4:13 PM
147	Off Drugs	3/1/2022 4:11 PM
148	Classes	3/1/2022 4:10 PM
149	None.	3/1/2022 4:07 PM
150	Staying on track	3/1/2022 4:05 PM
151	Groups	3/1/2022 3:54 PM
152	Job	3/1/2022 3:52 PM
153	Family	3/1/2022 2:50 PM
154	To accept more clients on different insurance	3/1/2022 2:45 PM
155	Attending groups	3/1/2022 2:43 PM
156	understanding	3/1/2022 2:19 PM
157	Go to Gipson for classes	3/1/2022 1:56 PM
158	Fairness and treating others well	3/1/2022 1:53 PM
159	Groups	3/1/2022 1:41 PM
160	Having SSI and Medi-Cal	3/1/2022 1:38 PM
161	Counseling	3/1/2022 1:35 PM
162	being independent	3/1/2022 1:33 PM
163	I don't know	3/1/2022 1:15 PM
164	Reliable person to help when needed	3/1/2022 1:12 PM
165	Correct treatment addressing the situation	3/1/2022 1:10 PM
166	Support	3/1/2022 1:07 PM
167	Having someone to talk to.	3/1/2022 1:05 PM
168	A good team of professionals	3/1/2022 1:04 PM
169	Family support + encouragement + ability to really listen	3/1/2022 11:01 AM
170	Making sure you ask for help	3/1/2022 10:56 AM
171	Trust	3/1/2022 10:55 AM
172	Understanding	3/1/2022 10:13 AM
173	Resources	3/1/2022 10:12 AM
174	The Psychiatrists	3/1/2022 10:08 AM
175	Helpful and caring staff	3/1/2022 10:06 AM
176	Medications	3/1/2022 9:46 AM
177	Don't Know	3/1/2022 9:43 AM
178	Hobbies and anxiety	3/1/2022 9:17 AM
179	Medication	3/1/2022 9:07 AM
180	None	3/1/2022 9:04 AM
181	Knowing your symptoms	3/1/2022 9:02 AM
182	Support	3/1/2022 8:55 AM
183	Easy communication	3/1/2022 8:49 AM

184	Medication	3/1/2022 8:43 AM
185	Meeting Availability	3/1/2022 8:28 AM
186	Support	3/1/2022 8:20 AM
187	Counselors staying passionate about Job	3/1/2022 8:17 AM
188	Materials and Staff	3/1/2022 8:14 AM
189	Counselors, they help us and try to understand us	3/1/2022 8:08 AM
190	Abstaining from Drug and Alcohol use	3/1/2022 8:03 AM
191	Boundaries / Boundaries	3/1/2022 8:00 AM
192	That i get out and go to a nice place to live	2/28/2022 4:10 PM
193	Do not get hi	2/28/2022 4:06 PM
194	The wellness center (Peer support)	2/28/2022 2:45 PM
195	Consistency and commitment and collaboration within services provided	2/28/2022 2:16 PM
196	Being strong	2/28/2022 1:52 PM
197	Going to groups and	2/28/2022 1:47 PM
198	Doctor	2/28/2022 1:42 PM
199	Availability of Services	2/28/2022 1:35 PM
200	Staff Support	2/28/2022 1:31 PM
201	Availability	2/28/2022 1:22 PM
202	Staffs support	2/28/2022 1:19 PM
203	If it's what you want to do it can be done with the effort	2/28/2022 1:17 PM
204	Meetings	2/28/2022 1:11 PM
205	Peace of mind	2/28/2022 11:26 AM
206	Open Mind	2/28/2022 11:24 AM
207	House	2/28/2022 11:11 AM
208	Consistency	2/28/2022 11:07 AM
209	Support from Everyone	2/28/2022 11:03 AM
210	Counseling	2/28/2022 10:32 AM
211	Individuals	2/28/2022 10:27 AM
212	Support	2/28/2022 10:25 AM
213	Socializing	2/28/2022 9:36 AM
214	Be aware of surroundings	2/28/2022 9:29 AM

Q18 What is the THIRD most important factor that contributes to wellness and recovery?

Answered: 198 Skipped: 177

#	RESPONSES	DATE
1	Children	3/18/2022 10:56 AM
2	N/A	3/18/2022 10:54 AM
3	good health both mental and physical	3/18/2022 10:52 AM
4	Eating health meals	3/18/2022 10:50 AM
5	C.D.C.C. (outpatient program) (Staying connected with the 2nd important factor that contributes to wellness and recovery)	3/18/2022 10:45 AM
6	Openness	3/18/2022 10:36 AM
7	Program	3/18/2022 10:28 AM
8	Willingness	3/18/2022 10:27 AM
9	Support system	3/18/2022 10:15 AM
10	Medications and therapy	3/18/2022 10:12 AM
11	Listening what is being said	3/17/2022 9:26 AM
12	The person intrest	3/17/2022 9:21 AM
13	N/A	3/16/2022 11:10 AM
14	No negativity - ever	3/16/2022 11:06 AM
15	Self-Care	3/16/2022 11:02 AM
16	Family	3/16/2022 10:43 AM
17	Bounes activities like Bingo give away zoom.	3/16/2022 10:17 AM
18	Helping people weed help	3/16/2022 9:09 AM
19	Staying grounded with spiritual leaders, groups, peers, making sure family understands our/the SJBHS staff handle patients with care and are professional in doing it's what is a huge part in keeping out/the structured programs available to communities of San Joaquin county's respect in all that we do / relearn as needed. continued education.	3/15/2022 3:48 PM
20	Food	3/15/2022 2:11 PM
21	Hammer	3/15/2022 2:06 PM
22	No	3/15/2022 1:45 PM
23	Management	3/15/2022 1:41 PM
24	?	3/15/2022 1:14 PM
25	Compassion	3/15/2022 1:13 PM
26	Changes for my health	3/15/2022 10:12 AM
27	N/A	3/15/2022 9:26 AM
28	Educated people	3/15/2022 9:23 AM
29	Therapy	3/15/2022 9:19 AM

30	Smart Doctors	3/15/2022 9:15 AM
31	Lived Experience	3/15/2022 8:42 AM
32	N/A	3/15/2022 8:40 AM
33	Competent staff	3/15/2022 8:39 AM
34	Training	3/15/2022 8:36 AM
35	Someone checking in with the person and validating their needs in all aspect.	3/15/2022 8:34 AM
36	recovery tools and coping skills. for me , CBT skills- that i use every day.	3/14/2022 4:34 PM
37	Med compliant	3/14/2022 4:27 PM
38	Community	3/14/2022 4:24 PM
39	Support via warm-line and more peer ran and staff compliance.	3/14/2022 4:22 PM
40	Meaningful role in life / Purpose	3/14/2022 4:14 PM
41	Support	3/14/2022 4:10 PM
42	Groups/Classes	3/14/2022 3:52 PM
43	Socialization	3/14/2022 3:48 PM
44	Family	3/14/2022 3:43 PM
45	Sleep	3/14/2022 3:34 PM
46	GUS.	3/14/2022 3:23 PM
47	Healthy	3/14/2022 2:53 PM
48	Listening	3/14/2022 2:51 PM
49	Improvement	3/14/2022 2:50 PM
50	Listening	3/14/2022 2:49 PM
51	Support	3/14/2022 2:47 PM
52	Learn	3/14/2022 2:30 PM
53	Understand	3/14/2022 2:28 PM
54	Professionalism	3/14/2022 2:23 PM
55	Support	3/14/2022 2:15 PM
56	Acceptance	3/14/2022 2:11 PM
57	Willingness	3/14/2022 11:06 AM
58	Family involvement	3/14/2022 11:00 AM
59	implementing positive choices	3/14/2022 10:22 AM
60	Telling people how you feel.	3/14/2022 9:35 AM
61	Respect of family roles (Kids have fun)	3/14/2022 9:31 AM
62	Always think positive and never negative	3/14/2022 9:01 AM
63	?	3/14/2022 8:54 AM
64	?	3/14/2022 8:49 AM
65	lose weight	3/11/2022 4:10 PM
66	Strong Support System	3/11/2022 4:04 PM
67	Staying physically active and being present	3/11/2022 4:01 PM

