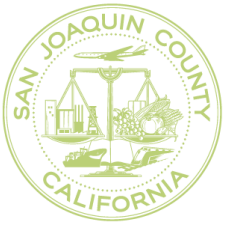


SAN JOAQUIN COUNTY

Greatness grows here.

San Joaquin County
Behavioral Health Services

Mental Health Services Act (MHSA)

Three-Year Program and Expenditure Plan
FY 2020-21, 2021-22, 2022-23

Date: July 17, 2020

Board of Supervisors Approval: September 1, 2020

SAN JOAQUIN COUNTY

MHSA FISCAL ACCOUNTABILITY CERTIFICATION

County/City: SAN JOAQUIN COUNTY

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

☐ Annual Update

☐ Annual Revenue and Expenditure Report

Local Mental Health Director		**County Auditor-Controller / City Financial Officer**	
Name:	Tony Vartan	Name:	Jerome C. Wilverding
Telephone Number:	209-468-8750	Telephone Number:	209-468-3925
E-mail:	tvartan@sjcbhs.org	E-mail:	jwilverding@sjgov.org
Local Mental Health Mailing Address:			
1212 N. California St. Stockton CA 95202			

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

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

Tony Vartan, _____ 7/29/2020
Mental Health Director Signature Date

I hereby certify that for the fiscal year ended June 30, 2019, 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, 2019. I further certify that for the fiscal year ended June 30, 2019, 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.

Jerome C. Wilverding, _____ 7-17-20
County Auditor Controller Signature Date

SAN JOAQUIN COUNTY
MHSA COMPLIANCE CERTIFICATION

County/City: SAN JOAQUIN COUNTY

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

☐ Annual Update

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

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

This 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 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 Three-Year Program and Expenditure Plan, attached hereto, was adopted by the County Board of Supervisors on 9/1/2020.

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 Three Year Program and Expenditure Plan are true and correct.

Tony Vartan, _____ 7/29/2020.
Mental Health Director Signature Date

Preface Statement

This Three-Year Mental Health Services Act (MHSA) Plan, developed by the San Joaquin County Behavioral Health Services (BHS) in Spring 2020, presents a continuation of most MHSA projects included in 2019-20 with other program edits being kept to a minimum. The Plan is intended to take a conservative approach to programming and limits changes from the prior year's Plan due to the uncertainty of the economy in the midst of the COVID-19 crisis.

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

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

A high-level summary of the changes in the 2020-23 plan's expenditures are included below:

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

Table of Contents

I. Introduction

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

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

- Prevention and Early Intervention (PEI),
- Community Services and Supports (CSS),
- Workforce Education and Training (WET),
- Innovation (INN), and
- 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, as well as address specific needs related to 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 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 9/1/2020.

All San Joaquin County MHSA plans may be reviewed at www.sjcbhs.org.

MHSA Program Priorities

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

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.

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 for consumers receiving mental health services and to reflect upon what is working for the diverse range of consumers served. The following activities were conducted to gather information regarding current services and to provide recommendations on the need for updates and revisions.

Quantitative Analysis:

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

Community Discussions:

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

Targeted Discussions:

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

Consumer and Stakeholder Survey:

9. 2019-20 MHSA Consumer and Stakeholder Survey

Assessment of Mental Health Needs

Population Served

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

Mental Health Services Provided in 2018-19

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

*Source: BHS Client Services Data

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

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

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

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

rates lower than is to be expected, compared to their proportion of the general population (27% of participants versus 42% of the population). Asian participants are also underrepresented by 7%.

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

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

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

Discussion Group Input and Stakeholder Feedback

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

Community Program Planning for 2019-20:

MHSA Showcase of Programs and Services Event

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

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

Behavioral Health Board Agenda Items

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

Community and Consumer Discussion Groups

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

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

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

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

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

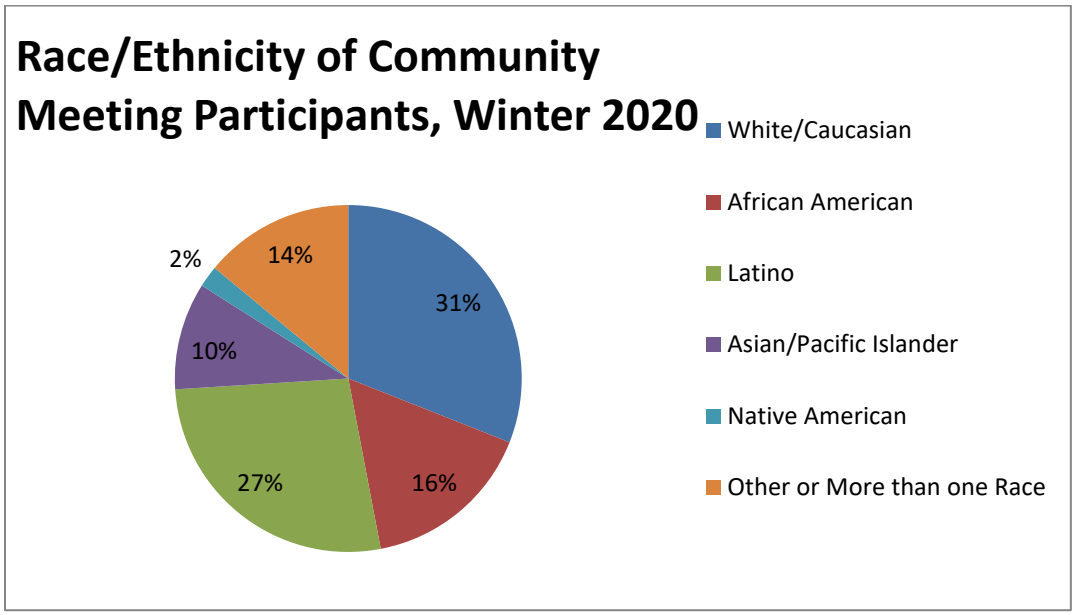
Community Discussion Groups were also attended by the following individuals representing the following groups:

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

- Health care providers
- Advocates for consumers

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

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



Survey Input and Stakeholder Feedback

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

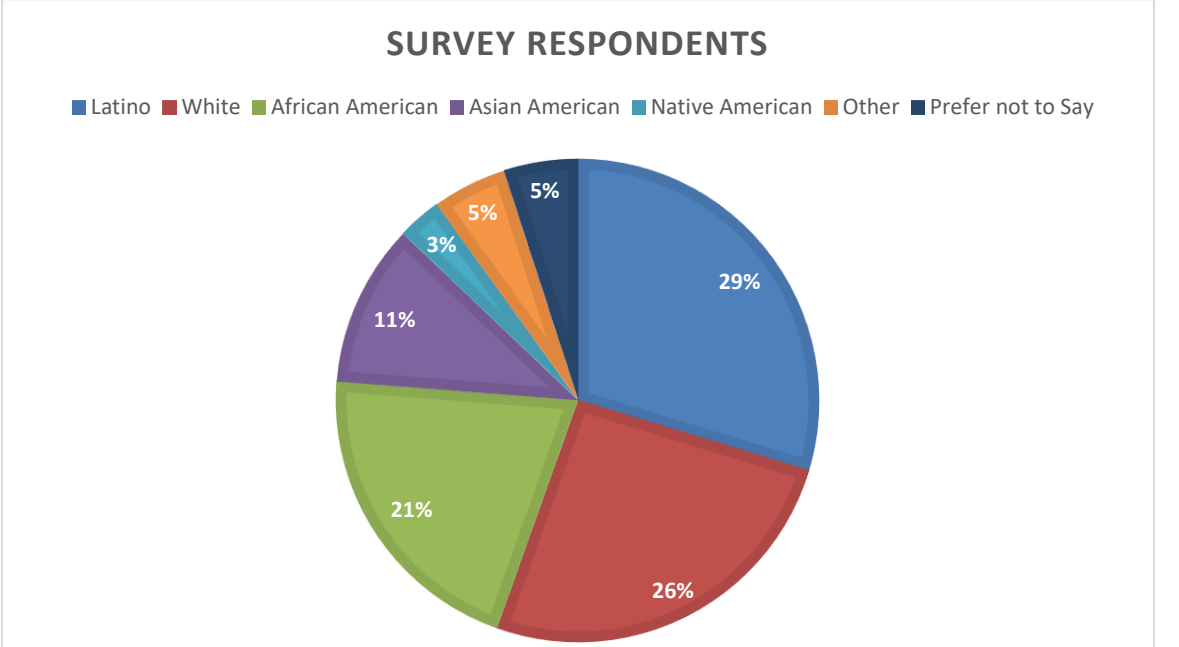
BHS consumers and their family members reported high levels of satisfaction with the services provided to address mental health and/or substance use disorder concerns, with 90% of the respondents reporting that they would recommend BHS services to others. Respondents to the surveys reported that the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

with statements regarding staff courtesy and professionalism, respect of cultural heritage, and the capacity to explain things in an easily understood manner.

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

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

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



Self-Reported Age/Gender of Stakeholder Respondents

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

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

The 502 respondents surveyed represent the broad diversity of stakeholders and consumers served by Behavioral Health Services. Most consumers have children, with 55% describing themselves as parents.

Consistent with the general population, 10% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQQI). Many have a disability, with 38% describing themselves as having a physical or developmental disability. Few are military veterans, with only 7% reporting that they had served in the US Armed Forces. Twenty percent (20%) of consumers reported experiencing homelessness more than four times or being homeless for at least a year; thirty five percent (35%) of respondents reported having been arrested or detained by the police.

Community Mental Health Issues

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

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

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

Recommendations to Strengthen Services for Children and Youth:

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

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

Stakeholders expressed the most concern for transition age youth who are easily missed by system partners such as those that have exited the foster care system, are college-age, or are from communities that are historically unserved or underserved by mental health services. Stakeholders identified some existing resources for transition age youth, but overall stated that outside of a few specialty treatment programs, most interventions target either children and youth, or adults. Despite these gaps, stakeholders remain optimistic that current resources can be leveraged in a better way to serve transitional age youth.

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

Recommendations to Strengthen Services for Transition Age Youth

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

funding for programs to address the behavioral health needs of transition age youth and adults experiencing or recovering from traumatic situations.

Key Issues for Adults

Consumers and stakeholders discussed the challenges of being homeless while recovering from a mental illness, and the need to develop more housing for people with mental illnesses. Criminal justice partners echoed the frustrations of consumers and family members regarding the need for increased housing options to prevent homelessness. Consumers expressed frustration that it is still difficult to find reliable information on the services and supports that are available, and asked BHS to consider different approaches to talking about mental health and the services available in the community .

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

Recommendations to Strengthen Services for Adults

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

- BHS should create more treatment and residential programs that work specifically with individuals diagnosed with co-occurring disorders.

Key Issues for Older Adults

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

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

Recommendations to Strengthen Services for Older Adults:

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

- Broaden suicide prevention efforts to target the adult community. Include targeted prevention information for middle age and older adult men. Address handgun and firearm safety when living with loved ones experiencing depression.

III. Public Review of 2020-23 MHSA Three Year Program and Expenditure Plan

Dates of the 30 day Review

The document was posted for review on the San Joaquin County Behavioral Health Services website at www.sjcbhs.org/mhsa/mhsaplan on May 15, 2020. Circulation was initiated May 15, 2020. The public review closed on June 17, 2020.

Comments are accepted via e-mail to: mhsacomments@sjcbhs.org

or via postal mail to:

San Joaquin County Behavioral Health Services
Attn: MHSA Planning Coordinator
1212 N. California St.
Stockton CA, 95202

Methods of Circulation

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

Public Hearing

June 17, 2020
5:00pm – 7:00pm
***1212 N. California St.**
Conference Rooms B & C
Stockton, CA 95202

*Due to COVID-19 limitations on gatherings, we may conduct a public meeting via zoom. If you would like to be informed whether we will be conducting an in-person or zoom meeting, please provide your contact email address to Isabel Espinosa – iespinosa@sjcbhs.org so that you may be notified via email.

A Public Hearing was held on Wednesday, June 17, 2020 in conjunction with the regularly scheduled Behavioral Health Board Meeting.

The San Joaquin County Board of Supervisors accepted the 2020-23 MHSA Three Year Program and Expenditure Plan on September 1, 2020.

Substantive Public Comments:

During the public comment period, we received several public comments. Written comments and feedback received to the MHSA Three Year Plan are included in the Appendix. Comments included and summarized below:

Written comments were received from:

- Jami L. Alexander, M.S. Director of Family Services – Child Abuse Prevention Council

  Funding for youth in foster care programs. Funding for programs such as CASA (Court Appointed Special Advocates) for Children via the Child Abuse Prevention Council. CASA advocates for youth in foster care in regards to their mental health needs, educational needs and have assisted and supported the youth in regards to justice issues and dual dependency.

- Bai Trieu, Chairman of the Board – VIVO

  There is a thriving and dense Asian population within San Joaquin County, however they are still limited in terms of receiving treatment services from the community. Even after the end of last BHS grant to VIVO Stockton, since July 1st, 2019, we have been continuing to receive phone calls from the community informing us of clients' frustrations in receiving treatment. The statements were that clients found it difficult to find reliable support who can speak their languages and who are readily available to provide mental health treatment or advice to these clients.

- Nicholas Hatten – ReInvent South Stockton Coalition

  Form an African American Cultural Competency Committee that is composed of community, clients and BHS representation that meets on a monthly basis. End the practice of online cultural competence training and hire African American Culturally Competent CBO's to offer these trainings. Create an African American crisis rapid response policy, in partnership with the African American community, all police departments and all school districts, and hire African American Culturally Competent CBO's & faith based organizations to participate in mobile crisis responses. Increase PEI funding and diversify your CBO & faith-based organizations portfolio that is funded to provide services for the African American Community. There is currently 10 million dollars not accounted for within this year's budget. We demand that those funds go to preventative mental illness services for demographics (African American, LatinX, Asian/Pan Pacific, Native American and LGBT+) that these funds are intended for.

- Lani Schiff-Ross, LCSW Director First 5 San Joaquin

  The exhaustive community research reported in the MHSA three-year plan states, "Strengthening services and supports for children and you and their families remains a major concern in San

Joaquin County." (pg. 15). In the vein of strengthening services and supports for children, it is critical to engage partnerships with agencies that are already doing this work. In addressing the recommendation, First 5 San Joaquin (F5SJ) asks for consideration for funding of the already existing HMG Call Center, which addresses the stakeholder recommendations and would be able to expand services through additional funding. HMG staff are qualified to conduct appropriate assessments and work with families to outline an action plan to ensure their children (ages 0-5) received all the services and supports necessary to thrive. The HMG model is a comprehensive, county-based system for early identification, referral and care coordination for children at risk for developmental delays and behavioral health concerns.