68	it helps a lot	3/11/2022 3:57 PM
69	knowing that this is a work in progress	3/11/2022 3:55 PM
70	talk to my doctor	3/11/2022 3:54 PM
71	HOpe	3/11/2022 3:50 PM
72	receiving the help i ask for	3/11/2022 3:30 PM
73	Getting Better	3/11/2022 3:26 PM
74	healthy eating	3/11/2022 3:23 PM
75	inableing	3/11/2022 3:20 PM
76	Doctor	3/11/2022 3:18 PM
77	talk to someone safe, write numbers down, keep reciepts	3/11/2022 3:17 PM
78	meds	3/11/2022 3:12 PM
79	effort	3/11/2022 3:07 PM
80	love	3/11/2022 3:05 PM
81	awareness	3/11/2022 3:03 PM
82	that you can function throughout the day without criticism and able to do a daily activity	3/11/2022 3:01 PM
83	Staying positive	3/11/2022 2:59 PM
84	I'm unsure	3/11/2022 2:55 PM
85	closure	3/11/2022 2:53 PM
86	Hope	3/11/2022 2:44 PM
87	Not Sure	3/11/2022 2:43 PM
88	Right medication/treatment	3/11/2022 2:40 PM
89	Support	3/11/2022 8:23 AM
90	Family resources	3/11/2022 8:12 AM
91	Sticking to program and/or medication	3/11/2022 8:00 AM
92	Willingness to try different treatment methods	3/11/2022 7:58 AM
93	The support for parents	3/11/2022 7:56 AM
94	Patience	3/11/2022 7:53 AM
95	Teaching them how to talk about their feeling	3/9/2022 3:29 PM
96	Good circle of support	3/9/2022 2:54 PM
97	Staff that is welcoming and responsive to my needs	3/9/2022 2:08 PM
98	Understanding what was happening	3/9/2022 1:58 PM
99	Success	3/9/2022 12:55 PM
100	Continue Meeting	3/9/2022 11:25 AM
101	Ayuda Pera la escuela	3/9/2022 11:22 AM
102	Getting educated	3/9/2022 11:14 AM
103	Not Sure	3/9/2022 11:12 AM
104	Medication	3/9/2022 11:08 AM
105	Preparing for wellness + getting off dependency of meds - when time.	3/9/2022 11:03 AM

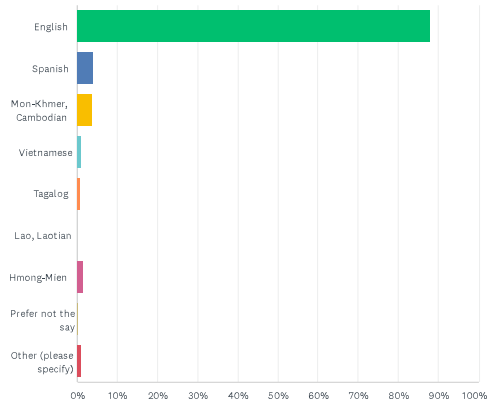
106	I feel like they will see me through my problems	3/9/2022 9:13 AM
107	A Caring DR.	3/9/2022 9:07 AM
108	stay focus	3/9/2022 9:00 AM
109	Health	3/9/2022 8:44 AM
110	Stay focused	3/8/2022 3:27 PM
111	N/A	3/8/2022 3:09 PM
112	Being understood	3/4/2022 1:36 PM
113	Medical personnel	3/4/2022 1:19 PM
114	Group / Classes	3/4/2022 8:49 AM
115	?	3/4/2022 8:47 AM
116	Frequent trips to this facility	3/4/2022 8:46 AM
117	Having a case worker, that cares and gives good advice.	3/4/2022 8:43 AM
118	Proper diet proper sleep	3/4/2022 8:00 AM
119	Recovery skills-	3/4/2022 7:57 AM
120	Understanding	3/3/2022 3:22 PM
121	Getting resources for help	3/3/2022 3:20 PM
122	Unknown	3/3/2022 3:11 PM
123	Others	3/3/2022 3:09 PM
124	Interacting with staff	3/3/2022 3:07 PM
125	My heart	3/3/2022 3:03 PM
126	Occupation	3/3/2022 2:52 PM
127	Person be valued and validated	3/3/2022 2:40 PM
128	Drug free	3/3/2022 2:37 PM
129	Having support	3/3/2022 2:31 PM
130	Focus on yourself	3/3/2022 2:29 PM
131	Well I would say it will happen in the program of new life skills program.	3/3/2022 2:19 PM
132	Medications	3/2/2022 1:57 PM
133	To be Responsible.	3/2/2022 1:23 PM
134	Honesty	3/2/2022 1:18 PM
135	Being positive	3/1/2022 4:21 PM
136	Peer support	3/1/2022 4:10 PM
137	None.	3/1/2022 4:07 PM
138	Being and staying recovered	3/1/2022 4:05 PM
139	Case manager	3/1/2022 3:54 PM
140	Income	3/1/2022 2:50 PM
141	Seeking counseling	3/1/2022 2:43 PM
142	willing to be well	3/1/2022 2:19 PM
143	If having issues talk to a doctor or somebody you can trust.	3/1/2022 1:56 PM

144	HIPPA compliance of your case	3/1/2022 1:53 PM
145	Housing - one on one talks	3/1/2022 1:41 PM
146	My family	3/1/2022 1:38 PM
147	Sobriety Awareness	3/1/2022 1:35 PM
148	stay drug free	3/1/2022 1:33 PM
149	I don't know	3/1/2022 1:15 PM
150	Guidance and direction when feeling lost	3/1/2022 1:12 PM
151	A strong support system	3/1/2022 1:10 PM
152	Consistency	3/1/2022 1:07 PM
153	Family support	3/1/2022 1:04 PM
154	Strive towards a better mental health.	3/1/2022 11:01 AM
155	Showing you can overcome anything	3/1/2022 10:56 AM
156	Honesty / Accountability	3/1/2022 10:55 AM
157	knowledge	3/1/2022 10:13 AM
158	Resources	3/1/2022 10:12 AM
159	The Medicine	3/1/2022 10:08 AM
160	Consistency	3/1/2022 10:06 AM
161	Healthy diet	3/1/2022 9:46 AM
162	Don't Know	3/1/2022 9:43 AM
163	Support	3/1/2022 9:17 AM
164	Courteous Staff	3/1/2022 9:07 AM
165	None	3/1/2022 9:04 AM
166	A safe place	3/1/2022 8:55 AM
167	Staff caring even the small details	3/1/2022 8:49 AM
168	Groups	3/1/2022 8:43 AM
169	Friendlyness	3/1/2022 8:28 AM
170	Participation	3/1/2022 8:20 AM
171	?	3/1/2022 8:17 AM
172	The Surroundings	3/1/2022 8:14 AM
173	The environment, its mellow and kind of feel like home	3/1/2022 8:08 AM
174	Being and Advocate of your own recovery	3/1/2022 8:03 AM
175	Honesty / Twelve Steps	3/1/2022 8:00 AM
176	To give good food	2/28/2022 4:10 PM
177	Do not no	2/28/2022 4:06 PM
178	Facilitators have lived experience	2/28/2022 2:45 PM
179	Meeting the actual needs and listening to the client. Time	2/28/2022 2:16 PM
180	Keep going.	2/28/2022 1:52 PM
181	Making a believable wellness plan you know you can follow and do.	2/28/2022 1:47 PM

182	Medication	2/28/2022 1:42 PM
183	Competent Staff	2/28/2022 1:35 PM
184	Resources	2/28/2022 1:31 PM
185	Locations	2/28/2022 1:22 PM
186	Available resources	2/28/2022 1:19 PM
187	Don't give up keep trying and you shall succeed	2/28/2022 1:17 PM
188	Support	2/28/2022 1:11 PM
189	Program at Groups	2/28/2022 11:26 AM
190	Consistent	2/28/2022 11:24 AM
191	Support Group	2/28/2022 11:11 AM
192	Independent Support	2/28/2022 11:07 AM
193	Attendance	2/28/2022 11:03 AM
194	Service, Resources	2/28/2022 10:32 AM
195	Individuals	2/28/2022 10:27 AM
196	Obediance	2/28/2022 10:25 AM
197	Art / Activities	2/28/2022 9:36 AM
198	Follow rules	2/28/2022 9:29 AM

Q19 Please indicate the language that is most frequently spoken in your home (please choose only one).

Answered: 346 Skipped: 29



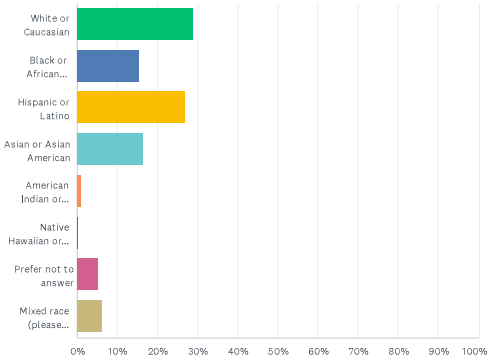
ANSWER CHOICES	RESPONSES	
English	87.86%	304
Spanish	4.05%	14
Mon-Khmer, Cambodian	3.76%	13
Vietnamese	1.16%	4
Tagalog	0.58%	2
Lao, Laotian	0.00%	0
Hmong-Mien	1.45%	5
Prefer not the say	0.29%	1
Other (please specify)	0.87%	3
TOTAL		346

#	OTHER (PLEASE SPECIFY)	DATE

1	Chinese	3/9/2022 9:14 AM
2	Chinese	3/1/2022 4:21 PM
3	Khmu	3/1/2022 9:32 AM

Q20 What is your race?

Answered: 358 Skipped: 17



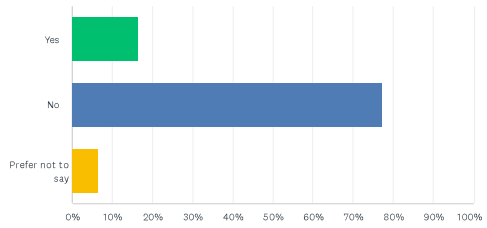
ANSWER CHOICES	RESPONSES	
White or Caucasian	28.77%	103
Black or African American	15.64%	56
Hispanic or Latino	26.82%	96
Asian or Asian American	16.48%	59
American Indian or Alaska Native	0.84%	3
Native Hawaiian or other Pacific Islander	0.28%	1
Prefer not to answer	5.03%	18
Mixed race (please specify)	6.15%	22
TOTAL		358

#	MIXED RACE (PLEASE SPECIFY)	DATE
1	Human	3/18/2022 10:34 AM
2	Black / Hispanic	3/14/2022 11:00 AM
3	White / Latino	3/14/2022 9:01 AM
4	White / Latino	3/14/2022 8:54 AM

5	Black / White	3/11/2022 3:18 PM
6	Mixed	3/11/2022 3:12 PM
7	White, Asian	3/11/2022 3:10 PM
8	White, Latino	3/11/2022 2:55 PM
9	Mexican, Filipino, Native American	3/11/2022 2:53 PM
10	French and Brizilian	3/9/2022 11:14 AM
11	White / Latino	3/4/2022 8:43 AM
12	Wht-Latino	3/3/2022 3:11 PM
13	Filipino, Spanish, Irish, German	3/2/2022 1:23 PM
14	_	3/1/2022 4:14 PM
15	_	3/1/2022 2:41 PM
16	White / Latin	3/1/2022 1:35 PM
17	Hmong	3/1/2022 9:04 AM
18	Caucasian + Black	3/1/2022 8:28 AM
19	Lebanese, Hispanic	2/28/2022 2:45 PM
20	Black + White	2/28/2022 1:40 PM
21	Mex / Italian / Filipino	2/28/2022 10:25 AM
22	White, Black, American Indian	2/28/2022 9:29 AM

Q21 Are you currently homeless or at risk of homelessness?

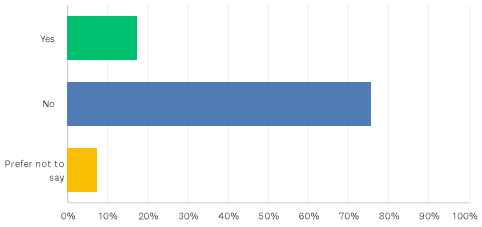
Answered: 359 Skipped: 16



ANSWER CHOICES	RESPONSES	
Yes	16.43%	59
No	77.16%	277
Prefer not to say	6.41%	23
TOTAL		359

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?

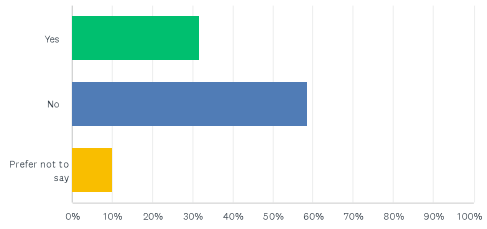
Answered: 360 Skipped: 15



ANSWER CHOICES	RESPONSES	
Yes	17.22%	62
No	75.56%	272
Prefer not to say	7.22%	26
TOTAL		360

Q23 Have you ever been arrested or detained by the police?

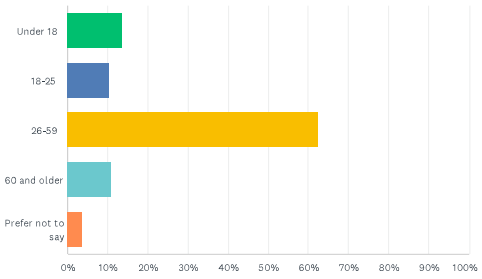
Answered: 360 Skipped: 15



ANSWER CHOICES	RESPONSES	
Yes	31.67%	114
No	58.33%	210
Prefer not to say	10.00%	36
TOTAL		360

Q24 Please indicate your age

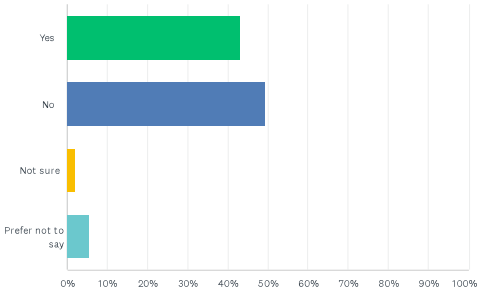
Answered: 360 Skipped: 15



ANSWER CHOICES	RESPONSES	
Under 18	13.33%	48
18-25	10.28%	37
26-59	62.50%	225
60 and older	10.56%	38
Prefer not to say	3.33%	12
TOTAL		360

Q25 Are you a parent or are you about to be a parent?

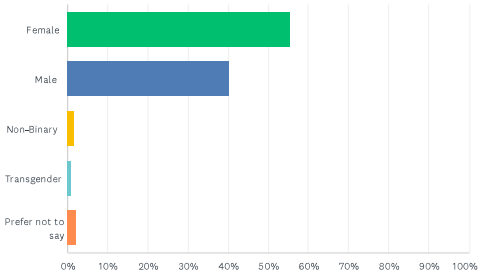
Answered: 358 Skipped: 17



ANSWER CHOICES	RESPONSES	
Yes	43.02%	154
No	49.44%	177
Not sure	1.96%	7
Prefer not to say	5.59%	20
TOTAL		358

Q26 Please indicate your gender

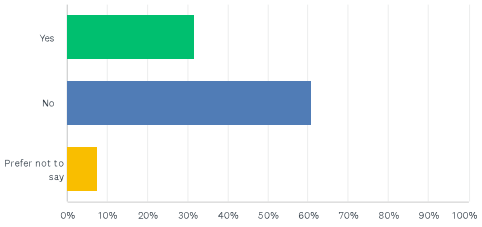
Answered: 360 Skipped: 15



ANSWER CHOICES	RESPONSES	
Female	55.28%	199
Male	40.28%	145
Non-Binary	1.39%	5
Transgender	0.83%	3
Prefer not to say	2.22%	8
TOTAL		360

Q27 Do you self-identify as someone with a physical or developmental disability?