- Kimberly Warmsley, Senior Project Coordinator – Reinvent South Stockton Coalition

  Improve and open the line of communication with marginalized communities. Formulate a community lead coalition of stakeholders in order to engage BHC staff surrounding quality of services. Increase and expand opportunities for other culturally specific CBO ability to apply for RFP's. Also improve BHC outreach when RFP's come out. Innovation funding should seek to improve innovate means of providing service to communities that have or impacted through environmental trauma, homelessness and cultural/subcultural barriers. The implications of COVID 19 have compromised BHC's ability to expand and gather insight, suggestions and feedback from stakeholders. Due to the implications of COVID 19, can BHC ask for an extension to submit the proposal so that more information can be sought out from the community and stakeholders. More discussion surrounding funding allocations for preventative substance abuse services and interventions. Consideration for community based organizations and targeted communities to provide educational services and preventative programming in order to create rapport, and then hand off to BHC for more intensive interventions. (The allocation of more funding. Allocation for affordable housing to include wrap around services. Expand contractual opportunities for other CBO's that are also doing the work.

- Amy Portello Nelson – Reinvent South Stockton Coalition

  Please dedicate time and funding to have a robust, ongoing community engagement strategy that is as diverse as San Joaquin County. We need conversations that are led by community leaders (not county staff) so they can be adaptive, culturally relevant and follow up with direct supports. We need more communication about what resources are available and how people can engage in conversations around this issue. It takes a deep level of trust and vulnerability to share about these issues publicly. The County can't expect large numbers of people to share to strangers at open forums a few times a year. Please invest in more local organizations that are serving the community with clinical and non-clinical forms of healing. Fund more community-based organizations to do this work as partners. Instead of simply trying to hire a more diverse BHS staff, invest in the community that is already listening to their voices, speaking their languages, and know their stories. Invest more funds into community projects that will help address social determinants of health, including more counselors and nonprofits focused on

restorative justice in schools, community led activities in parks and community centers, community outreach workers based at CBO's who can refer to social or health services as needed. All of these things heal the community, but they also give our residents a sense of purpose and connection.

- Virginia A. Wimmer, SMSgt USAF (Ret), MSW, CVSO – Deputy Director, Veterans Service Office, San Joaquin County

  San Joaquin County Veterans Service Office (VSO) provides mental health outreach services that promote programs that encourage early intervention of mental health needs for veterans and their families. The VSO assists veterans in applying for, receiving Federal VA benefits. VSO serves and advocates for 32,000 veterans and their dependents. We educate the community about the mental health issues that can affect transitioning service members from military life. VSO collaborates with community based veteran service organizations to ensure they are afforded the opportunity to participate in Mental Health First Aid and Applied Suicide Intervention Training Workshops. Through increased training opportunities – the veteran's community is better equipped to mitigate suicide, and provide support during a mental health crisis. As part of the collaboration of federal, state, community, and County agencies VSO is able to carry out these duties and actions on a limited and stifled budget and with part time temporary staffing levels.

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 comments received during this period will be incorporated into ongoing implementation activities and will help guide future planning efforts. Specific actions taken as a result of public comments include:

i. A review of School-Based Community Service Agreement language, to be released post COVID-19, to ensure that trauma, adverse childhood experiences, and experiences of racism, social inequality and injustice will be addressed in existing programs

ii. A review of upcoming Request for Proposals/Qualifications/Applications to further explore opportunities to engage community partners

iii. Discussions with cultural-based organizations, community leaders and coalition representatives to further explore opportunities for collaboration.

IV. MHSA Component Funding for FY 2020-23

MHSA Component Worksheets describe the total planned expenditures for Fiscal Years 2020-23

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 2020/21 Mental Health Services Act Annual Update
Funding Summary

County: San Joaquin County

Date: 5/13/2020

	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 2020/21 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	35,528,568	14,425,664	13,507,174	404,234	7,914,627	
2. Estimated New FY 2020/21 Funding	29,754,035	7,438,509	1,957,502			
3. Transfer in FY 2020/21	(6,041,337)			500,000	5,541,337	0
4. Access Local Prudent Reserve in FY 2020/21						
5. Estimated Available Funding for FY 2020/21	59,241,266	21,864,173	15,464,676	904,234	13,455,964	
B. Estimated FY 2020/21 MHSA Expenditures	46,498,584	14,295,135	3,905,412	532,498	7,124,058	
G. Estimated FY 2020/21 Unspent Fund Balance	12,742,682	7,569,038	11,559,264	371,736	6,331,906	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2019	12,160,831
2. Contributions to the Local Prudent Reserve in FY 2019/20	184,599
3. Distributions from the Local Prudent Reserve in FY 2019/20	(5,405,564)
4. Estimated Local Prudent Reserve Balance on June 30, 2020	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 2020/21 Mental Health Services Act Annual Update
Community Services and Supports (CSS) Funding

County: San Joaquin Date: 5/13/2020

	Fiscal Year 2020/21					
	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	9,512,579	7,888,632	1,622,997			950
2. Transitional Age Youth FSP	811,219	484,337	325,882			1,000
3. Adult FSP	8,871,511	5,010,352	3,845,609			15,550
4. Older Adult FSP	1,415,656	938,691	476,715			250
5. Community Corrections FSP	1,610,775	1,307,639	302,036			1,100
6. InSPIRE FSP	686,859	573,109	112,750			1,000
7. Intensive Adult FSP	2,020,000	2,020,000				
8. Intensive Justice Response FSP	2,020,000	2,020,000				
9. Housing Empowerment Services FSP	750,707	750,707				
10. High-Risk Transition Team	727,200	727,200				
11. Adult Residential Treatment Services	1,010,000	1,010,000				
Non-FSP Programs						
12. Mental Health Outreach and Engagement	238,305	238,305				
13. Mobile Crisis Support Team	980,060	906,904	70,656			2,500
14. Peer Navigation	303,000	303,000				
15. Wellness Center	534,943	534,943				
16. Project Based Housing	9,090,000	9,090,000				
17. Employment Recovery Services	368,484	368,484				
18. Community Behavioral intervention Services	825,141	515,514	308,027			1,600
19. Housing Coordination Services	2,439,198	2,439,198				
20. Crisis Services Expansion	6,255,299	3,708,068	2,510,681			36,550
21. System Development Expansion	1,418,657	1,398,386	20,271			
CSS Administration	5,029,214	4,265,115	764,099			
Total CSS Program Estimated Expenditures	56,918,807	46,498,584	10,359,723	0	0	60,500
FSP Programs as Percent of Total	55.0%					

FY 2020/21 Mental Health Services Act Annual Update
Prevention and Early Intervention (PEI) Funding

County: San Joaquin Date: 5/13/2020

	Fiscal Year 2020/21					
	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	723,273	723,273				
2. Mentoring for Transitional Age Youth	868,908	868,908				
Early Intervention Programs for Children and Youth						
3. Early Mental Health Services	2,518,586	2,298,020	215,066			5,500
4. School Based Interventions	2,914,526	2,914,526				
5. Early Interventions to Treat Psychosis	1,118,568	567,996	550,472			100
Early intervention Programs for Adults and Older Adults						
6. Trauma Services for Adults	1,200,000	1,200,000				
7. Recovery Services for Nonviolent Offenders	464,708	464,708				
8. Forensics Access and Engagement	600,000	600,000				
Access and Linkage to Treatment Program						
9. Whole Person Care Project	718,566	688,566				30,000
Outreach for Increasing Recognition of the Early Signs of Mental Illness						
10. Increasing Recognition of Mental Illnesses	70,366	70,366				
Stigma and Discrimination Reduction Program						
11. Information and Education Campaign	1,739,130	1,739,130				
Suicide Prevention Program						
12. Suicide Prevention with Schools	598,170	598,170				
13. Suicide Prevention Awareness Campaign	652,174	652,174				
PEI Administration	889,298	889,298				
PEI Assigned Funds						
Funds assigned to CalMHSA	20,000	20,000				
Total PEI Program Estimated Expenditures	15,096,273	14,295,135	765,538	0	0	35,600

FY 2020/21 Mental Health Services Act Annual Update
Innovations (INN) Funding

County: San Joaquin

Date: 5/13/2020

	Fiscal Year 2020/21					
	A	B	C	D	E	F
	Estimated Total Mental Health Expenditures	Estimated INN Funding	Estimated Medi Cal FFP	Estimated 1991 Realignment	Estimated Behavioral Health Subaccount	Estimated Other Funding
INN Programs						
1. Assessment and Respite Center	2,148,468	2,148,468				
2. Progressive Housing	1,718,276	1,718,276				
	0					
	0					
	0					
	0					
INN Administration	38,668	38,668				
Total INN Program Estimated Expenditures	3,905,412	3,905,412	0	0	0	0

FY 2020/21 Mental Health Services Act Annual Update
Workforce, Education and Training (WET) Funding

County: San Joaquin Date: 5/13/2020

	Fiscal Year 2020/21					
	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	263,042	263,042				
2. Internship Incentive	200,000	200,000				
	0					
	0					
	0					
WET Administration	69,456	69,456				
Total WET Program Estimated Expenditures	532,498	532,498	0	0	0	0

FY 2020/21 Mental Health Services Act Annual Update
Capital Facilities/Technological Needs (CFTN) Funding

County: San Joaquin Date: 5/13/2020

	Fiscal Year 2020/21					
	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	7,836,846	2,406,660				5,430,186
2. Facility Renovations	0					
3. Facility Repair and Upgrades	3,788,173	3,788,173				
	0					
CFTN Programs - Technological Needs Projects						
4. Technology Equipment and Software	0					
	0					
CFTN Administration	929,225	929,225				
Total CFTN Program Estimated Expenditures	12,554,244	7,124,058	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 three 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
- *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) Service Support Plan*: For youth in treatment in a FSP, service support plans describe the treatment modalities and services recommended to support recovery. Planning may occur in one or more sessions. 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. Plans will be updated as needed or every six months. The plan is developed through Child Family Team meetings conducted every 30 days.

- *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 Care Coordination are available for children, youth, and their families for any children or youth who meet Specialty Mental Health Services, and who would benefit from those services.
  - Substance Use Disorder Treatment Services are available through the Substance Abuse Services Division and include a range of outpatient, intensive outpatient, and residential treatment programs. BHS also contracts with qualified community partners to provide medication assisted treatment for individuals with co-occurring disorders.

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

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

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

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

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

Monitoring Treatment Progress

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

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

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

Transition to Community or Specialty Mental Health Services

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

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

- *Post FSP Services*: FSP consumers stepping down from an FSP program will be linked with an FSP Engagement worker. The FSP Engagement program conducts community-based engagement services to help individuals and their families overcome stigma or other concerns about seeking mental health treatment services. Engagement 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.

Community Services and Supports Funded Programs

Full Service Partnerships

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

Outreach & Engagement

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

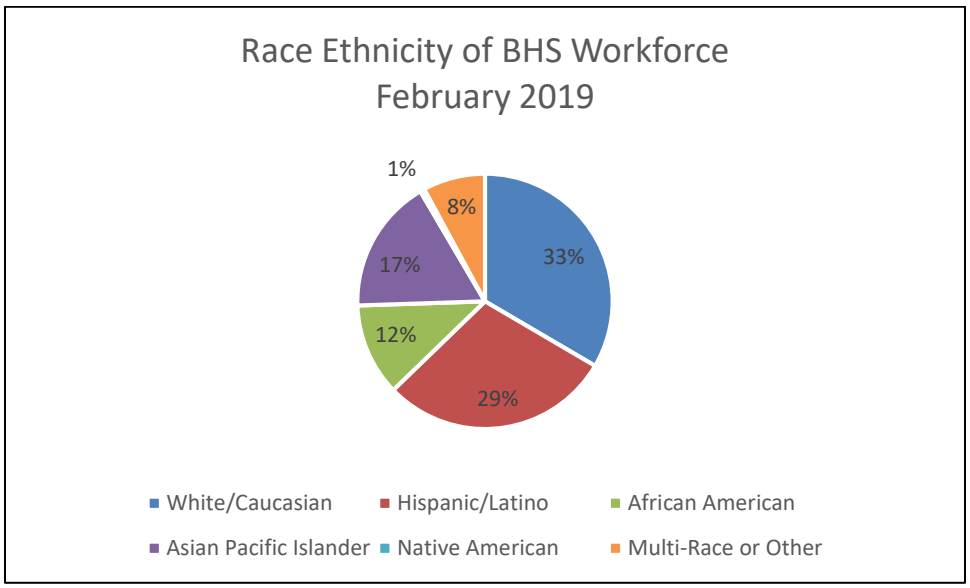
General System Development

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

Capacity to Implement CSS Programs

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

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



BHS works hard to recruit and retain a diverse workforce. Compared to the general population the BHS workforce is relatively diverse, and somewhat reflective of the residents of San Joaquin County. Data shows that Hispanic/Latino individuals are under-represented in the workforce, comprising 29% of the workforce, compared to 42% of the county population and 46% of Medi-Cal Beneficiaries.

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 eight FSP programs that are implemented by seventeen different clinical teams comprised of psychiatrists, clinicians, case managers, peer partners, nurses, psychiatric technicians and others. Annually, over 1,700 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 2018/19
Full Service Partnership Programs	
1. Children and Youth FSP (2 Teams)	559
2. Transitional Age Youth (TAY) FSP (1 Team)	77
3. Adult FSP (7 Teams)	1,029
4. Older Adult FSP (1 Team)	105
5. Community Corrections FSP (1 Team)	272
6. InSPIRE FSP (1 Team)	39
7. Intensive Adult FSP (2 Teams; direct services initiated in 2019-20)	0
8. Intensive Justice Response FSP (2 Teams; direct services initiated in 2019-20)	0
9. High Risk Transition Team FSP (1 Team; launching in 2020-21)	0
TOTAL CLIENTS ENROLLED IN FSP PROGRAMS	**2,081**

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.

Intensive 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 clinical team has special training in working with the dependency system and works under partnership agreements with local agencies. The purpose of the Dependency FSP team is to provide a very intensive level of engagement and stabilization services with a goal of stepping clients down into one of the Standard FSP Treatment Teams as recovery goals are met.

2. MHSA Pathways FSP Team

This FSP serves children and youth with the highest and most acute treatment needs. Youth will receive community-based Intensive Care Coordination (ICC) in compliance with State mandates, and Intensive Home Based Services (IHBS) per State Medi-Cal regulations. ICC will include 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 Teams (CFT). 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.

Standard FSPs for Children and Youth

3. BHS Child and Youth (CYS) FSP Team

Full Spectrum of clinical treatment services in addition to providing family therapy and rehabilitation 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. 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.

4. Community Contracted CYS FSP Team

In addition to providing a full spectrum of clinical treatment services, CYS FSP programs are designed to support the social, emotional, and basic living needs of *children and their families* to ensure ongoing participation in treatment services and stabilization in the recovery process. CYS FSP services work with children ages 0-18, and their families.

Clients Served within the Children and Youth FSP Program

Client Demographics

Children and Youth FSP Program 2018-2019 N=559		
	Number	**Percent**
Total by Age Group Served		
▪ Children and Youth	384	69%
▪ Transitional Age Youth	175	31%
Gender Identity		
▪ Female	288	52%
▪ Male	271	48%
Race/Ethnicity		
▪ African American	113	20%
▪ Asian / Pacific Islander	15	3%
▪ Hispanic/Latino	189	34%
▪ Native American	3	1%
▪ White/Caucasian	175	31%
▪ Other / Not-Identified	64	11%
Linguistic Group		
▪ English	532	95%
▪ Spanish	18	3%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	9	2%

Cost per Client

Number Served	**Total Expenditures**
559	$2,110,072
Average Annual Cost	**Average Monthly Cost**
$3,774.73	$315

Client Projections

BHS projects that the number and composition of CYS FSP clients served in 2018-2019 will increase by 90 clients in FY 2020-21 .