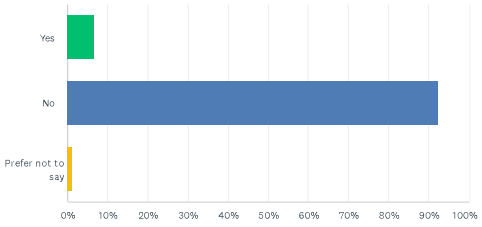
Answered: 359 Skipped: 16



ANSWER CHOICES	RESPONSES	
Yes	31.75%	114
No	60.72%	218
Prefer not to say	7.52%	27
TOTAL		359

Q28 Are you a U.S. Military Veteran of the Army, Navy, Marines, Air Force, or Coast Guard?

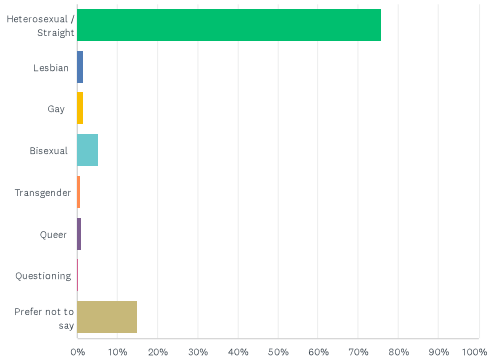
Answered: 360 Skipped: 15



ANSWER CHOICES	RESPONSES	
Yes	6.67%	24
No	92.22%	332
Prefer not to say	1.11%	4
TOTAL		360

Q29 What is your sexual orientation?

Answered: 357 Skipped: 18



ANSWER CHOICES	RESPONSES	
Heterosexual / Straight	75.63%	270
Lesbian	1.40%	5
Gay	1.40%	5
Bisexual	5.04%	18
Transgender	0.56%	2
Queer	0.84%	3
Questioning	0.28%	1
Prefer not to say	14.85%	53
TOTAL		357

Q30 Is there anything else you want to share about what is needed to better support your wellness and recovery?

Answered: 148 Skipped: 227

#	RESPONSES	DATE
1	No	3/18/2022 10:56 AM
2	No	3/18/2022 10:54 AM
3	No	3/18/2022 10:52 AM
4	P.E.	3/18/2022 10:50 AM
5	Parenting	3/18/2022 10:36 AM
6	Help with housing	3/18/2022 10:34 AM
7	No	3/18/2022 10:28 AM
8	Victory outreach	3/18/2022 10:15 AM
9	Thanks BHS <3	3/18/2022 10:12 AM
10	Therapist	3/17/2022 9:26 AM
11	No	3/17/2022 9:23 AM
12	No	3/16/2022 11:10 AM
13	Just want to sincerely thank Jeanette for her kindness, patience and encouragement she is instrumental in my continued journey <3	3/16/2022 11:06 AM
14	I love the work mental health has helped me achieve in my recovery.. THANK YOU!<3	3/16/2022 10:43 AM
15	No im fine.	3/16/2022 10:17 AM
16	Help with jobs to get on feet	3/16/2022 9:09 AM
17	More programs	3/15/2022 3:55 PM
18	Safe environment, communication, understanding of whos, my landlord, lease holder who actually lives in the home, are they mentally stable, do they understand of options for health care/services, county programs.	3/15/2022 3:48 PM
19	Just to fully recover, and take the correct medication	3/15/2022 3:22 PM
20	Need support	3/15/2022 3:18 PM
21	Shelter and food support EBT :)	3/15/2022 3:16 PM
22	Keep the ball rolling	3/15/2022 1:49 PM
23	Help from someone	3/15/2022 1:45 PM
24	No.	3/15/2022 1:41 PM
25	I'd like to thanks god for my life. Amen	3/15/2022 10:12 AM
26	No	3/15/2022 9:26 AM
27	Insurance	3/15/2022 9:23 AM
28	Nice Reception please	3/15/2022 9:19 AM
29	Staff Attitude	3/15/2022 9:15 AM
30	Groups and Classes	3/15/2022 8:42 AM

31	N/A	3/15/2022 8:40 AM
32	N/A	3/15/2022 8:39 AM
33	San Joaquin is in desperate need of peer support in underserved and at risk populations	3/15/2022 8:36 AM
34	te ongoing support i receive at the wellness venter and recovery support groups i attend helps tremendously, to keep my recovery in valance and strong. i need my psychiatrist and clinicians, but i also need peer support. without it, i am at much higher risk of decompensating	3/14/2022 4:34 PM
35	Lived experience	3/14/2022 4:24 PM
36	Updated website that is consumer friendly and consumer approved.	3/14/2022 4:14 PM
37	Emotional Support	3/14/2022 3:48 PM
38	No	3/14/2022 3:26 PM
39	AMOMGUS	3/14/2022 3:23 PM
40	N/A	3/14/2022 2:51 PM
41	NA	3/14/2022 2:50 PM
42	None	3/14/2022 2:49 PM
43	None	3/14/2022 2:47 PM
44	None	3/14/2022 2:30 PM
45	No	3/14/2022 2:23 PM
46	More culturally specific trainings	3/14/2022 2:15 PM
47	Seeing more often	3/14/2022 11:00 AM
48	No	3/14/2022 10:24 AM
49	No thank you	3/14/2022 10:20 AM
50	No	3/14/2022 9:33 AM
51	No	3/14/2022 8:54 AM
52	None	3/11/2022 4:10 PM
53	Talk Therapy and Problem Resolution focus	3/11/2022 4:01 PM
54	no	3/11/2022 3:57 PM
55	BHS has been very good to me throughout the years and I have been coming here.	3/11/2022 3:54 PM
56	Enjoy your life	3/11/2022 3:50 PM
57	Need Help Finding Therapy -	3/11/2022 3:33 PM
58	Nope, we good!	3/11/2022 3:30 PM
59	listen and trust me	3/11/2022 3:23 PM
60	Juices and Snacks	3/11/2022 3:20 PM
61	Pain Medication	3/11/2022 3:18 PM
62	more awareness	3/11/2022 3:12 PM
63	no thanks	3/11/2022 2:55 PM
64	I would like to start my therapy	3/11/2022 2:53 PM
65	love & kindness + understanding from doctor's & willing to work w/ patients needs for recovery	3/11/2022 2:40 PM
66	N/A	3/9/2022 3:29 PM
67	This city needs more programs specific to high functioning autism youth, mild-moderate	3/9/2022 2:08 PM