CSS: FSP-Children & Youth FSP

Cost Center(s): 6320,6321,6325, New TBD

RU(s): 9095FS, 9095AP, 9095EC, 9095MM

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Chief Mental Health Clinician	2.700	$314,541.00	$179,001.00	$493,542.00
Deputy Director BHS- Clinical	0.350	$52,678.00	$22,692.00	$75,370.00
Mental Health Clinician I	7.900	$524,865.00	$369,464.00	$894,329.00
Mental Health Clinician II	4.800	$347,400.00	$254,016.00	$601,416.00
Mental Health Clinician III	3.800	$333,600.00	$247,283.00	$580,883.00
Mental Health Outreach Worker	5.000	$174,480.00	$79,088.00	$253,568.00
Mental Health Specialist II	8.750	$506,716.00	$290,826.00	$797,542.00
Office Assistant	1.950	$75,918.00	$68,062.00	$143,980.00
Office Assistant Specialist	0.250	$11,556.00	$9,940.00	$21,496.00
Office Supervisor	1.000	$39,770.00	$38,467.00	$78,237.00
Office Worker I	0.750	$23,272.00	$1,779.00	$25,051.00
Sr. Office Assistant	0.500	$21,809.00	$11,150.00	$32,959.00
Staff Nurse IV - AMB	0.500	$63,995.00	$44,672.00	$108,667.00
Total	**38.25**	**$2,490,600.00**	**$1,616,440.00**	**$4,107,040.00**
Overtime				$500.00
Doctor Incentive				$30,500.00
Rounding				-$1.00

	FY18-19 ACTUALS	FY19-20 YTD ACTUALS as of 12/31/2019	FY20-21 PROPOSED BUDGET *incl S&B (above)	FY21-22 PROPOSED BUDGET	FY22-23 PROPOSED BUDGET
OPERATING COSTS	$97,988.80	$50,888.77	$286,690.00		
NON-RECURRING COSTS	$20,289.42	$3,389.51	$1,500.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$956,849.92	$588,342.59	$4,057,398.00		
ADMINISTRATIVE / INDIRECT			$1,028,952.00		
PERSONNEL COSTS	$1,720,452.59	$1,024,169.15	$4,138,039.00		
TOTAL GROSS EXPENDITURES	**$2,795,580.73**	**$1,666,790.02**	**$9,512,579.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$730,472.60	$117,986.79	$1,622,997.00		
Realignment	$682,681.50	$417,831.52			
Other	$42.88	$202.83	$950.00		
Total	**$1,413,196.98**	**$536,021.14**	**$1,623,947.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$1,382,383.75**	**$1,130,768.88**	**$7,888,632.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a full service partnership mental health program.

Brief description of items included in Non-Recurring Costs:

Small furniture and Equipment $1,000 Computers $500

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Victor Community Support Services -Pathways to Well Being - $1,786,182

CSS Project 2: Transitional Age Youth (TAY) FSP

Project Description

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

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

Target Population 1: Exiting or Former Foster Care Youth

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

Target Population 2: Transitional Age Youth

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

Project Components

There is one FSP team working with Transitional Age Youth.

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

Client Demographics

Transitional Age Youth FSP Program 2018-2019 N=77		
	Number	**Percent**
Total by Age Group Served		
▪ Children and Youth	19	25%
▪ Transitional Age Youth	58	75%
Gender Identity		
▪ Female	29	38%
▪ Male	48	62%
Race/Ethnicity		
▪ African American	24	31%
▪ Asian / Pacific Islander	3	4%
▪ Hispanic/Latino	14	18%
▪ Native American	1	1%
▪ White/Caucasian	29	38%
▪ Other / Not-Identified	6	8%
Linguistic Group		
▪ English	72	94%
▪ Spanish	2	3%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	3	4%

Cost per Client

Number Served	**Total Expenditures**
77	$622,301
Average Annual Cost	**Average Monthly Cost**
$8,082	$673

Client Projections

BHS projects that the number and composition of TAY FSP clients served in 2018-2019 will remain relatively consistent for FY 2020-21. No significant program expansions or contractions are predicted.

CSS: FSP-Transition Age Youth (TAY) FSP

Cost Center(s): 6375
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Chief Mental Health Clinician	0.50	$55,321	$32,092	$87,413.00
Mental Health Clinician I	0.25	$16,531	$12,984	$29,515.00
Mental Health Clinician III	1.50	$119,877	$79,703	$199,580.00
Mental Health Outreach Worker	2.00	$79,431	$66,796	$146,227.00
Mental Health Specialist II	1.70	$88,265	$66,260	$154,525.00
Psychiatrist	0.18	$58,352	$15,133	$73,485.00
				$0.00
				$0.00
				$0.00
Total	**6.13**	**$417,777.00**	**$272,968.00**	**$690,745.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$44,096.08	$9,194.02	$54,450.00		
NON-RECURRING COSTS	$238.00	$167.99	$1,200.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER			$1,650.00		
ADMINISTRATIVE / INDIRECT			$63,174.45		
PERSONNEL COSTS	$331,229.16	$223,173.87	$690,745.00		
TOTAL GROSS EXPENDITURES	**$375,563.24**	**$232,535.88**	**$811,219.45**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$287,781.16	$24,774.58	$325,882.00		
Realignment					
Other	$1,460.88	$2,613.01	$1,000.00		
Total	**$289,242.04**	**$27,387.59**	**$326,882.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$86,321.20**	**$205,148.29**	**$484,337.45**	**$0.00**	**$0**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a full service partnership mental health program.

Brief description of items included in Non-Recurring Costs:

Small furniture & equipment $1,000 Computer supplies $200

Brief description of items included in Consultant/Contract Costs:

Contract Psychiatry $1,650

Brief description of items included in Contracted Service Provider:

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 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 and #7 in order to better define and account for the specialized services provided by these teams.

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

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

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

Clients Served within the Adult FSP Program

Client Demographics

Adult FSP Program 2018-2019 N=1,029		
	Number	**Percent**
Total by Age Group Served		
▪ Transitional Age Youth	87	8%
▪ Adults	851	83%
▪ Older Adults	91	9%
Gender Identity		
▪ Female	520	55%
▪ Male	509	45%
Race/Ethnicity		
▪ African American	190	18%
▪ Asian / Pacific Islander	182	18%
▪ Hispanic/Latino	181	18%
▪ Native American	65	6%
▪ White/Caucasian	342	33%
▪ Other / Not-Identified	69	7%
Linguistic Group		
▪ English	794	77%
▪ Spanish	49	5%
▪ Other, Asian	93	9%
▪ Arabic or Farsi	0	0%
▪ Other non-English	93	9%

Cost per Client

Number Served	**Total Expenditures**
1,029	$6,798,551
Average Annual Cost	**Average Monthly Cost**
$6,612	$551

Client Projections

BHS projects that the number and composition of Adult FSP clients served in 2018-2019 will remain relatively consistent for FY 2020-2021. No significant program expansions or contractions are predicted.

CSS: FSP-Adult FSP

Cost Center(s): 6311, 6312, 6313, 6330, 6340, 6350

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Chief Mental Health Clinician	1.30	$140,858.00	$84,237.00	$225,095.00
Chief Psychiatric Technician	1.00	$64,438.00	$45,235.00	$109,673.00
Mental Health Clinician I	9.36	$659,285.00	$495,963.00	$1,155,248.00
Mental Health Clinician II	3.62	$260,537.00	$217,311.00	$477,848.00
Mental Health Clinician III	2.50	$224,378.00	$158,527.00	$382,905.00
Mental Health Interpreter II	2.80	$118,844.00	$111,402.00	$230,246.00
Mental Health Outreach Worker	9.50	$368,712.00	$270,286.00	$638,998.00
Mental Health Specialist II	12.05	$603,615.00	$401,080.00	$1,004,695.00
Mental Health Specialist III	1.00	$60,778.00	$59,269.00	$120,047.00
Nurse Practitioner II	0.50	$53,789.00	$27,669.00	$81,458.00
Office Assistant	2.25	$96,616.00	$52,226.00	$148,842.00
Office Supervisor	0.75	$36,238.00	$26,954.00	$63,192.00
Office Worker II	0.75	$31,169.00	$2,383.00	$33,552.00
Psychiatric Technician	2.12	$99,502.00	$24,170.00	$123,672.00
Psychiatrist	1.06	$332,754.00	$32,782.00	$365,536.00
Sr. Office Assistant	7.30	$302,267.00	$247,299.00	$549,566.00
Staff Nurse III	1.00	$108,578.00	$70,746.00	$179,324.00
Staff Nurse IV	1.93	$237,537.00	$160,658.00	$398,195.00
Temporary Physician	0.85	$265,333.00	$14,316.00	$279,649.00
Total	**61.64**	**$4,065,228.00**	**$2,502,513.00**	**$6,567,741.00**
Overtime				$4,239.00
Doctor Incentive				$70,000.00

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$1,335,647.75	$322,082.55	$1,074,988.00		
NON-RECURRING COSTS	$9,680.80	$11,132.21	$77,326.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$249,016.65	$3,354.37	$423,693.00		
ADMINISTRATIVE / INDIRECT			$653,524.20		
PERSONNEL COSTS	$6,583,372.56	$2,388,186.45	$6,641,980.00		
TOTAL GROSS EXPENDITURES	**$8,177,717.76**	**$2,724,755.58**	**$8,871,511.20**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$3,210,029.32	$324,130.95	$3,845,609.00		
Realignment					
Other	$9,007.24	$7,620.39	$15,550.00		
Total	**$3,219,036.56**	**$331,751.34**	**$3,861,159.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$4,958,681.20**	**$2,393,004.24**	**$5,010,352.20**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a full service partnership mental health program.

Brief description of items included in Non-Recurring Costs:

Small furniture & equipment $10,805 Computer & software $26,521 Office reconfiguration $40,000

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Contract Psychiatry $417,144

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.

Clients Served within the Older Adult FSP Program

Client Demographics

Older Adult FSP Program 2018-2019 N=105		
	Number	**Percent**
Total by Age Group Served		
▪ Older Adults	105	100%
Gender Identity		
▪ Female	61	58%
▪ Male	44	42%
Race/Ethnicity		
▪ African American	26	24%
▪ Asian / Pacific Islander	19	20%
▪ Hispanic/Latino	19	19%
▪ Native American	2	3%
▪ White/Caucasian	34	30%
▪ Other / Not-Identified	5	5%
Linguistic Group		
▪ English	65	62%
▪ Spanish	17	16%
▪ Other, Asian	18	17%
▪ Arabic or Farsi	0	0%
▪ Other non-English	5	5%

Cost per Client

Number Served	**Total Expenditures**
105	$1,165,039
Average Annual Cost	**Average Monthly Cost**
$11,096	$925

Client Projections

BHS projects that the number and composition of Older Adult FSP clients served in 2018-2019 will remain relatively consistent for FY 2020-2021. No significant program expansions or contractions are predicted.

CSS: FSP-Older Adult FSP

Cost Center(s): 6370

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Chief Mental Health Clinician	0.50	$54,908.00	$38,696.00	$93,604.00
Deputy Director BHS- Clinical	0.15	$19,212.00	$8,136.00	$27,348.00
Mental Health Clinician I	1.50	$101,748.00	$70,439.00	$172,187.00
Mental Health Clinician II	0.50	$36,779.00	$31,831.00	$68,610.00
Mental Health Clinician III	0.50	$39,354.00	$29,179.00	$68,533.00
Mental Health Outreach Worker	1.13	$41,337.00	$3,160.00	$44,497.00
Mental Health Outreach Worker Trainee	0.38	$13,337.00	$1,019.00	$14,356.00
Mental Health Specialist II	2.00	$92,486.00	$53,641.00	$146,127.00
Office Assistant Specialist	0.75	$34,336.00	$25,855.00	$60,191.00
Psychiatric Technician	0.25	$12,924.00	$8,559.00	$21,483.00
Psychiatrist	0.83	$222,042.00	$102,294.00	$324,336.00
Rehabilitation Specialist I	0.25	$15,044.00	$12,015.00	$27,059.00
Staff Nurse IV- Cinical Ambulatory	0.50	$62,541.00	$50,183.00	$112,724.00
				$0.00
Total	**9.23**	**$746,048.00**	**$435,007.00**	**$1,181,055.00**

Overtime	$100.00

	FY18-19 ACTUALS	FY19-20 YTD ACTUALS as of 12/31/2019	FY20-21 PROPOSED BUDGET *incl S&B (above)	FY21-22 PROPOSED BUDGET	FY22-23 PROPOSED BUDGET
OPERATING COSTS	$68,787.34	$25,878.96	$108,063.00		
NON-RECURRING COSTS	$43,120.32	$295.26	$4,000.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$145,850.47		$0.00		
ADMINISTRATIVE / INDIRECT			$122,437.95		
PERSONNEL COSTS	$1,056,498.59	$476,677.17	$1,181,155.00		
TOTAL GROSS EXPENDITURES	**$1,314,256.72**	**$502,851.39**	**$1,415,655.95**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$317,938.04	$26,807.14	$476,715.00		
Realignment					
Other	$1,252.05	$4,428.93	$250.00		
Total	**$319,190.09**	**$31,236.07**	**$476,965.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$995,066.63**	**$471,615.32**	**$938,690.95**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a full service partnership mental health program.

Brief description of items included in Non-Recurring Costs:

Small furniture and equipment $1,000 Computer and software $3,000

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

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 Projects #8 in order to better define and account for the specialized services provided by these teams.

2. **Standard FSP**
   Forensic FSP Team

Clients Served within the Community Corrections FSP Program

Client Demographics

Community Corrections FSP Program 2018-2019 N=272		
	Number	**Percent**
Total by Age Group Served		
▪ Transitional Age Youth	34	13%
▪ Adults	226	83%
▪ Older Adults	12	4%
Gender Identity		
▪ Female	92	34%
▪ Male	180	66%
Race/Ethnicity		
▪ African American	60	22%
▪ Asian / Pacific Islander	19	7%
▪ Hispanic/Latino	64	24%
▪ Native American	21	8%
▪ White/Caucasian	99	35%
▪ Other / Not-Identified	13	5%
Linguistic Group		
▪ English	240	88%
▪ Spanish	7	3%
▪ Other, Asian	2	1%
▪ Arabic or Farsi	0	0%
▪ Other non-English	23	8%

Cost per Client

Number Served	**Total Expenditures**
272	$655,228
Average Annual Cost	**Average Monthly Cost**
$2,409	$201

Client Projections

BHS projects that the number and composition of Community Corrections FSP clients served in 2018-2019 will remain relatively consistent for FY 2020-2021 No significant program expansions or contractions are predicted.