	developmentally delayed (Not VMRC), more resources and programs for youth with substance disorders	
68	No	3/9/2022 12:55 PM
69	N/A	3/9/2022 11:14 AM
70	No not really	3/9/2022 11:12 AM
71	n/a	3/9/2022 11:08 AM
72	Listen to the patient more not just throw drugs at them.	3/9/2022 11:03 AM
73	I am very stratified with my mental health facility/office	3/9/2022 9:13 AM
74	you great	3/9/2022 9:07 AM
75	need transportation to clinic	3/9/2022 9:00 AM
76	Be yourself!	3/8/2022 3:27 PM
77	N/A	3/8/2022 3:09 PM
78	No just want to be clean	3/4/2022 1:36 PM
79	No	3/4/2022 1:19 PM
80	Get a sponsor.	3/4/2022 8:49 AM
81	No	3/4/2022 8:47 AM
82	Help with filling out applications explaining my mental disability	3/4/2022 8:46 AM
83	Mental health helps me to take care of myself like my mental state of mind with medications help.	3/4/2022 8:43 AM
84	Please keep wellness center open	3/4/2022 8:04 AM
85	No	3/4/2022 8:00 AM
86	Peers in a clinical setting is offering support w/out family.	3/3/2022 3:22 PM
87	More support groups at BHS	3/3/2022 3:20 PM
88	No	3/3/2022 3:11 PM
89	Everything is fine.	3/3/2022 3:07 PM
90	More Humor	3/3/2022 3:03 PM
91	I loss my son to a wreck and drugs. I think we need more help in the city.	3/3/2022 2:58 PM
92	More days open to clients.	3/3/2022 2:52 PM
93	Varied staff - more funding	3/3/2022 2:37 PM
94	Yes	3/3/2022 2:27 PM
95	I must want to move onforward and important duties for my life that I am trying to get out of being homeless.	3/3/2022 2:19 PM
96	None.	3/2/2022 1:57 PM
97	No.	3/2/2022 1:23 PM
98	I would like to explore different options for a psychiatrist	3/2/2022 1:14 PM
99	No	3/2/2022 1:05 PM
100	No	3/2/2022 1:04 PM
101	None at this time.	3/2/2022 10:28 AM
102	The ability to have telephonic / Virtual appointments. Also it'd be cool if there was a patient portal and scheduling system. Kaiser really sucks for mental health services but they're so	3/2/2022 9:23 AM

	convenient. SJC Behavioral Health is top notch thought and hopefully one day they get hip to the skip tech wise. one day!	
103	Tired of thoughts controlled street drugs to make there lies sustainable. pau for there drug and mess making addictions. Tired of being mistreated d/t the jealous, playa haten human trafficking people and unauthorized truth sermon to be set up to fail. I can't take any more fx for there entertainment!	3/2/2022 8:56 AM
104	Better understanding	3/1/2022 4:14 PM
105	No	3/1/2022 4:13 PM
106	No	3/1/2022 4:10 PM
107	More updates on new meds	3/1/2022 2:50 PM
108	Accept my Application	3/1/2022 2:45 PM
109	Being around sober and right minded people income patience friends family responsibilities (not to much)	3/1/2022 2:19 PM
110	N/A	3/1/2022 1:56 PM
111	The truth always set you free!	3/1/2022 1:53 PM
112	A home of my own where I may cook, clean, rest, and do my hobbies w/SSI/SSA and or survivor benefits	3/1/2022 1:41 PM
113	Getting off meds	3/1/2022 1:33 PM
114	Make affordable to all.	3/1/2022 1:10 PM
115	No	3/1/2022 1:07 PM
116	No	3/1/2022 11:01 AM
117	More Black People! Especially Men!	3/1/2022 10:12 AM
118	No.	3/1/2022 10:08 AM
119	Continues Meds	3/1/2022 9:43 AM
120	None	3/1/2022 9:32 AM
121	No	3/1/2022 9:17 AM
122	None	3/1/2022 9:04 AM
123	N/A	3/1/2022 8:49 AM
124	I need my own home	3/1/2022 8:43 AM
125	CANDY ALWAYS HELPS!!!	3/1/2022 8:28 AM
126	No.	3/1/2022 8:20 AM
127	Nope	3/1/2022 8:14 AM
128	Just need to speak to my counselor more	3/1/2022 8:08 AM
129	Thank you	3/1/2022 8:03 AM
130	Progress reports to Steve Ryan - A place central valley has funding available	3/1/2022 8:00 AM
131	I'm thankful to be here blessed. Saved my life the issues are small and everyone of the staff are good hardworking people. Thankful this program is here. Not alot of successful programs in thhis area or easy to get into.	2/28/2022 4:18 PM
132	I like it here.	2/28/2022 4:10 PM
133	More wrap groups	2/28/2022 2:50 PM
134	Services in the southside of town	2/28/2022 2:48 PM
135	More celebrations and community events	2/28/2022 2:45 PM

136	Explaining to the client why a prescription is being prescribed after not fully evaluating the client or offering different services if they chose to not take the medication and want more time.	2/28/2022 2:16 PM
137	Just eat and exercise and do healthier things as much as you can	2/28/2022 1:47 PM
138	Waiting for Appointment	2/28/2022 1:42 PM
139	More income and support	2/28/2022 1:31 PM
140	Put forth the effort to keep trying and all Things can become possible for you to accomplish and don't give up.	2/28/2022 1:17 PM
141	Find a psychologist to see.	2/28/2022 11:26 AM
142	N/A	2/28/2022 11:24 AM
143	Jobs / Place to Live Homes	2/28/2022 11:11 AM
144	One day at a time	2/28/2022 11:07 AM
145	Appointment Reminders	2/28/2022 10:32 AM
146	N/A	2/28/2022 10:27 AM
147	Please have books	2/28/2022 9:36 AM
148	Let me go to store to buy things for myself.	2/28/2022 9:29 AM

SAN JOAQUIN COUNTY
Behavioral Health Services

Encuesta de la MHSA 2021- 2022 Para Consumidores y Partes Interesadas

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 los materiales informativos de BHS, tales como volantes, folletos o el sitio web?

Necesita mejorar	Razonable	Bien	Muy Bien	Excelente
★	★	★	★	★

Si seleccionó “Necesita Mejorar”: ¿Qué cambios le gustaría ver?

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
★	★	★	★	★

Si seleccionó “Necesita Mejorar”: ¿Qué tipos de intervenciones individuales o en grupo le gustaría ver?

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

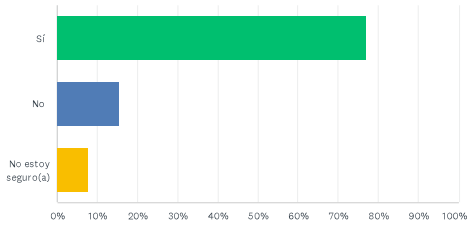
29. ¿Usted se identifica como Lesbiana, Gay, Bisexual, Transgénero, u Homosexual/Cuestionándose (LGBTQ)?

- 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?

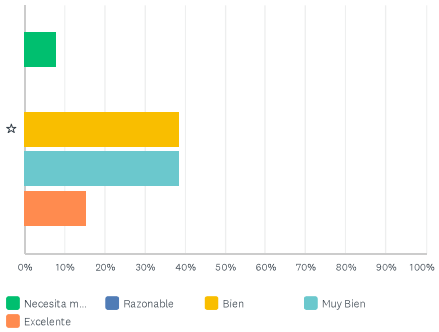
Answered: 13 Skipped: 0



ANSWER CHOICES	RESPONSES	
Sí	76.92%	10
No	15.38%	2
No estoy seguro(a)	7.69%	1
TOTAL		13

Q2 ¿Cómo calificaría la ubicación de donde proveemos nuestros servicios?

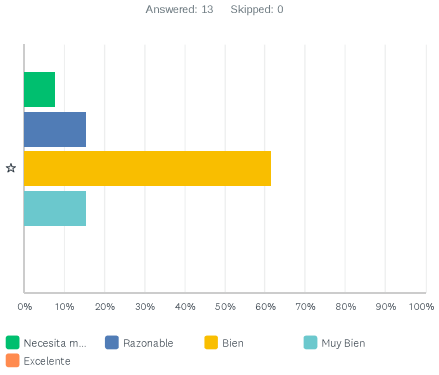
Answered: 13 Skipped: 0



	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	7.69% 1	0.00% 0	38.46% 5	38.46% 5	15.38% 2	13	3.54

Q3 ¿Cómo calificaría los materiales informativos de BHS, tales como volantes, folletos o el sitio web?

Answered: 13 Skipped: 0

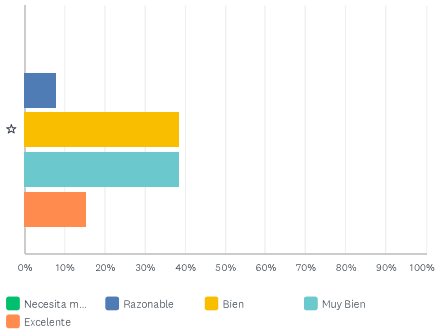


	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	7.69% 1	15.38% 2	61.54% 8	15.38% 2	0.00% 0	13	2.85

#	SI SELECCIONÓ "NECESITA MEJORAR": ¿QUÉ CAMBIOS LE GUSTARÍA VER?	DATE
1	Bien, No mas medicamento	3/17/2022 9:33 AM
2	Es muy puca o case nada	3/9/2022 4:25 PM

Q4 ¿Cómo calificaría la duración para recibir una cita?

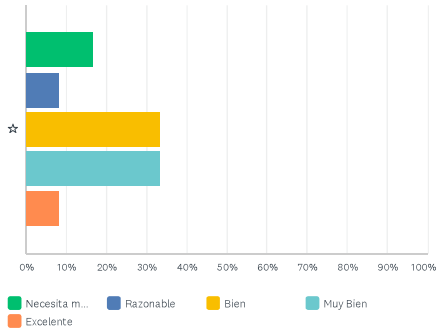
Answered: 13 Skipped: 0



	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	0.00% 0	7.69% 1	38.46% 5	38.46% 5	15.38% 2	13	3.62

Q5 ¿Cómo calificaría los tipos de intervención en grupo o individual que son ofrecidos?

Answered: 12 Skipped: 1

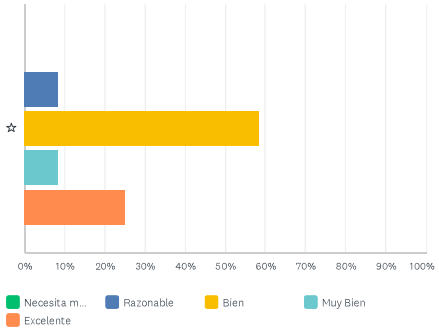


	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	16.67% 2	8.33% 1	33.33% 4	33.33% 4	8.33% 1	12	3.08

#	SI SELECCIONÓ "NECESITA MEJORAR": ¿QUÉ TIPOS DE INTERVENCIONES INDIVIDUALES O EN GRUPO LE GUSTARÍA VER?	DATE
1	Necesito mejoran y quiero participan en solo un grepo	3/17/2022 9:33 AM
2	Pues Mejoror (well, improve)	3/17/2022 8:27 AM
3	Todavia Sigo esporads apoyo. como madre del paumte	3/9/2022 4:25 PM

Q6 ¿Cómo calificaría la rigurosidad de los servicios proporcionados?

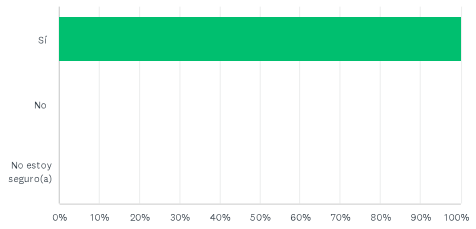
Answered: 12 Skipped: 1



	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	0.00% 0	8.33% 1	58.33% 7	8.33% 1	25.00% 3	12	3.50

Q7 ¿Recomendaría nuestros servicios a gente que necesite ayuda por una preocupación relacionada a la salud mental o consumo de sustancias?

Answered: 12 Skipped: 1



ANSWER CHOICES	RESPONSES	
Sí	100.00%	12
No	0.00%	0
No estoy seguro(a)	0.00%	0
TOTAL		12

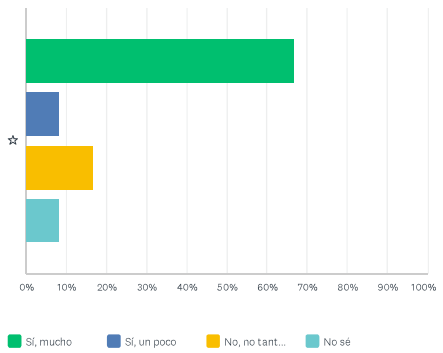
Q8 ¿Qué servicios o apoyos necesitan el mayor mejoramiento y qué puede hacer BHS para mejorarlos?

Answered: 6 Skipped: 7

#	RESPONSES	DATE
1	Comunication con los padre, thermanosy	3/17/2022 9:33 AM
2	Medicina al paciente, mejoror (improve the medications to the patients)	3/17/2022 8:27 AM
3	No se, reciente estoy aqui.	3/11/2022 8:04 AM
4	Que responda ion mas prontitud. Tanto uns de padre o Madre a fronte rlas con estas cituauaus de salud mental en los hijos	3/9/2022 4:25 PM
5	Aqui Todos los servieios son buenos y amudein mucho a los que le neresiten	3/9/2022 3:19 PM
6	No se como contestar.	3/1/2022 1:24 PM

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?

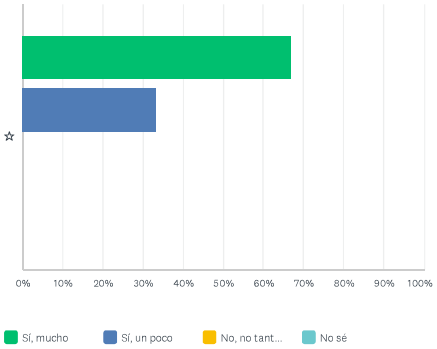
Answered: 12 Skipped: 1



	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	66.67% 8	8.33% 1	16.67% 2	8.33% 1	12	1.67

Q10 ¿Los empleados de BHS son amables y profesionales?

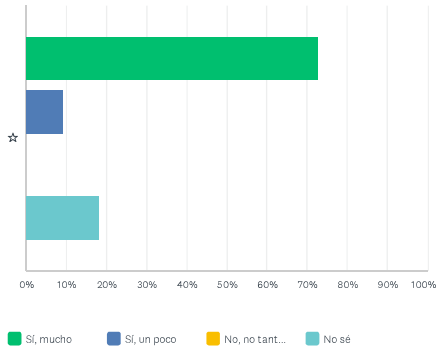
Answered: 12 Skipped: 1



	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	66.67% 8	33.33% 4	0.00% 0	0.00% 0	12	1.33

Q11 ¿Los empleados de BHS son respetuosos de su patrimonio cultural?

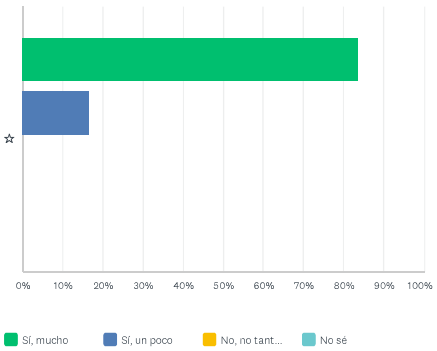
Answered: 11 Skipped: 2



	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	72.73% 8	9.09% 1	0.00% 0	18.18% 2	11	1.64

Q12 ¿Los empleados de BHS explican las cosas de una manera que le gusta y endiente?

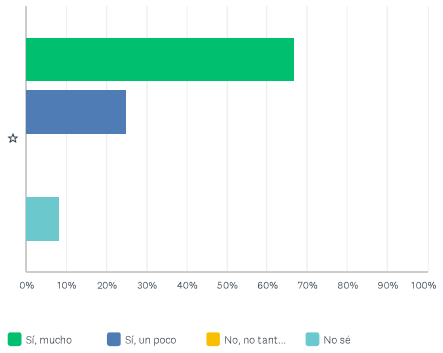
Answered: 12 Skipped: 1



	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	83.33% 10	16.67% 2	0.00% 0	0.00% 0	12	1.17

Q13 ¿Los programas de BHS son útiles para muchos tipos de gente?