CSS: FSP-Community Corrections FSP

Cost Center(s): 6360

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Chief Mental Health Clinician	1.85	$200,007.00	$109,271.00	$309,278.00
Deputy Director BHS- Clinical	0.20	$30,101.00	$17,244.00	$47,345.00
Mental Health Clinician I	2.00	$135,710.00	$77,179.00	$212,889.00
Mental Health Specialist II	2.00	$107,358.00	$74,581.00	$181,939.00
Office Assistant Specialist	1.00	$37,690.00	$37,405.00	$75,095.00
Psychiatrist	0.15	$40,371.00	$13,360.00	$53,731.00
Sr. Nurse Practitioner	0.08	$14,237.00	$1,088.00	$15,325.00
Sr. Office Assistant	2.00	$78,656.00	$76,724.00	$155,380.00
Sr. Psychiatric Technician	1.00	$59,322.00	$70,482.00	$129,804.00
Substance Abuse Counselor II	1.00	$41,444.00	$39,322.00	$80,766.00
				$0.00
				$0.00
				$0.00
				$0.00
Total	**11.28**	**$744,896.00**	**$516,656.00**	**$1,261,552.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$251,606.17	$42,035.05	$106,961.00		
NON-RECURRING COSTS	$1,573.04	$743.75	$1,700.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER			$70,000.00		
ADMINISTRATIVE / INDIRECT			$170,561.55		
PERSONNEL COSTS	$930,133.60	$502,274.65	$1,261,552.00		
TOTAL GROSS EXPENDITURES	**$1,183,312.81**	**$545,053.45**	**$1,610,774.55**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$101,249.28	$9,972.95	$302,036.00		
Realignment					
Other	$1,624.91	$380.00	$1,100.00		
Total	**$102,874.19**	**$10,352.95**	**$303,136.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$1,080,438.62**	**$534,700.50**	**$1,307,638.55**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a full service partnership mental health program.

Brief description of items included in Non-Recurring Costs:

Small Furniture $500 Computer Equipment and Software $1,200

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Contract Psychiatry $70,000

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.

Clients Served within the InSPIRE FSP Program

Client Demographics

InSPIRE FSP Program 2018-2019 N=39		
	Number	**Percent**
Total by Age Group Served		
▪ Adults	37	95%
▪ Older Adults	2	5%
Gender Identity		
▪ Female	13	33%
▪ Male	26	67%
Race/Ethnicity		
▪ African American	9	23%
▪ Asian / Pacific Islander	5	13%
▪ Hispanic/Latino	1	3%
▪ Native American	2	5%
▪ White/Caucasian	22	56%
▪ Other / Not-Identified	0	0%
Linguistic Group		
▪ English	39	10%
▪ Spanish	0	0%
▪ Other, Asian	0	0%
▪ Arabic or Farsi	0	0%
▪ Other non-English	1	0%

Cost per Client

Number Served	**Total Expenditures**
39	$341,427
Average Annual Cost	**Average Monthly Cost**
$8,755	$730

Client Projections

BHS projects that the number and composition of InSPIRE FSP clients served in 2018-2019 will remain relatively consistent for FY 2020-2021. No significant program expansions or contractions are predicted.

CSS: FSP-InSPIRE FSP

Cost Center(s): 6377

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Chief Mental Health Clinician	0.30	$34,071.00	$26,179.00	$60,250.00
Mental Health Clinician I	1.00	$63,911.00	$46,001.00	$109,912.00
Mental Health Outreach Worker	2.00	$80,041.00	$64,478.00	$144,519.00
Mental Health Specialist II	2.00	$106,463.00	$79,706.00	$186,169.00
Psychiatric Technician	1.00	$46,289.00	$26,717.00	$73,006.00
				$0.00
				$0.00
				$0.00
				$0.00
Total	**6.30**	**$330,775.00**	**$243,081.00**	**$573,856.00**
Overtime				$2,000.00

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$27,759.88	$3,501.34	$35,250.00		
NON-RECURRING COSTS			$1,000.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER					
ADMINISTRATIVE / INDIRECT			$74,753.40		
PERSONNEL COSTS	$430,488.16	$223,282.02	$575,856.00		
TOTAL GROSS EXPENDITURES	**$458,248.04**	**$226,783.36**	**$686,859.40**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$117,774.11	$5,753.27	$112,750.00		
Realignment					
Other	$1,317.56	$496.20	$1,000.00		
Total	**$119,091.67**	**$6,249.47**	**$113,750.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$339,156.37**	**$220,533.89**	**$573,109.40**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a full service partnership mental health program.

Brief description of items included in Non-Recurring Costs:

Small furniture and equipment $1,000

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

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.

2019 Implementation Update: A Request for Proposals was released for this project in fall 2018. Following a review of submissions two organizational providers were identified to implement this program. Program services launched in 2019-20.

Client Projections

BHS projects that the number and composition of Intensive Adult FSP clients served in FY 2020-21 will be 65 clients.

CSS: FSP-Intensive Adults FSP

Cost Center(s): 6355

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$131,299.83	$175,911.75	$2,000,000.00	$0.00	
ADMINISTRATIVE / INDIRECT			$20,000.00		
PERSONNEL COSTS			$0.00		$0.00
TOTAL GROSS EXPENDITURES	**$131,299.83**	**$175,911.75**	**$2,020,000.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal					
Realignment					
Other					
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$131,299.83**	**$175,911.75**	**$2,020,000.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Contracted FSP services - Telecare and Turning Point

CSS Project 8: Intensive Justice Response FSP

This Intensive Adult 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 will be two Intensive Justice Response FSP teams.
- Teams provide *Intensive FSP* services for adults.

2019 Implementation Update: A Request for Proposals was released for this project in fall 2018. Following a review of submissions two organizational providers were identified to implement this program. Program services launched in 2019-20.

Client Projections

BHS projects that the number and composition of Intensive Justice Response FSP clients served in FY 2020-21 will be 65 clients.

CSS: FSP-Intensive Justice Response FSP

Cost Center(s): 6365

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$119,831.69	$191,328.54	$2,000,000.00		
ADMINISTRATIVE / INDIRECT			$20,000.00		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$119,831.69**	**$191,328.54**	**$2,020,000.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal					
Realignment					
Other					
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$119,831.69**	**$191,328.54**	**$2,020,000.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Contracted FSP services - Two providers,Telecare and Turning Point

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.

CSS: FSP-Housing Empowerment Services

Cost Center(s): 6385
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$533,480.52	$184,579.41	$743,274.00		
ADMINISTRATIVE / INDIRECT			$7,432.74		
PERSONNEL COSTS	$58,454.84	$57,327.40	$0.00		
TOTAL GROSS EXPENDITURES	**$591,935.36**	**$241,906.81**	**$750,706.74**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal					
Realignment					
Other		$100,000.00			
Total	**$0.00**	**$100,000.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$591,935.36**	**$141,906.81**	**$750,706.74**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

CVLHIC Choice Housing $743,274

CSS Project 10: High-Risk Transition Team FSP

This project will provide 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.

CSS: FSP-High-Risk Transition Team

Cost Center(s): 6323

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS		$0.00			
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER			$720,000.00		
ADMINISTRATIVE / INDIRECT			$7,200.00		
PERSONNEL COSTS		$0.00	$0.00		
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$727,200.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal					
Realignment					
Other					
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$727,200.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

RFP 2020-21 $720,000

CSS Project 11: FSP Adult Residential Treatment Services

Project Description

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

Program Requirements

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

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

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

Per state licensing requirements, services will include:

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

Program Components

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

CSS: FSP-Adult Residential Treatment Services

Cost Center(s): 6323
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS		$0.00			
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER			$1,000,000.00		
ADMINISTRATIVE / INDIRECT		$0.00	$10,000.00		
PERSONNEL COSTS		$0.00	$0.00		
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$1,010,000.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal					
Realignment					
Other					
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$1,010,000.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

RFP 2020-21 $1,000,000

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 LGBT, 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

CSS: O&E-Mental Health Outreach & Engagement

Cost Center(s): 6318
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Mental Health Outreach Worker		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS		$0.00			
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$554,303.44	$67,882.17	$235,946.00		
ADMINISTRATIVE / INDIRECT			$2,359.46		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$554,303.44**	**$67,882.17**	**$238,305.46**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal					
Realignment					
Other					
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$554,303.44**	**$67,882.17**	**$238,305.46**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Veterans Services Office $160,000, Central Valley Low Income Housing Corp. $75,946

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.

CSS: O&E-Mobile Crisis Support Team

Cost Center(s): 6389
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Mental Health Clinician I	2.00	$144,048.00	$101,659.00	$245,707.00
Mental Health Clinician II	2.00	$140,981.00	$100,620.00	$241,601.00
Mental Health Clinician III	0.14	$11,019.00	$8,170.00	$19,189.00
Mental Health Outreach Worker	4.75	$174,840.00	$122,119.00	$296,959.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**8.89**	**$470,888.00**	**$332,568.00**	**$803,456.00**
Overtime				$15,177.00

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$19,412.02	$6,479.38	$43,135.00		
NON-RECURRING COSTS	$57,656.70				
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER					
ADMINISTRATIVE / INDIRECT			$118,291.80		
PERSONNEL COSTS	$903,121.35	$553,200.71	$818,633.00		
TOTAL GROSS EXPENDITURES	**$980,190.07**	**$559,680.09**	**$980,059.80**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$72,204.97	$7,905.62	$70,656.00		
Realignment					
Other	$492,060.26	$10.00	$2,500.00		
Total	**$564,265.23**	**$7,915.62**	**$73,156.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$415,924.84**	**$551,764.47**	**$906,903.80**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a mobile crisis support mental health program.

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

CSS Project 14: Peer Navigation

Project Description

The Peer Navigation program will serve 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 will 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 will 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 will 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 work with one or more community partners to develop a Peer Navigation Program through an RFP process. Community partners 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 shall 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 will also 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 will work with BHS Crisis Services to engage clients following a crisis encounter. Duties and responsibilities of the Peer Navigators may include but are not limited to:

- Provide warm outreach and engagement to clients following a crisis episode
- Provide information about community services available to support consumers

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

Skills and Competencies:

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

CSS: O&E-Peer Navigation

Cost Center(s): 6323
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER			$300,000.00		
ADMINISTRATIVE / INDIRECT			$3,000.00		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$303,000.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal			$0.00		
Realignment			$0.00		
Other			$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$303,000.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

RFP'd in 2019-20 - Contractor to be awarded in 2020-21 $300,000

CSS Project 15: Wellness Center

Project Description

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

Project Goal

The primary objectives for this program will be to:

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

Target Population

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

Project Components

The Wellness Center will provide the following services:

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

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

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

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

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

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

CSS: GSD-Wellness Center

Cost Center(s): 6300

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$497,288.40	$277,850.31	$529,647.00		
ADMINISTRATIVE / INDIRECT			$5,296.47		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$497,288.40**	**$277,850.31**	**$534,943.47**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal			$0.00		
Realignment			$0.00		
Other			$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$497,288.40**	**$277,850.31**	**$534,943.47**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Peer Recovery Services $529,647

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:
   Up to $8.5 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 future Project Based Housing Programs. Previous funded housing projects will be completed by December, 2020. The total number of housing units to be completed is 37; exceeding the Three Year Program and Expenditure Plan goal of developing 34 units of housing for the mentally ill.

   - Crossway Residences I, located at 448 S. Center Street. The project will include 14 client apartments and one resident manager apartment.
   - Crossway Residences II, located at 421 S. El Dorado Street. The project will include 12 client apartments.

- Park Residences, located at 32 W. Park Street. The project will include 11 client apartments and one resident manager apartment.

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.

CSS: GSD-Project Based Housing

Cost Center(s): 6385

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

Overtime

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS			$500,000.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$666,857.16	$261,584.35	$8,500,000.00		
ADMINISTRATIVE / INDIRECT			$90,000.00		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$666,857.16**	**$261,584.35**	**$9,090,000.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal			$0.00		
Realignment			$0.00		
Other			$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$666,857.16**	**$261,584.35**	**$9,090,000.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Capitalized Operating Subsidy Reserve $500,000

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Housing Authority of San Joaquin $8,500,000

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.

CSS: GSD-Employment Recovery Services

Cost Center(s): 6385
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Employment Training Specialist I	1.00	$54,059.00	$59,400.00	$113,459.00
Mental Health Outreach Worker	0.10	$4,318.00	$3,298.00	$7,616.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**1.10**	**$58,377.00**	**$62,698.00**	**$121,075.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$148,457.10	$46,129.47	$199,346.00		
ADMINISTRATIVE / INDIRECT			$48,063.15		
PERSONNEL COSTS			$121,075.00		
TOTAL GROSS EXPENDITURES	**$148,457.10**	**$46,129.47**	**$368,484.15**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal					
Realignment					
Other					
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$148,457.10**	**$46,129.47**	**$368,484.15**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

UOP Employment Recovery Services $199,346

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.

CSS: GSD-Community Behavioral Intervention Services

Cost Center(s): 6390

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$649,443.20	$240,183.90	$820,037.00		
ADMINISTRATIVE / INDIRECT			$5,104.10		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$649,443.20**	**$240,183.90**	**$825,141.10**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$295,315.31	$30,107.58	$308,027.00		
Realignment					
Other			$1,600.00		
Total	**$295,315.31**	**$30,107.58**	**$309,627.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$354,127.89**	**$210,076.32**	**$515,514.10**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Community Behavioral Intervention Services $820,037

CSS Project 19: Housing Coordination Services

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

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

Project Components

Project 1: Housing Referral and Linkage

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

Project 2: Housing-based Case Management

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

Project 3: Housing Stabilization Resources

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

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

CSS: GSD-Housing Coordination Services

Cost Center(s): 6386
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Chief Mental Health Clinician	0.65	$65,228.00	$33,144.00	$98,372.00
Mental Health Clinician I	1.00	$66,123.00	$51,931.00	$118,054.00
Mental Health Clinician III	1.00	$82,188.00	$50,058.00	$132,246.00
Mental Health Outreach Worker	0.25	$10,795.00	$7,472.00	$18,267.00
Mental Health Specialist II	3.00	$156,013.00	$112,787.00	$268,800.00
Mental Health Specialist III	0.50	$30,001.00	$19,325.00	$49,326.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**6.40**	**$410,348.00**	**$274,717.00**	**$685,065.00**
Overtime				$0.00

	FY18-19 ACTUALS	FY19-20 YTD ACTUALS as of 12/31/2019	FY20-21 PROPOSED BUDGET *incl S&B (above)	FY21-22 PROPOSED BUDGET	FY22-23 PROPOSED BUDGET
OPERATING COSTS	$426,273.24	$1,609.15	$2,475.00		
NON-RECURRING COSTS	$279.86	$360.43	$6,750.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER		$401,698.00	$1,628,756.00		
ADMINISTRATIVE / INDIRECT			$116,152.30		
PERSONNEL COSTS	$222,955.10	$231,637.43	$685,065.00		
TOTAL GROSS EXPENDITURES	**$649,508.20**	**$635,305.01**	**$2,439,198.30**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$1,962.53				
Realignment					
Other					
Total	**$1,962.53**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$647,545.67**	**$635,305.01**	**$2,439,198.30**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support a housing coordination mental health program.