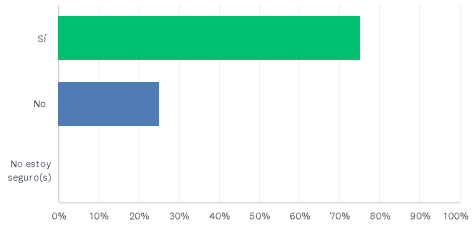
Answered: 12 Skipped: 1



	SÍ, MUCHO	SÍ, UN POCO	NO, NO TANTO	NO SÉ	TOTAL	WEIGHTED AVERAGE
☆	66.67% 8	25.00% 3	0.00% 0	8.33% 1	12	1.50

Q14 ¿Usted o algún familiar ha usado los servicios de interpretación de BHS?

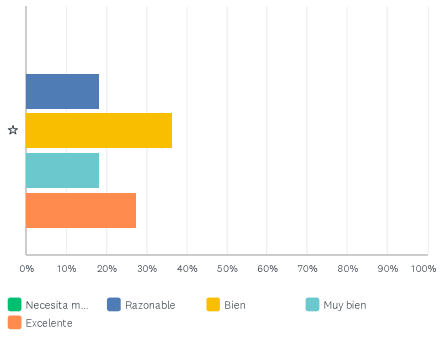
Answered: 12 Skipped: 1



ANSWER CHOICES	RESPONSES	
Sí	75.00%	9
No	25.00%	3
No estoy seguro(s)	0.00%	0
TOTAL		12

Q15 Si ha usados los servicios de interpretación de BHS, ¿cómo describiría la calidad de los servicios de interpretación?

Answered: 11 Skipped: 2



	NECESITA MEJORAR	RAZONABLE	BIEN	MUY BIEN	EXCELENTE	TOTAL	WEIGHTED AVERAGE
☆	0.00% 0	18.18% 2	36.36% 4	18.18% 2	27.27% 3	11	3.55

Q16 ¿Cuál es el factor MÁS importante que contribuye al bienestar y recuperación?

Answered: 9 Skipped: 4

#	RESPONSES	DATE
1	Hpvenim mas a salud mental y que me dejeh en paz	3/17/2022 9:33 AM
2	Medicina (Medication)	3/17/2022 8:27 AM
3	La sicologos q siquiatras	3/11/2022 8:25 AM
4	Hablar las cosas con sinceridad	3/11/2022 8:04 AM
5	La buena comunicacion	3/9/2022 4:25 PM
6	Es la comunicacion sobre todo la union familiar compreencion	3/9/2022 3:19 PM
7	Provccdor - informacion	3/1/2022 1:30 PM
8	no	3/1/2022 1:25 PM
9	visitas con la psiquiarta	3/1/2022 1:24 PM

Q17 ¿Cuál es el SEGUNDO factor más importante que contribuye al bienestar y recuperación?

Answered: 9 Skipped: 4

#	RESPONSES	DATE
1	comermejon sane	3/17/2022 9:33 AM
2	Teraia sera (Therapy Perhaps)	3/17/2022 8:27 AM
3	Ponev de su parte d paccente	3/11/2022 8:25 AM
4	Comunicacion	3/11/2022 8:04 AM
5	a cudor a las cilas	3/9/2022 4:25 PM
6	siempre comunicourse con la familia	3/9/2022 3:19 PM
7	constancia	3/1/2022 1:30 PM
8	no	3/1/2022 1:25 PM
9	visitas con la psicologa	3/1/2022 1:24 PM

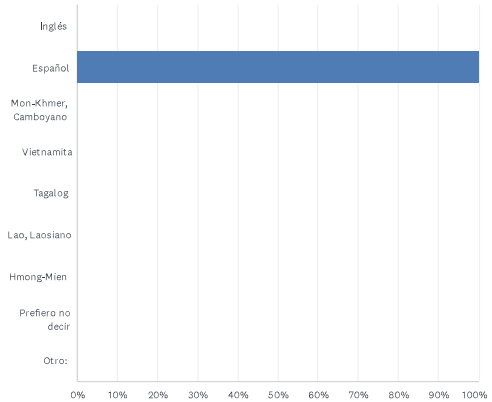
Q18 ¿Cuál es el TERCER factor más importante que contribuye al bienestar y recuperación?

Answered: 9 Skipped: 4

#	RESPONSES	DATE
1	que me entienden que jo conozeo mis deneches	3/17/2022 9:33 AM
2	Medicina (Medication)	3/17/2022 8:27 AM
3	La confianza que dan los profesionales	3/11/2022 8:25 AM
4	Honestidad	3/11/2022 8:04 AM
5	darle seguimiento a los casas	3/9/2022 4:25 PM
6	union familiar y siempre ayuner para que salga adelente.	3/9/2022 3:19 PM
7	desicion de pedio ayuda	3/1/2022 1:30 PM
8	no	3/1/2022 1:25 PM
9	servicios de interpretacion	3/1/2022 1:24 PM

Q19 Por favor indique el idioma que se habla con más frecuencia en su hogar (por favor elija solo uno):

Answered: 13 Skipped: 0



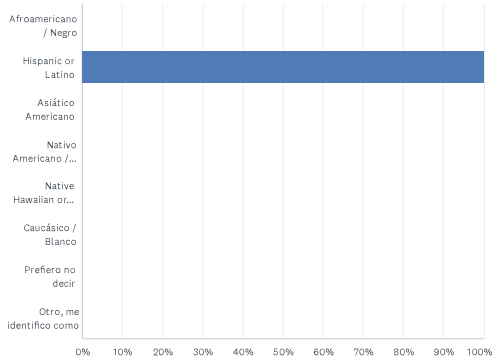
ANSWER CHOICES	RESPONSES	
Inglés	0.00%	0
Español	100.00%	13
Mon-Khmer, Camboyano	0.00%	0
Vietnamita	0.00%	0
Tagalog	0.00%	0
Lao, Laosiano	0.00%	0
Hmong-Mien	0.00%	0
Prefiero no decir	0.00%	0
Otro:	0.00%	0
TOTAL		13

#	OTRO:	DATE

	There are no responses.	

Q20 ¿Cuál es su raza?

Answered: 11 Skipped: 2

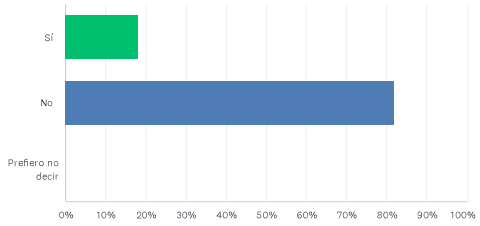


ANSWER CHOICES	RESPONSES	
Afroamericano / Negro	0.00%	0
Hispanic or Latino	100.00%	11
Asiático Americano	0.00%	0
Nativo Americano / Primeras Naciones (incluyendo Hawaiano o Natal de Alaska)	0.00%	0
Native Hawaiian or other Pacific Islander	0.00%	0
Caucásico / Blanco	0.00%	0
Prefiero no decir	0.00%	0
Otro, me identifico como	0.00%	0
TOTAL		11

#	OTRO, ME IDENTIFICO COMO	DATE
	There are no responses.	

Q21 ¿Actualmente está desamparado o en riesgo de estar desamparado?

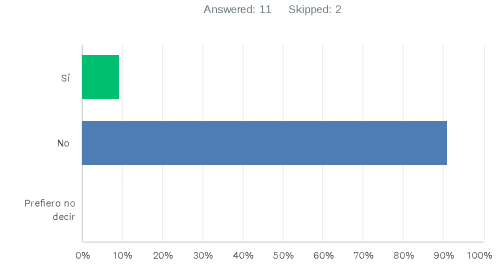
Answered: 11 Skipped: 2



ANSWER CHOICES	RESPONSES	
Sí	18.18%	2
No	81.82%	9
Prefiero no decir	0.00%	0
TOTAL		11

Q22 ¿En los últimos tres años ha estado desamparado por más de un año o ha experimentado estar desamparado más de cuatro veces?