Brief description of items included in Non-Recurring Costs:

Small furniture $1,750 Computer equipment $5,000

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Enhanced Board and Care Homes $1,628,756

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.

CSS: GSD-Crisis Services Expansion

Cost Center(s): 6395

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Chief Mental Health Clinician	1.25	$141,124.00	$89,544.00	$230,668.00
Chief Mental Psychiatric Technician	0.84	$53,967.00	$41,608.00	$95,575.00
Deputy Director BHS- Clinical	0.25	$37,626.00	$21,555.00	$59,181.00
Mental Health Clinician I	7.00	$471,193.00	$228,159.00	$699,352.00
Mental Health Clinician II	7.58	$581,433.00	$371,106.00	$952,539.00
Mental Health Clinician III	2.00	$191,402.00	$160,318.00	$351,720.00
Mental Health Court Liason	0.25	$18,554.00	$16,126.00	$34,680.00
Mental Health Outreach Worker	11.50	$477,725.00	$218,174.00	$695,899.00
Mental Health Outreach Worker Trainee	0.75	$24,192.00	$1,850.00	$26,042.00
Mental Health Specialist I	0.38	$16,045.00	$1,227.00	$17,272.00
Mental Health Specialist II	6.38	$312,649.00	$137,145.00	$449,794.00
Office Assistant	2.50	$104,203.00	$75,789.00	$179,992.00
Office Assistant Specialist	0.25	$9,423.00	$9,350.00	$18,773.00
Office Supervisor	1.25	$60,197.00	$47,432.00	$107,629.00
Office Worker II	1.50	$54,440.00	$4,164.00	$58,604.00
Psychiatric Technician	3.43	$176,859.00	$58,619.00	$235,478.00
Psychiatrist	0.18	$56,495.00	$16,359.00	$72,854.00
Sr. Office Assistant	3.00	$129,622.00	$98,462.00	$228,084.00
Sr. Psychiatric Technician	1.63	$96,398.00	$75,551.00	$171,949.00
Staff Nurse III	1.13	$131,378.00	$62,091.00	$193,469.00
Staff Nurse IV	0.20	$26,875.00	$18,604.00	$45,479.00
Staff Nurse V Asst Nursing Dept Mgr	0.25	$34,809.00	$25,479.00	$60,288.00
Substance Abuse Counselor II	1.00	$52,454.00	$34,867.00	$87,321.00
Variance - Benefits			$14,711.00	$14,711.00
Total	**54.46**	**$3,259,063.00**	**$1,828,290.00**	**$5,087,353.00**
Overtime				$145,000.00
Holiday				$20,000.00

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$379,569.96	$118,791.13	$511,385.00		
NON-RECURRING COSTS	$25,538.50	$228.96	$7,900.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER					
ADMINISTRATIVE / INDIRECT			$483,661.05		
PERSONNEL COSTS	$3,645,651.93	$2,030,908.41	$5,252,353.00		
TOTAL GROSS EXPENDITURES	**$4,050,760.39**	**$2,149,928.50**	**$6,255,299.05**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$2,284,032.39	$206,519.65	$2,510,681.00		
Realignment					
Other	$36,491.38	$20,455.57	$36,550.00		
Total	**$2,320,523.77**	**$226,975.22**	**$2,547,231.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$1,730,236.62**	**$1,922,953.28**	**$3,708,068.05**	**$0.00**	**$0.00**
			$3,708,068.05		

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support crisis program expansion.

Brief description of items included in Non-Recurring Costs:

Small furniture and equipment $4,650 Computers and software $3,250

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

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 nearly 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 and linkage to services.
- Development of consumer and family driven services, including the use of peer partners, recovery coaches, and consumer or family member outreach workers throughout the mental health system of care.
- Expanded use of nurses and psychiatric nurse practitioners to strengthen linkages between specialty mental health and primary care providers.
- Expanded use of Independent Living Skills programming.

CSS: GSD-System Development Expansion

Cost Center(s): 6317, 6322

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS			$875,812.00		
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER			$529,000.00		
ADMINISTRATIVE / INDIRECT			$13,845.41		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$1,418,657.41**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal			$20,271.00		
Realignment					
Other					
Total	**$0.00**	**$0.00**	**$20,271.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$1,398,386.41**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Expansion of core services

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Victor Community Support Services - Expanded Outpatient Services - $529,000

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
- Mentoring for Transitional Age youth

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

San Joaquin PEI Early Intervention Programs – Children and Youth

- Early Mental Health Services
    - CARES Foster Care Project
    - Juvenile Justice Project
- School Based Interventions
- Early Interventions to Treat Psychosis

San Joaquin PEI Early Intervention Programs – Adults and Older Adults

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

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

- Whole Person Care Project

Outreach for Increasing Recognition of Early Signs of a Mental Illness: Outreach is the process of engaging, encouraging, educating, training, and learning from potential responders about ways to recognize and respond effectively to early signs of potentially severe and disabling mental illness. "Potential Responders" includes families, primary care providers, school personnel, community service providers, peer providers, law enforcement personnel, etc. (California Code of Regulations § 3715)

- Increasing Recognition of Mental Illnesses

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

- Information and Education Campaign

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

- Suicide Prevention with Schools
- Suicide Prevention for the Community

All MHSA funded prevention programs utilize evidence based practices. Evaluation findings from the 2016/17, 2017/18, 2018/19 fiscal years are 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: Prevention-Skill Building for Parents & Guardians

Cost Center(s): 6397
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Chief Mental Health Clinician	0.18	$23,755.00	$13,714.00	$37,469.00
Deputy Directory-BHS-Clinical	0.25	$37,626.00	$16,209.00	$53,835.00
Management Analyst II	1.15	$90,513.00	$57,623.00	$148,136.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**1.58**	**$151,894.00**	**$87,546.00**	**$239,440.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$26,164.67	$0.00	$1,500.00		
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS	$12,756.67		$20,000.00		
CONTRACTED SERVICE PROVIDER	$432,221.53	$153,565.41	$482,333.00		
ADMINISTRATIVE / INDIRECT	$75,033.87	$0.00	$111,490.95		
PERSONNEL COSTS	$77,914.84	$0.00	$239,440.00		
TOTAL GROSS EXPENDITURES	**$624,091.58**	**$153,565.41**	**$854,763.95**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal			$0.00		
Realignment			$0.00		
Other			$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$624,091.58**	**$153,565.41**	**$854,763.95**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support the PEI Program.

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Catholic Charities $159,166, Parents By Choice $160,727, Child Abuse Prevention Council $162,440

PEI Project 2: Mentoring for Transitional Age Youth

Community Need

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

Project Description

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

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

Project Components

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

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

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

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

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

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

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

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

PEI: Prevention-Mentoring for Transition Age Youth

Cost Center(s): 6397
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
CHIEF MENTAL HEALTH CLINICIAN		$0.00	$0.00	$0.00
DEPUTY DIRECTOR-BHS-CLINICAL		$0.00	$0.00	$0.00
MANAGEMENT ANALYST II		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$26,164.67	$0.00			
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS	$12,756.67				
CONTRACTED SERVICE PROVIDER	$727,319.48	$304,242.57	$868,908.00		
ADMINISTRATIVE / INDIRECT	$75,033.87	$0.00	$8,689.08		
PERSONNEL COSTS	$77,914.84	$0.00	$0.00		
TOTAL GROSS EXPENDITURES	**$919,189.53**	**$304,242.57**	**$877,597.08**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal			$0.00		
Realignment			$0.00		
Other			$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$919,189.53**	**$304,242.57**	**$877,597.08**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Child Abuse Prevention Council $451,948, Womens Center Youth and Family Services $416,960

PEI Project 3: Early Mental Health Services

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

Project Description
This project serves children and youth who are engaged in the Juvenile Justice or Child Welfare systems. Projects operate in in partnership with San Joaquin County Probation Department and San Joaquin Child Welfare Services. Services are designed to align with statewide mandates to provide early mental health support services to high-risk youth. This project also aligns with the vision and direction of the San Joaquin County Board of Supervisors.

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

Juvenile Justice Center Intervention Team

Many of the children and youth detained in the County's Juvenile Justice Center (JJC) suffer from social or emotional disturbances and early onset of mental illness. Most have been victims of abuse and trauma prior to involvement with the juvenile justice system. Left untreated, they are likely to continue the behaviors that resulted in incarceration or experience ongoing behavioral health crises.

This project provides behavioral health screening, assessment, individual and group rehabilitative interventions, and referrals to higher levels of care for youth detained in San Joaquin County's Juvenile Detention Center.

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

  Screening**:** As part of booking and detention procedures, staff of San Joaquin County's JJC conduct a behavioral health screening using the validated, evidence-based Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2). For more information about MAYSI-2 see: http://www.nysap.us/MAYSI2.html

  Assessment**:** Youth who are on psychotropic medications or whose MAYSI-2 score indicate high to moderate behavioral health risk receive an evaluation by BHS staff within 24 hours. During this evaluation, a Mental Status Exam is done, risk factors are assessed, services are offered, and accessing mental health services while at JJC is explained. Youth with low to moderate indicators are evaluated within five days.

  Crisis intervention: Youth who disclose suicidal ideation or threaten suicide during booking or at any time during their detention are immediately referred to BHS clinicians for evaluation.

Coordination of services: JJC clinicians inform the outpatient coordinator when a youth with an open behavioral health case is booked at the JJC. The JJC mental health service provider collaborates with the outpatient coordinator to continue treatment within BHS or a range of community based providers.

Behavioral health interventions: Detained youth receive behavioral health interventions in accordance with their clinical assessment. Interventions include medication management and individual and/or group therapy, and case management. The development of the client treatment plan and case management activities is conducted in collaboration with the youth, parents/caregivers, probation officers and social workers.

Release planning: BHS staff work with youth, family members, probation and child welfare workers to ensure that services and supports are not interrupted upon release or transfer from the JCC.

Supportive Program Milieu: Utilize emerging best practices to promote trauma informed approaches and create organization partnerships that are responsive to the behavioral health needs of youth in custody.

Coping and Resiliency Education Services (CARES)

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

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

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

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

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

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

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

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

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.

- *CRAXES (Children Reach Achieve and eXcel through Empowerment Strategies) —12 session program for children ages 5-11. This curriculum mirrors the PRAXES components but is interactive and configured for younger children.*

- *YRAXES (Youth Reach Achieve and eXcel through Empowerment Strategies) —12 session program for youth ages 12-18. This curriculum mirrors the PRAXES components but is interactive and configured for adolescents.*

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

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

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

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

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

Collaborative Meetings: San Joaquin County BHS will initiate quarterly meetings with Children's Services. Meetings will involve PEI program staff and Child Welfare staff responsible for program development and referrals. 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.

PEI: EI for C&Y-Early Mental Health Services

Cost Center(s): 6391,6394

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Chief Mental Health Clinician	0.75	$80,283.00	$48,633.00	$128,916.00
Mental Health Clinician I	5.00	$345,089.00	$226,281.00	$571,370.00
Mental Health Clinician II	0.75	$52,270.00	$3,997.00	$56,267.00
Mental Health Clinician III	3.00	$269,467.00	$187,766.00	$457,233.00
Mental Health Outreach Worker	4.00	$152,690.00	$130,440.00	$283,130.00
Mental Health Specialist II	7.00	$345,149.00	$222,894.00	$568,043.00
Psych Technician	1.00	$49,308.00	$33,259.00	$82,567.00
Psychiatrist	0.36	$131,105.00	$13,220.00	$144,325.00
Sr. Office Assistant	1.00	$43,618.00	$25,176.00	$68,794.00
Sr. Psych Technician	1.00	$59,317.00	$38,374.00	$97,691.00
				$0.00
Total	**23.86**	**$1,528,296.00**	**$930,040.00**	**$2,458,336.00**
Overtime				$1,000.00

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$25,622.21	$8,723.70	$41,500.00		
NON-RECURRING COSTS	$44,668.04	$5,176.13	$17,750.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER					
ADMINISTRATIVE / INDIRECT	$316,054.07	$165,696.28	$344,703.00		
PERSONNEL COSTS	$2,080,897.17	$1,090,742.00	$2,459,336.00		
TOTAL GROSS EXPENDITURES	**$2,467,241.49**	**$1,270,338.11**	**$2,863,289.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$97,034.71	$11,138.65	$215,066.00		
Realignment					
Other	$8,878.41	$319.82	$5,500.00		
Total	**$105,913.12**	**$11,458.47**	**$220,566.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$2,361,328.37**	**$1,258,879.64**	**$2,642,723.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support the PEI Program.

Brief description of items included in Non-Recurring Costs:

Small furniture and equipment $8,100 Computer equipment $9,650

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

PEI Project 4: School-based Interventions

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

Project Description
This project provides funding for brief mental health counseling and early intervention services for children and youth with emerging mental health concerns in order to promote recovery, improve functional outcomes, reduce suffering, and avert potential negative outcomes associated with untreated mental health concerns including suicide, incarceration, school failure or drop-out, etc.

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. Examples of risk factors include but are not limited, adverse childhood experiences, experience of severe trauma, ongoing stress, exposure to drugs or toxins including in the womb, poverty, family conflict or domestic violence, experiences of racism and social inequality, etc.

Funding will be allocated through rate based contracts to qualified Organizational Providers that agree to provide desired on-site school based interventions and other support services. Contracts will be developed through a public procurement process to identify qualified vendors. BHS intends to contract with multiple qualified vendors. School Districts will be able to request school-based mental health early intervention services from BHS approved providers for schools that meet criteria through an application process.

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

High School Criteria (9-12):

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

Elementary / Middle School Criteria (K-8):

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

Exceptions: A school district may contact BHS to request school-based intervention services following a traumatic event that affects the majority of students in the school.

Implementation

Establish a List of Qualified Providers

BHS shall identify potential Organizational Providers through a request for qualifications process. Organizational Providers must have a demonstrated capacity to provide mental health counseling and early intervention services to children and youth on school campuses.

Minimum qualifications: Program partners must demonstrate:

- Possession of certification as a Short-Doyle Medi-Cal Organizational Provider.
- Experience providing clinical treatment services to children and youth.
- Experience providing social, emotional, and rehabilitative group services to children and youth.
- Demonstrated training and capacity to provide evidence-based treatment interventions, including cognitive behavioral and trauma-informed services.
- Experience providing services within a school milieu.
- Capacity to work in partnership with schools to provide services around an academic calendar.
- A client management and billing system that meets CA Medi-Cal requirements.
- Adequate supervision plan and ratios for any unlicensed clinical staff.
- Capacity to assign dedicated "Clinicians on Campus" to work with partnering schools for a minimum of two days a week, for periods of at least six hours per on-site day.
- Capacity to provide on-site school-based service to at least ten different schools.

District Request for Services

BHS shall notify school districts of availability of funding. Schools districts with schools that meet the eligibility requirements will be asked to submit a request for services form. The request for services form must be signed by the Superintendent and the Principal for each school for which services will be provided. Principals must provide the following:

- Partner preferences: a ranked listing of the preferred program partner.
- Justification for clinician hours in excess of twelve (12) per week. Justification may include large campus size (more than 600 students); high rates of suspension or expulsions; other community justification associated with experiences of severe trauma.
- Dedicated desk space for clinician during their time on campus.
- Dedicated space for confidential one-on-one or group activities to be conducted.
- A preferred work schedule for clinicians on campus.
- A dedicated campus point of contact.

This program will have limited capacity at start-up. Program capacity will be restricted by clinician availability and funding resources. BHS intends to ensure that multiple school districts, throughout the County, can participate in the program. However, due to limited resources, access to the program services will be prioritized for the schools with the highest rated need and best fit between school and Organizational Provider capacity. Superintendents must provide the following:

- Rank order of the schools within the district for which services should be provided upon availability of clinicians and funding resources.
- Partner preferences: a ranked listing of the preferred program partner.
- Evidence that the School District has adopted policies to promote a safe and supportive school climate. Examples would include resolutions and/or polices promoting evidence based practices, including but not limited to, restorative justice, positive behavioral interventions, etc.
- Agreement to enter into a memorandum of understanding between BHS and the District. The partnership agreement will include requirements for data collection, quarterly reports, and participation in evaluation activities. Participation in a program evaluation is required for receipt of PEI funds.
- Agreement to assign a project coordinator to meet with BHS on a regular basis.

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

Project Components

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

Clinical staff will provide:

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

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

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

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

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

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

3. **Student Support Teams**: Schools and parents may jointly decide to form a student support team to address the needs of a student. As appropriate, on-site clinicians will participate in student support team meetings.

4. Program Operations and Supervision:

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

PEI: EI for C&Y-School Based Interventions

Cost Center(s): 6388
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS		$0.00			
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER			$2,914,526.00		
ADMINISTRATIVE / INDIRECT		$0.00	$29,145.26		
PERSONNEL COSTS		$0.00	$0.00		
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$2,943,671.26**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal			$0.00		
Realignment			$0.00		
Other			$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$2,943,671.26**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Multiple service providers.

PEI Project 5: Early Interventions to Treat Psychosis

Community Need

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

Project Description

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

Promising models include, but are not limited to:

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

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

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

Project Components

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

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

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

PEI: EI for C&Y-Early Interventions to Treat Psychosis

Cost Center(s): 6398

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$739,192.31	$235,575.78	$1,118,568.00		
ADMINISTRATIVE / INDIRECT	$110,878.85		$5,679.96		
PERSONNEL COSTS	$7,716.84		$0.00		
TOTAL GROSS EXPENDITURES	**$857,788.00**	**$235,575.78**	**$1,124,247.96**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$350,223.67	$35,715.81	$550,472.00		
Realignment					
Other	$40.00	$41.21	$100.00		
Total	**$350,263.67**	**$35,757.02**	**$550,572.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$507,524.33**	**$199,818.76**	**$573,675.96**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Telecare $1,118,568

PEI Project 6: Community Trauma Services for Adults

Community Need

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

Project Description

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

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

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

Additional priority populations are:

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

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

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

Project Components

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

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

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

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

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

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

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

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

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

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

7. **Referrals:** All TAY, adults and older adults 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: Community Trauma Services for Adults

Cost Center(s): 6392
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER			$1,200,000.00		
ADMINISTRATIVE / INDIRECT			$180,000.00		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$1,380,000.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal			$0.00		
Realignment			$0.00		
Other			$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$1,380,000.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

RFP 20-21 $1,200,000

PEI Project 7: Recovery Services for Nonviolent Offenders

Community Need

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

Project Description

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

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

Project Components

Project 1: Law Enforcement Assisted Diversion (LEAD)

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

Project 2: Offender Assessment Services

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

PEI: EI for Adults-Recovery Services for Nonviolent Offenders

Cost Center(s): 6306

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Mental Health Outreach Worker	3.50	$125,808.00	$77,396.00	$203,204.00
Mental Health Specialist II	2.50	$112,520.00	$46,355.00	$158,875.00
Mental Health Specialist III	1.00	$45,126.00	$41,203.00	$86,329.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**7.00**	**$283,454.00**	**$164,954.00**	**$448,408.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$2,239.87	$2,007.91	$16,300.00		
NON-RECURRING COSTS	$2,193.87	$0.00	$0.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER		$3,966.94			
ADMINISTRATIVE / INDIRECT	$5,869.11	$7,719.41	$69,706.20		
PERSONNEL COSTS	$34,693.63	$56,079.72	$448,408.00		
TOTAL GROSS EXPENDITURES	**$44,996.48**	**$69,773.98**	**$534,414.20**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$0.00	$0.00	$0.00		
Realignment	$0.00	$0.00	$0.00		
Other	$0.00	$0.00	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$44,996.48**	**$69,773.98**	**$534,414.20**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support the PEI Program.

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

PEI Project 8: Forensic Access and Engagement

Community Need

Repeat offenders with behavioral health concerns may be charged and remanded to one of San Joaquin County Superior Court's Collaborative Court Programs designed for individuals with behavioral health or other special concerns. BHS currently provides mental health treatment interventions for all individuals served by the collaborative court system with serious mental illnesses through its Forensic Full Service Partnership Program. Through PEI funding, behavioral health services may also be provided to eligible collaborative court participants with mild/moderate or emerging mental health concerns.

Project Description

BHS will provide funding to a community based organization to work with individuals with mild-moderate mental health concerns that, left untreated are resulting in repeat incarcerations, prolonged suffering, and risk of homelessness. This project is a collaborative endeavor between BHS, San Joaquin County Probation Department, and the Superior Court. Activities may include but are not limited to screening and assessment, individualized case management, rehabilitative groups and activities, and navigation support to engage and maintain in needed treatment services, including substance use treatment services.

Project Components

- Outreach: Meet with clients while they are custody or remanded to court 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 and develop a client treatment plan for mental health and substance use treatment services.
- Placement and Stabilization Planning: Work with clients to review housing options. 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.
- Case Management: Assist clients in accessing primary and behavioral health care services, peer-based services, and financial, educational, prevocational, rehabilitative or other community based services and supports needed by clients to meet their personal goals.
- Meaningful Activities: Provide support and linkages for clients to enroll in educational of vocational programs (including pre-vocational readiness to work programs) and /or community service activities.

PEI: EI for Adults-Forensic Access & Engagement

Cost Center(s): 6384
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER		$35,000.00	$600,000.00		
ADMINISTRATIVE / INDIRECT			$6,000.00		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$0.00**	**$35,000.00**	**$606,000.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$0.00	$0.00	$0.00		
Realignment	$0.00	$0.00	$0.00		
Other	$0.00	$0.00	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$35,000.00**	**$606,000.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Mary Magdalene $600,000

PEI Project 9: Whole Person Care Project

Community Need

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

Project Description

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

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

Project Components

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

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

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

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

PEI: Access & Linkage-Whole Person Care Project

Cost Center(s): 6387

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Chief Mental Health Clinician	0.50	$53,483.00	$37,553.00	$91,036.00
Mental Health Clinician I	1.00	$65,969.00	$41,771.00	$107,740.00
Mental Health Outreach Worker	1.00	$36,231.00	$36,658.00	$72,889.00
Mental Health Specialist II	2.00	$99,406.00	$66,922.00	$166,328.00
Substance Abuse Counselor II	3.00	$124,332.00	$117,966.00	$242,298.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**7.50**	**$379,421.00**	**$300,870.00**	**$680,291.00**

Overtime $500.00

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$15,310.72	$5,798.08	$33,775.00		
NON-RECURRING COSTS	$918.87		$4,000.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER					
ADMINISTRATIVE / INDIRECT			$103,284.90		
PERSONNEL COSTS	$435,323.85	$172,653.86	$680,791.00		
TOTAL GROSS EXPENDITURES	**$451,553.44**	**$178,451.94**	**$821,850.90**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$0.00	$0.00	$0.00		
Realignment	$0.00	$0.00	$0.00		
Other	$73,311.93	$9,487.25	$30,000.00		
Total	**$73,311.93**	**$9,487.25**	**$30,000.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$378,241.51**	**$168,964.69**	**$791,850.90**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Small furniture and equipment $1,000 Computer supplies $3,000

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

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: Outreach-Increasing Recognition of Mental Illnesses

Cost Center(s): 6397
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS			$27,750.00		
CONTRACTED SERVICE PROVIDER			$42,616.00		
ADMINISTRATIVE / INDIRECT			$703.66		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$71,069.66**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$0.00	$0.00	$0.00		
Realignment	$0.00	$0.00	$0.00		
Other	$0.00	$0.00	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$71,069.66**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

NAMI of San Joaquin - $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: Information and Education Campaign

Cost Center(s): 6392
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$39,578.48		$1,739,130.00		
ADMINISTRATIVE / INDIRECT			$17,391.30		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$39,578.48**	**$0.00**	**$1,756,521.30**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$0.00	$0.00	$0.00		
Realignment	$0.00	$0.00	$0.00		
Other	$0.00	$0.00	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$39,578.48**	**$0.00**	**$1,756,521.30**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

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 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

- 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.

PEI: Suicide Prevention with Schools

Cost Center(s): 6397
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$26,164.66	$0.00			
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS	$12,756.66				
CONTRACTED SERVICE PROVIDER	$505,915.44	$214,769.58	$598,170.00		
ADMINISTRATIVE / INDIRECT	$75,033.87	$0.00	$5,981.70		
PERSONNEL COSTS	$77,914.84	$0.00	$0.00		
TOTAL GROSS EXPENDITURES	**$697,785.47**	**$214,769.58**	**$604,151.70**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$0.00	$0.00	$0.00		
Realignment	$0.00	$0.00	$0.00		
Other	$0.00	$0.00	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$697,785.47**	**$214,769.58**	**$604,151.70**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

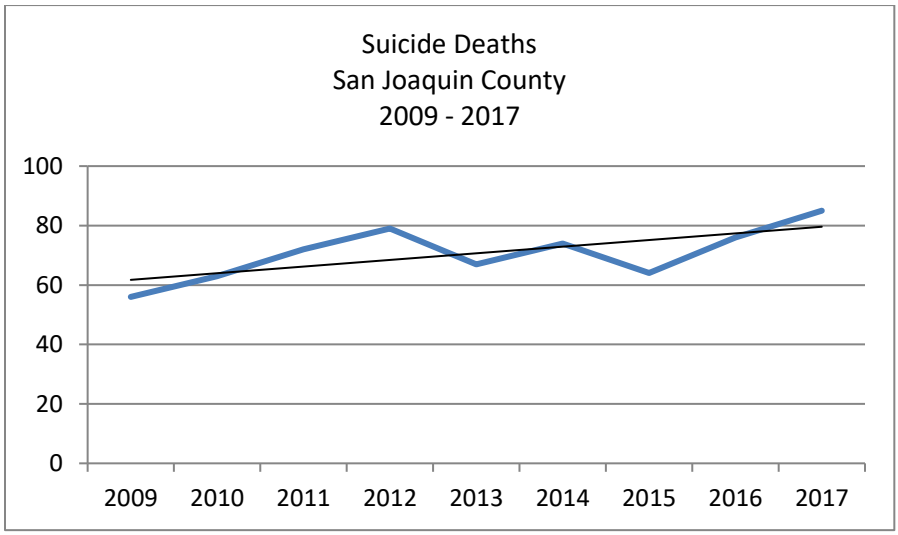
Brief description of items included in Contracted Service Provider:

Child Abuse Prevention Council $598,170

PEI Project 13: Suicide Prevention 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 between the ages of 15-64. Suicide prevention campaign information will align its messaging with

[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

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.

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

PEI: Suicide Prev-Suicide Prevention for the Community

Cost Center(s): 6392

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER			$652,174.00		
ADMINISTRATIVE / INDIRECT			$6,521.74		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$658,695.74**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$0.00	$0.00	$0.00		
Realignment	$0.00	$0.00	$0.00		
Other	$0.00	$0.00	$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$658,695.74**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

SPEK $652,174

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

Project 2: Progressive Housing

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 other 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.

INN: Assessment & Respite Center

Cost Center(s): 6396
RU(s):

PERSONNEL COSTS

Position Description & Position #	FY20-21 Proposed Budget FTE	MHSA Salary	MHSA Benefits	Total Salary & Benefits
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	FY19-20 YTD ACTUALS as of 12/31/2019	FY20-21 PROPOSED BUDGET *incl S&B (above)	FY21-22 PROPOSED BUDGET	FY22-23 PROPOSED BUDGET
OPERATING COSTS					
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS	$421,353.28	$177,799.00	$117,800.00		
CONTRACTED SERVICE PROVIDER			$2,030,668.00		
ADMINISTRATIVE / INDIRECT			$21,484.68		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$421,353.28**	**$177,799.00**	**$2,169,952.68**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal					
Realignment					
Other					
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$421,353.28**	**$177,799.00**	**$2,169,952.68**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

UC Davis $117,800

Brief description of items included in Contracted Service Provider:

CMC $2,030.668

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.

INN: Progressive Housing

Cost Center(s): 6396

RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Chief Mental Health Clinician	0.15	$15,052.00	$7,649.00	$22,701.00
Mental Health Outreach Worker	0.75	$32,386.00	$22,414.00	$54,800.00
Mental Health Specialist III	0.25	$15,000.00	$9,664.00	$24,664.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**1.15**	**$62,438.00**	**$39,727.00**	**$102,165.00**
Overtime				$0.00
		$1,718,276.00		

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$1,305.57	$4,893.25	$67,400.00		
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER	$357,048.54	$262,869.10	$1,548,711.00		
ADMINISTRATIVE / INDIRECT			$17,182.76		
PERSONNEL COSTS	$74,819.93	$47,767.47	$102,165.00		
TOTAL GROSS EXPENDITURES	**$433,174.04**	**$315,529.82**	**$1,735,458.76**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$58.27		$0.00		
Realignment			$0.00		
Other			$0.00		
Total	**$58.27**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$433,115.77**	**$315,529.82**	**$1,735,458.76**	**$0.00**	**$0**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs required to support the INN Program as outline in the MHSOAC approved plan.

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

Stockton Self Help Housing $1,548,711

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

Significant Considerations in Workforce, Education and Training

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

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

(1) Training and Technical Assistance

The Training and Technical Assistance Funding Category may fund: programs and/or activities that increase the ability of the Public Mental Health System workforce to support the participation of consumers and family members; increase collaboration and partnerships;

promote cultural and linguistic competence; develop and deliver trainings; and promote and support the *General Standards* of specialty mental health care services.