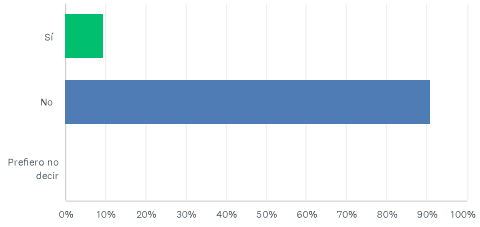
Answered: 11 Skipped: 2



ANSWER CHOICES	RESPONSES	
Sí	9.09%	1
No	90.91%	10
Prefiero no decir	0.00%	0
TOTAL		11

Q23 ¿Ha sido arrestado(a) o detenido(a) por la policía?

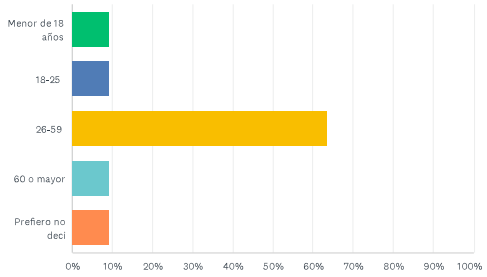
Answered: 11 Skipped: 2



ANSWER CHOICES	RESPONSES	
Sí	9.09%	1
No	90.91%	10
Prefiero no decir	0.00%	0
TOTAL		11

Q24 Por favor indique su edad:

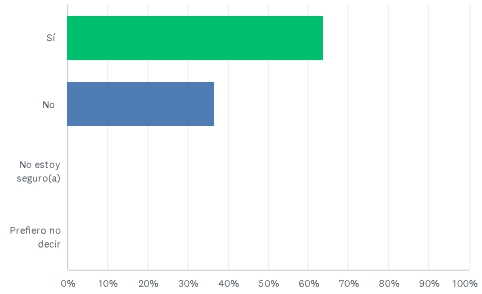
Answered: 11 Skipped: 2



ANSWER CHOICES	RESPONSES	
Menor de 18 años	9.09%	1
18-25	9.09%	1
26-59	63.64%	7
60 o mayor	9.09%	1
Prefiero no deci	9.09%	1
TOTAL		11

Q25 ¿Es padre o a punto de ser padre?

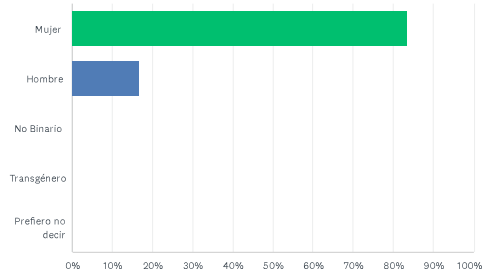
Answered: 11 Skipped: 2



ANSWER CHOICES	RESPONSES	
Sí	63.64%	7
No	36.36%	4
No estoy seguro(a)	0.00%	0
Prefiero no decir	0.00%	0
TOTAL		11

Q26 Por favor indique su género

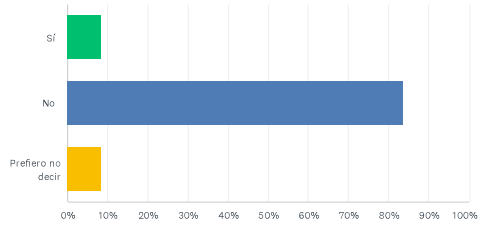
Answered: 12 Skipped: 1



ANSWER CHOICES	RESPONSES	
Mujer	83.33%	10
Hombre	16.67%	2
No Binario	0.00%	0
Transgénero	0.00%	0
Prefiero no decir	0.00%	0
TOTAL		12

Q27 ¿Usted se identifica como alguien con una discapacidad física o del desarrollo?

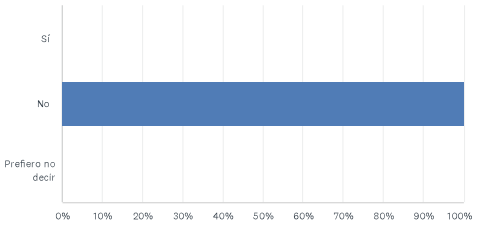
Answered: 12 Skipped: 1



ANSWER CHOICES	RESPONSES	
Sí	8.33%	1
No	83.33%	10
Prefiero no decir	8.33%	1
TOTAL		12

Q28 Si es un adulto, ¿es un Veterano Militar Estadunidense, Naval, Marina, Fuerza Aérea o Guardacostas?

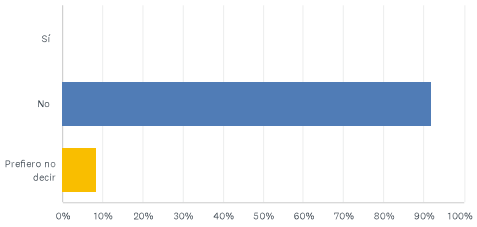
Answered: 12 Skipped: 1



ANSWER CHOICES	RESPONSES	
Sí	0.00%	0
No	100.00%	12
Prefiero no decir	0.00%	0
TOTAL		12

Q29 ¿Usted se identifica como Lesbiana, Gay, Bisexual, Transgénero, u Homosexual/Cuestionándose (LGBTQ)?

Answered: 12 Skipped: 1



ANSWER CHOICES	RESPONSES	
Sí	0.00%	0
No	91.67%	11
Prefiero no decir	8.33%	1
TOTAL		12

Q30 ¿Hay alguna otra cosa que quisiera compartir sobre qué se necesitaría para apoyar de mejor manera su bienestar y recuperación?

Answered: 6 Skipped: 7

#	RESPONSES	DATE
1	No	3/17/2022 9:33 AM
2	No	3/17/2022 8:27 AM
3	N/A	3/11/2022 8:04 AM
4	Que imbolucren alos padres en tallerus de como manarar la inteligencia emocional de los hijos en mi cueso soparte, ajesoial	3/9/2022 4:25 PM
5	No, muchisimas gracias ahorita estamos mucho mejor.	3/9/2022 3:19 PM
6	no	3/1/2022 1:25 PM

SAN JOAQUIN COUNTY

Greatness grows here.

San Joaquin County Behavioral Health Services Mental Health Services Act 2022-23 Annual Update

Public Hearing – Behavioral Health Board

May 18, 2022

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

Component 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/Early Interventions
  - Children, Youth, and Families
  - Adults and Older Adults
  - Trauma Services for Adults
  - School-Based Interventions
- Reducing Stigma & Discrimination
- Increasing Recognition of Mental Illnesses
- Suicide Prevention
  - Schools
  - Community-wide

MHSA Annual Update Planning Activities

- Community Planning Meetings – January 2022
- Consumer Discussion Groups – January 2022
- Stakeholder Surveys – Feb/March – 423 (2022) vs. 117 (2021)
- Key Informant Interviews – March 2022
- MHSA Consortium – January and February
- Cultural Competency Committee, QAPI Council, BHS Managers – February 2022
- Behavioral Health Board – December, January, February, April
- Draft Plan for 30-day Public Review - April 18 – May 18
- Public Hearing at Behavioral Health Board - May 18, 2022
- Presentation to the Board of Supervisors - June 2022

Highlights of 2022-23 MHSA Annual Update

- Documentation of Outcomes & Challenges in CSS programs
- FSP Clients served in each age group and projected clients to be served for the next 3 years
- Funding to expand Intensive FSP Teams
- Funding to expand Wellness Center into North and South County
- Expand supportive services for Independent Living and Interpersonal Skills programming
- NEW PEI PROJECT – Prevention for Children 0-5
- Funding to expand Community Trauma Services for Adults
- Fund 15.5 Million in Project Based Housing

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 Luke Vlavianos at the end of this meeting

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 Approval**
  - June 2022 (*Anticipated)*

THANK YOU!

Send Further Comments to:

mhsacomments@sjcbhs.org

Angelo Balmaceda
MHSA Coordinator
abalmaceda@sjcbhs.org