(2) Mental Health Career Pathway Programs

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

(3) Residency and Internship Programs

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

(4) Financial Incentive Programs

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

(5) Workforce Staffing Support

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

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

WET Project 1: Training and Technical Assistance Academy

Community Need

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

Project Description

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

Project Components

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

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

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

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

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

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

WET: Training & Technical Assistance Academy

Cost Center(s): 6399
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Management Analyst II	0.50	$35,730.00	$26,013.00	$61,743.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.50**	**$35,730.00**	**$26,013.00**	**$61,743.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$93,070.92	$52,035.31			
NON-RECURRING COSTS			$201,299.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER					
ADMINISTRATIVE / INDIRECT	$13,960.64	$1,841.22	$39,456.30		
PERSONNEL COSTS		$4,497.16	$61,743.00		
TOTAL GROSS EXPENDITURES	**$107,031.56**	**$58,373.69**	**$302,498.30**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal					
Realignment					
Other					
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$107,031.56**	**$58,373.69**	**$302,498.30**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

To support BHS Training Academy

Brief description of items included in Contracted Service Provider:

WET Project 2: Internship and Financial Assistance Program

Community Need:

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

Project Description:

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

Project Components:

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

WET: Internship and Financial Assistance Project

Cost Center(s): 6399
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS	$93,070.92	$52,035.31	$200,000.00		
NON-RECURRING COSTS					
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER					
ADMINISTRATIVE / INDIRECT	$13,960.64	$1,841.22	$30,000.00		
PERSONNEL COSTS		$4,497.16	$0.00		
TOTAL GROSS EXPENDITURES	**$107,031.56**	**$58,373.69**	**$230,000.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal					
Realignment					
Other					
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$107,031.56**	**$58,373.69**	**$230,000.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Funding to support Internship and Financial Assistance Project

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

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 2020-21 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 2020-21. Budget estimates presumes additional funds will be required in subsequent years to complete the project.

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.

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 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.

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.

CFTN: Capital Facilities - Residential Treatment Facilities for COD

Cost Center(s): 63XX
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS			$7,836,846.00		
CONSULTANT/CONTRACT COSTS					
CONTRACTED SERVICE PROVIDER					
ADMINISTRATIVE / INDIRECT			$360,999.00		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$0.00**	**$0.00**	**$8,197,845.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal			$0.00		
Realignment			$0.00		
Other			$5,430,186.00		
Total	**$0.00**	**$0.00**	**$5,430,186.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$0.00**	**$2,767,659.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

CFTN: Capital Facilities-Facility Repair and Upgrades

Cost Center(s): 6316, 63XX CHFFA
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS		$3,861.31	$74,599.00		
NON-RECURRING COSTS	$282,546.37	$41,793.63	$3,643,173.00		
CONSULTANT/CONTRACT COSTS		$72,887.10			
CONTRACTED SERVICE PROVIDER			$70,401.00		
ADMINISTRATIVE / INDIRECT			$568,225.95		
PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$282,546.37**	**$118,542.04**	**$4,356,398.95**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal					
Realignment					
Other					
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$282,546.37**	**$118,542.04**	**$4,356,398.95**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Funding to cover MHSA related manintenance and grounds cost.

Brief description of items included in Non-Recurring Costs:

Facility Projects

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

CFTN: Technology Needs-Technology Equipment and Software

Cost Center(s): 6315
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.00**	**$0.00**	**$0.00**	**$0.00**

	FY18-19 ACTUALS	**FY19-20 YTD ACTUALS as of 12/31/2019**	**FY20-21 PROPOSED BUDGET** *incl S&B (above)	**FY21-22 PROPOSED BUDGET**	**FY22-23 PROPOSED BUDGET**
OPERATING COSTS					
NON-RECURRING COSTS		$63,000.00	$0.00		
CONSULTANT/CONTRACT COSTS			$0.00		
CONTRACTED SERVICE PROVIDER			$0.00		
ADMINISTRATIVE / INDIRECT PERSONNEL COSTS			$0.00		
TOTAL GROSS EXPENDITURES	**$0.00**	**$63,000.00**	**$0.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal			$0.00		
Realignment			$0.00		
Other			$0.00		
Total	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$0.00**	**$63,000.00**	**$0.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Brief description of items included in Non-Recurring Costs:

Brief description of items included in Consultant/Contract Costs:

Brief description of items included in Contracted Service Provider:

CSS: Administration

Cost Center(s): 6310
RU(s):

PERSONNEL COSTS

	FY20-21 Proposed Budget			
Position Description & Position #	**FTE**	**MHSA Salary**	**MHSA Benefits**	**Total Salary & Benefits**
Management Analyst II	0.30	$25,285.00	$14,589.00	$39,874.00
New Position		$47,800.00	$3,657.00	$51,457.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
		$0.00	$0.00	$0.00
Total	**0.30**	**$73,085.00**	**$18,246.00**	**$91,331.00**

Overtime	$500.00
Med Ins-Retirees	$28,950.00
Pending	$1,332.00
Parking	$3,538.00

	FY18-19 ACTUALS	FY19-20 YTD ACTUALS as of 12/31/2019	FY20-21 PROPOSED BUDGET *incl S&B (above)	FY21-22 PROPOSED BUDGET	FY22-23 PROPOSED BUDGET
OPERATING COSTS	$2,469,467.71	$591,079.02	$642,770.00		
NON-RECURRING COSTS	$201,571.50	$50,130.50	$459,500.00		
CONSULTANT/CONTRACT COSTS	$0.00	$14,525.25	$72,500.00		
CONTRACTED SERVICE PROVIDER	$109,650.00		$177,556.00		
ADMINISTRATIVE / INDIRECT	$0.00	$1,659,217.58	$3,551,237.00		
PERSONNEL COSTS	$195,134.81	$111,062.25	$125,651.00		
TOTAL GROSS EXPENDITURES	**$2,975,824.02**	**$2,426,014.60**	**$5,029,214.00**	**$0.00**	**$0.00**
Offsetting Revenue					
Medi-Cal	$0.00	$0.00	$764,099.00		
Realignment	$0.00				
Other	$0.00				
Total	**$0.00**	**$0.00**	**$764,099.00**	**$0.00**	**$0.00**
TOTAL NET EXPENDITURES	**$2,975,824.02**	**$2,426,014.60**	**$4,265,115.00**	**$0.00**	**$0.00**

Brief description of items included in Operating Costs (e.g. Office supplies, staff training & education, motor pool, client training, incentives, etc):

Comprised of general operating service and supply costs associated with the direct admininstration of MHSA programs.

Brief description of items included in Non-Recurring Costs:

Small furniture and equipment $1,000 Computers and Software $209,500

Brief description of items included in Consultant/Contract Costs:

Consultants for strategic planning and evaluation $215,000

Brief description of items included in Contracted Service Provider:

Website and other systemwide ugrades $625,000

X. MHSA Funds – Reduction of the Prudent Reserve Balance

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

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

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

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

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

XI. Attachments: Evaluation and Planning Reports

Workforce Analysis

Cultural Competency Plan

PEI Evaluation

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
2019-20 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 in a broad range of behavioral health services that include mental health and substance use disorder services in a culturally competent and linguistic appropriate manner to meet the prevention, intervention, treatment and recovery needs of San Joaquin County residents.

This document serves as a brief annual update, reviewing the efforts of Fiscal Year 2018-2019 and to provide strategic guidance and baseline development on upcoming efforts for 2019-20. The Brief Annual update will focus on the eight criteria laid out by the State's Cultural Competency Plan Requirements of 2010, reflective of the current Medi-Cal population to provide strategies on improvement and enhancement of Culturally Competent and Linguistically Appropriate Services, for agency staff, community partners and consumers.

Criterion 1: Commitment to Cultural Competence

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

BHS continues its efforts to expand and enhance its Cultural Competency efforts. BHS began tracking, monitoring and measuring strategies via the BHS QI Work Plan. The addition of this process allowed for accountability to review measurable objectives throughout the 2018-19 Cultural Competency Plan Update.

A new four to five hour online training entitled, "Improving Cultural Competency for Behavioral Health Professionals", released in May 2019, was introduced to the cultural competency committee. The training's learning objectives are to: 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. After review by the Cultural Competency Committee, the training was selected as agency-wide online training course to replace the former online training.

2018-19 Accomplishments: Two significant strategies were implemented to enhance agency commitment to Cultural Competency. These were:

- Measured and monitored cultural competency standards through the 2018-19 Quality Improvement Work Plan (See Attachment 1)
- Adopted a new, updated online training entitled "Improving Cultural Competency for Behavioral Health Professionals" by the Federal Office of Minority Health to replace an older training. (See Attachment 2)

2019-20 Strategies: BHS plans to further enhance its cultural competence by:

- Developing measurable standards for culturally competent services for substance use disorder (SUD) services by December 31, 2019.

- Developing a plan to measure and monitor the cultural competency standards for SUD services through the data dashboard and/ or the Quality Improvement Work Plan by December 31, 2019.
- Conducting 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 March 30, 2020.
- Strategizing and developing an action plan to address findings of the CBMCS Survey by June 30, 2020

Criterion 2: Updated Assessment of Service Needs

(CLAS Standard 2)

BHS conducted assessments of service needs through two methods:

1. Mental Health Services Act (MHSA) Community Planning Process on the needs and gaps in services to diverse communities in the County. The assessment of service needs is detailed in the 2019-20 Annual Update to the Three Year Program and Expenditure Plan, pages 7 through 18 (See attachment 3).
2. Review of county-specific Medi-Cal Approved Claims Data for both mental health (MH) and SUD utilization provided by CALEQRO. The data provided by CALEQRO contains Medi-Cal Beneficiaries served by race and ethnicity and penetration rates by age, gender and ethnicity (See attachment 4).

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

- African Americans are disproportionately represented amongst consumers compared to their proportion of the general population (19% of participants, though comprising 7% of the population of the County).
- Latinos are enrolled as lower rates compared to their proportion of the general population (26% of participants while comprising 42% of the population) – though this rate is up slightly from prior years.
- Participation amongst children and youth is more reflective of the racial demographics of the overall population, with over a third of services provided to young Latinos (35%), suggesting that while stigma, language or cultural barriers, or access to health care services continue to impeded access for Latino adults with behavioral health needs more services are reaching the younger populations.
- Survey Input and Stakeholder feedback displayed race/ethnicity data reflective of the BHS client population. Notably children and youth are more likely to be Hispanic/Latino than adult survey respondents. Adult survey respondents were more likely to be African American, Asian, or Native American than is reflective of the general population.
- Feedback from self-reported demographics found that Adult Consumers represented 11% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQQI). Amongst children and youth 12% self-identified as LGBTQQI.

Data provided by CALEQRO for MH Medi-Cal Beneficiaries showed that:

- The penetration rate for individuals 60+ is higher than the statewide average.
- The penetration rate for Asian/Pacific Islanders is higher than the statewide average.
- The penetration rate for Latino/Hispanic communities (2.65%) is lower than the statewide average of 3.78%

Data provided by CALEQRO for SUD Medi-Cal Beneficiaries showed that:

- The penetration rate for individuals 65+ is higher than statewide average
- The penetration rate for African-American group is higher than statewide and medium sized counties average
- The penetration rate for Latino/Hispanic communities (.8%) is higher that the statewide average.

From this data, the BHS Cultural Competency Committee has laid out recommendations for strategies to increase Latino/Hispanic Communities within San Joaquin County (See Attachment 5).

2018-19 Accomplishments: BHS implemented a comprehensive community planning process that included:

- Six community discussions and about the needs and challenges experienced by MH consumers with a focus on the diverse range of consumers served.
- Five targeted discussion groups with MH consumers, family members and community stakeholders.
- Assessment of program services, including utilization, timeliness and client satisfaction.
- Cultural Competency Committee presentation to multiple stakeholder groups throughout the BHS System.
- California Brief Multicultural Competency Survey (CBMCS) online survey developed for distribution to both MH and SUD direct hire staff.

2019-20 Strategies:

- Conduct a series of MHSA community planning discussions on the needs and challenges experienced by MH consumers with a focus on the diverse range of consumers served by January 31, 2020.
- Develop online and paper needs assessment surveys to reach individuals who are unable to attend community planning sessions or who may be unwilling or unable to provide public comment in person at meetings by January 31, 2020.
- Distribute and collect needs assessment surveys by February 15, 2020.
- Complete an annual MHSA assessment of needs by February 29, 2020.
- Conduct a series of planning discussions on the needs and challenges experienced by SUD consumers with a focus on the diverse range of consumers served by May 31, 2020.
- Develop online and paper needs assessment surveys to reach individuals who are unable to attend community planning sessions or who may be unwilling or unable to provide public comment in person at meetings by May 31, 2020.
- Distribute and collect needs assessment surveys by June 1, 2020.
- Complete an annual SUD assessment of needs by June 30, 2020.
- 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 March 30, 2020,
- Develop strategies and an action plan to address CBMCS findings by June 30, 2020.

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

(CLAS Standard 1, 10, 14)

The new Behavioral Health Assessment and Respite Center, which opened in June 2018, is designed as a "friendly front door" to services for individuals who are unlikely to access MH and SUD services from the public behavioral health system. Community Medical Centers (CMC), a local non-profit community health care provider and a Federally Qualified Health Center (FQHC), was selected as the lead project partner because it has a long standing reputation in the community for serving racial and ethnic minorities, having started over forty years ago providing health care services in the fields to migrant farm workers. Over the years it has grown to a network of 12 community clinics serving over 80,000 patients. Ninety-seven percent of patients are low-income and 83% identify as ethnic or racial minorities.

As of 5/30/2019, a total of 445 individuals have either been referred or self-referred to receive services delivered as of part of the Homeward Bound Initiative.

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)	34%	38%	46%
Latinx	41%	24%	26%
Asian	15%	11%	5%
African American	7%	19%	12%
Other	4%	8%	13%

Increasing engagement across different racial and ethnic groups has been more challenging, assuming the need for Homeward Bound services across these groups is somewhat similar. As highlighted in the original proposal, the proportion of Latinx consumers who utilize San Joaquin County BHS is significantly lower than the San Joaquin population average (24% of BHS consumers are Latinx, relative to 41% of the San Joaquin population).The preliminary findings presented here suggest that the Homeward Bound Initiative is experiencing comparable levels of under-engagement (26% of consumers reporting being of Latinx ethnicity). Based on the feedback from CMC providers it is possible that at least part of this difference may be attributable to a greater number of Latinx consumers refusing to answer questions regarding their race and ethnicity, and limitations in how the data was captured. However, even factoring this into consideration, engagement with Latinx populations appears relatively low. Additionally, the proportion of consumers of Latinx ethnicity who were assessed but declined services was slightly higher relative to other racial and ethnic groups. These differences were evident despite 10 of the 15 members who deliver SUD services at CMC being Spanish speaking (67%); translation services being available where necessary; CMC's historical track record of providing physical, behavioral, and social care to migrant farm workers and their families dating back to the 1960's; and extensive current outreach efforts. One example of such outreach efforts includes a questionnaire distributed to the local community to better understand the needs of the population. Notably, a number of individuals of Latinx ethnicity initially requested additional information, but when called back either declined to engage or denied requesting such information. The engagement rates reported were calculated on relatively small sample sizes, so at this stage no firm conclusions can be drawn. Nevertheless, these findings suggest that even more extensive outreach efforts to engage a greater number of people of Latinx (and Asian) race and ethnicity may be warranted.

2018-19 Accomplishments

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

2019-20 Strategies

- Cultural Competency Committee to Review data from First Year Evaluation Report related to race and ethnicity and provide recommendations for further engagement of the Latinx and Asian population by April 30, 2020
- Implement adjustments to the activities of the Assessment and Respite Center in the annual contract review process by June 30, 2020.

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

(CLAS Standard 13)

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

- A Cultural Competency Committee comprised of BHS staff, consumers/family members, and other stakeholders.
- The 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 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 focus on cultural competence and language proficiency. The Co-Chair of the Cultural Competency Committee is responsible for planning the Consortium activities along with community stakeholders. The Consortium has become a vehicle through which the Cultural Competency Committee informs our stakeholders of continuous Cultural Competency efforts.

2018-19 Accomplishments: The Cultural Competency committee achieved significant successes with the development of three major projects:

- Integrated SUD services staff into the Cultural Competency Committee
- Introduced a new mandatory online staff training on Cultural Competence (see attachment 2)

2019-20 Strategies

- Hold at least eight meetings involving representation from management staff, direct services staff, consumer, community members and representatives of cultures from the community by June 30, 2020.
- Elicit, suggest, review, monitor and support at least two new strategies to increase penetration and retention rates for identified community groups by June 30, 2020.
- Recruit additional 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, 2020.

Criterion 5: County Culturally Competent Training Activities

(CLAS Standard 4)

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

2018-19 Accomplishments:

- Adopted new online course curriculum entitled, “Improving Cultural Competency for Behavioral Health Professionals”
- BHS has also continued its efforts in providing cultural competency presentations via the Consortium as outlined in Criterion 4.

2019-20 Strategies:

- Implement new online Cultural Competency Training by November 30, 2019.
- Expand Cultural Competency Training agency wide by providing Train-the-Trainers for the Health Equity Multicultural Diversity Training by (Ca. Institute for Behavioral Health Services (CIBHS)).

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

(CLAS Standard 7)

BHS conducted a system Workforce Needs Assessment in February 2019 (Attachment 6). The results of the Workforce Needs Assessment are included in attachment 6. The table below compares proportional data on BHS employees to client data from CALEQRO and the United States Census data:

	BHS staff (Number)	BHS staff %	MH Medi-Cal Beneficiaries % (CALEQRO)	SUD Medi-Cal Beneficiaries % (CALEQRO)	County % (Census)
Caucasian/White	225	33.4%	17.2%	19%	31.8%
Hispanic	197	29.2%	45.7%	44%	41.6%
Asian	115	17.0%	9.7%	16%	16.7%
Black/African American	79	11.7%	9.7%	10%	8.2%
Other	57	8.4%	13.0%	10%	1.7%
Total	673	100%	100%	100%	100%

Data shows that BHS staff continue to be underrepresented in staff that are Hispanic, a decrease in African-American Beneficiaries shows that BHS Staff % is now just slightly above representation. Data also shows that Asian SUD Beneficiaries match BHS representation.

2018-19 Accomplishments

- Conducted system-wide Workforce Needs Assessment in February 2019.
- Reviewed staff data to determine areas in which the BHS staff was over or under-represented.

2019-20 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 and by June 30, 2020.

Criterion 7: County System Language Capacity

(CLAS Standard 5,6,8)

The BHS Cultural Competency Committee reviewed the language capacity of its staff collected with an in-house database. The data, provided below, shows improvement in language capacity from previous fiscal year in Cambodian, Vietnamese and Laotian Languages. Other unrepresented languages are American Sign Language and Korean.

Primary languages spoken by clients and staff	# of Clients	# of BHS Staff Providing Direct Services (2017-18)	Staff to client ratio (2017-18)	# of Clients	# of BHS Staff Providing Direct Services (2018-19)	Staff to client ratio
English	13,782	705	1:20	13717	736	1:19
Spanish	830	80	1:10	818	80	1:10
Cambodian	391	4	1:98	391	7	1:56
Vietnamese	193	0	n/a	192	7	1:27
Laotian	89	0	n/a	87	6	1:15
Hmong	78	8	1:10	78	8	1:10
Tagalog	47	42	1:1	6	42	1:1
Arabic and Farsi	30	2	1:15	20	2	1:10
Chinese (Mandarin and Cantonese)	18	1	1:18	16	1	1:16
American Sign Language	10	0	n/a	7	0	n/a
Korean	3	0	n/a	3	0	n/a

2018-19 Accomplishments:

- Maintained an in-house database of language capacity of BHS staff.
- Completed Workforce Needs Assessment in 2018-19
- Improvement in language capacity in Cambodian, Vietnamese and Laotian.

2019-20 Strategies:

- The BHS Cultural Competency Committee will partner with Recruitment and Retention Committee to develop strategies for increasing the recruitment of staff that speak Cambodian, Vietnamese, and Laotian by June 30, 2020.

Criterion 8: County Adaptation of Services

(CLAS Standard 12)

BHS documented the necessity of cultural and linguistic competency in its contractual requirements and monitors contractors to ensure that services are being implemented accordingly. BHS has included the requirement for cultural and linguistic competence in each of the project descriptions in its Requests for Proposals (RFP).

2018-19 Accomplishments:

- BHS contracts document the requirement for cultural and linguistic competence. (Attachment Boilerplate Contract)

- BHS created monitoring item in contracting document that will monitor contractors to ensure that

new services are being implemented with cultural and linguistic competence. (Attachment Contract Monitoring Tool)

2019-20- Strategies:

- Work with training coordinator to enhance access to Cultural Competency Training for BHS Contractors

Attachments:

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

Attachment 1: BHS MH QAPI Work Plan

S. Structure and Operations										
S.H. Cultural Competency- The MHP incorporates cultural competency principles in the systems of care to	18/19 Work Plan Reference	Goals	Target	Baseline	Data Source	Department Responsible	Review Committee	Frequency of Review	Action Plan
S.H.2 The MHP identifies strategies and resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its eligible.	6.c.i.	Create workforce that is representative of the population.	By 6/30/2020, BHS will increase the Hispanic/Latino proportion of staff to 45%.	31% FY18/19	Human Resources	Cultural Competence Committee	Cultural Competence Committee	Quarterly	Enact recruitments for language-specific positions. Assess opportunities for recruitment in cultural arenas of the community and implement two strategies.
S.H.3 The MHP implements strategies and uses resources to meet the cultural, ethnic, racial, and linguistic clinical needs of its eligible.	6.a.	Improve cultural competency of staff	As described in the Cultural Competence Plan, 100% of staff and contractors hired during FY18/19 will receive online Cultural Competency Training within 12 months of employment	66% FY18/19 for FY17/18	Department Managers	Training	Cultural Competence	Quarterly	Managers and supervisors will require new staff to complete online cultural competence training during the initial probationary period.

Attachment 2: BHS SUD QAPI Work Plan

Initiative 6: Develop Staff and Enhance Cultural Competency

#	Goal	FY18/19 Strategic Actions and Objectives	FY18/19 Strategic Actions and Objectives
6a	Linguistically and culturally diverse staff	Document the linguistic capabilities of SAS staff and compare to Medi-Cal eligible populations to determine capacity of existing staff to meet linguistic needs of the population.	Review findings in QAPI Council and Cultural Competency Committee to establish recruitment objectives for fiscal year.
6b	Staff and leadership trained in cultural responsiveness	Implement a train the trainer cultural responsiveness training initiative throughout the behavioral health department	Trained trainers provide ongoing training and coaching to all SJCBHS staff.
6c	Promotion of culturally and linguistically appropriate services, policies, and practices	SJCBHS's Cultural Competency Committee (CCC) recruits 3 new SUD members from diverse cultural backgrounds and from different disciplines within the department and community.	Cultural Competency Committee reviews service utilization and outcome data disaggregated by key demographic categories, and provides input on culturally relevant performance objectives, performance improvement strategies, programs, and organizational policies.
6d	American Society of Addiction Medicine (ASAM) training	All SUD staff complete 2-day in-person ASAM training, which provides participants with opportunities for skill practice at every stage of the treatment process; assessment, engagement, treatment planning, continuing care and discharge or transfer.". Two forensics mental health clinicians and three mental health adult outpatient clinicians receive ASAM training as well, to support integration of services and ensure that mental health services support clients with co-occurring disorders.	All SUD staff will receive five on-line ASAM training modules, including "ASAM Multidimensional Assessment", "From Assessment to Service Planning and Level of Care" and "Introduction to the SAM Criteria (p384 of STCs).

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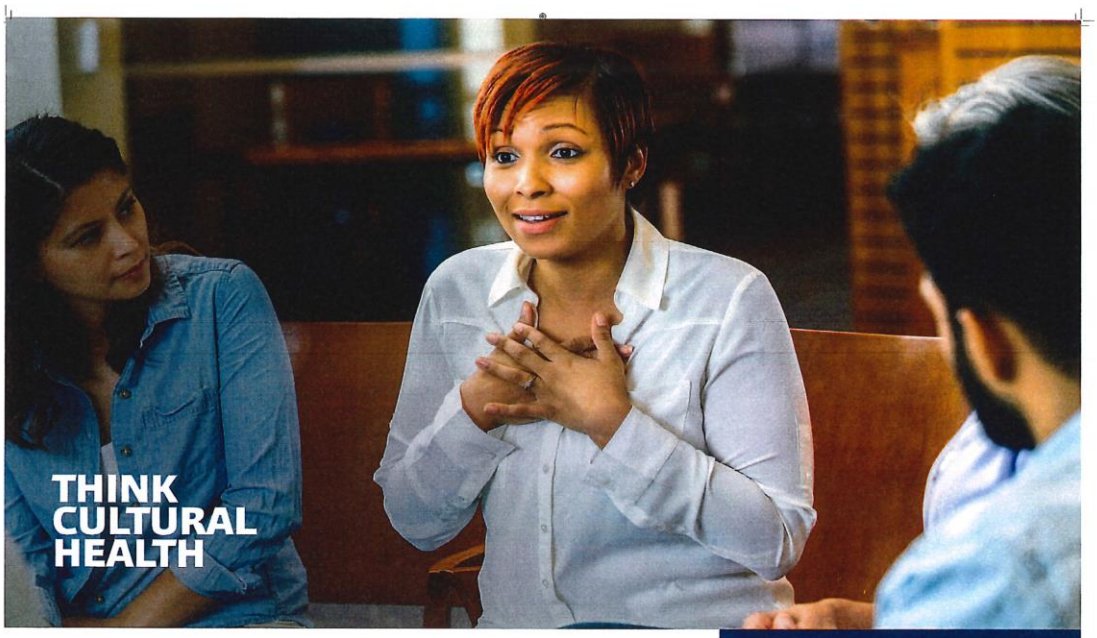
Attachment 3:



NEW!

Improving Cultural Competency for Behavioral Health Professionals

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

This e-learning program covers:

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

AT A GLANCE

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

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

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

Attachment 4: 2019-20 Annual Update to the Three Year Mental Health Services Act Program and Expenditure Plan, pages 10-21

Community Program Planning Process

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

Quantitative Analysis:

- BHS Program Service Assessment: September – March
  - Utilization Analysis
  - Penetration and Retention Reports
  - External Quality Review
- Workforce Needs Assessment
- Evaluation of Prevention and Early Intervention Programs for 2017/18

Community Discussions:

- MHSA Showcase of Programs and Services
  - October 10, 2018
- Behavioral Health Board:
  - October 2018 – Discussion of Homelessness, Housing, and the Mentally Ill
  - November 2018 – MHSA, Community Planning Meeting
- General Public Forums
  - November 5, 2018 at Behavioral Health Services in Stockton, CA
  - November 7, 2018 at the Larch Clover Community Center in Tracy, CA
  - November 8, 2018 at the Lodi Public Library in Lodi, CA

Targeted Discussion Groups

- Consumer Focus Groups
  - November 8, 2018 at the Wellness Center
  - November 15, 2018 at the Martin Gipson Socialization Center
- Consortium of MHSA Providers and Stakeholders
  - December 5, 2018

Consumer and Family Member Surveys

- 2018-19 MHSA Youth or Family Member of Children and Youth Survey
- 2018-19 MHSA Adult consumer Survey

Assessment of Mental Health Needs

Population Served

San Joaquin County Behavioral Health Services (BHS) provides behavioral health services, including mental health and substance use disorder treatments to nearly 15,900 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 fiscal year 2017-18, provides a general overview of program participation and county population.

Mental Health Services provided FY 2017-18

Services provided by Age	Number of BHS Clients*	Percent of BHS Clients
Children	3022	19.0%
Transitional Age Youth	3087	19.5%
Adults	8104	51.0%
Older Adults	1661	10.5%
Total	**15,874**	**100%**

*Source: BHS Client Services Data

Program participation is reflective of anticipated demand for services, with the majority of services being delivered to adults, ages 25-59 years of age. The participation amongst other age groups is consistent with their percentage within the total population.

Race/Ethnicity	County Population by Race/Ethnicity*	Percent of County Population		Clients Served by BHS	Percent of BHS Clients
White	235,440	32%		5,908	37%
Latino	310,067	42%		4,086	26%
African American	50,693	7%		2,953	19%
Asian	111,968	15%		1,642	10%
Other	31,932	4%		745	5%
Native American	1,337	0%		479	3%
Pacific Islander	3,987	1%		61	0%
Total	**745,424**	**100%**		**15,874**	**100%**

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

Diversity of participants is similar to the distribution in prior years. African Americans are disproportionately over-represented amongst consumers compared to their proportion of the general population (19% of participants, though comprising 7% of the population of the County). Native Americans are also over-represented within the service continuum (3% of clients are Native American) and data indicates that nearly one-third of the Native American's in the County received services from BHS at least one time during the past year. Latinos are enrolled in mental health treatment services at rates lower than is be expected compared to

their proportion of the general population (26% of participants though comprising 42% of the population). 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 populations.

City	County Population by City*	Percent of County Population		Clients Served by BHS	Percent of BHS Clients
Stockton	315,103	42%		10,591	67%
Lodi	67,121	9%		1,313	8%
Tracy	92,553	12%		966	6%
Manteca	81,345	11%		1,000	6%
Lathrop	24,268	3%		282	2%
Ripon	15,847	2%		107	1%
Escalon	7,558	1%		89	1%
Balance of County	154,949	20%		1,526	10%
Total	**758,744**	**100%**		**15,874**	**100%**

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

The majority of clients are residents of the City of Stockton. Stockton is the County seat and largest city in the region, accounting for 42% of the county population. The majority of services and supports for individuals receiving public support benefits (including mental health) are located in Stockton.

Discussion Group Input and Stakeholder Feedback

Several different types of community forums and discussion groups were convened in the Fall of 2018 to provide opportunities for a range of community stakeholders to participate in the Community Program Planning Process.

Community Program Planning for 2019-20 began in October 2018. The first set of activities included

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

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

2. Announcement at the October 2018 Behavioral Health Board

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

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

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

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

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

One hundred and seventy-one individuals (N=171) participated in the community meetings and focus groups. Of these over half, (N=57%) 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 however 22% were older adults and 5% were youth ages 18-25.

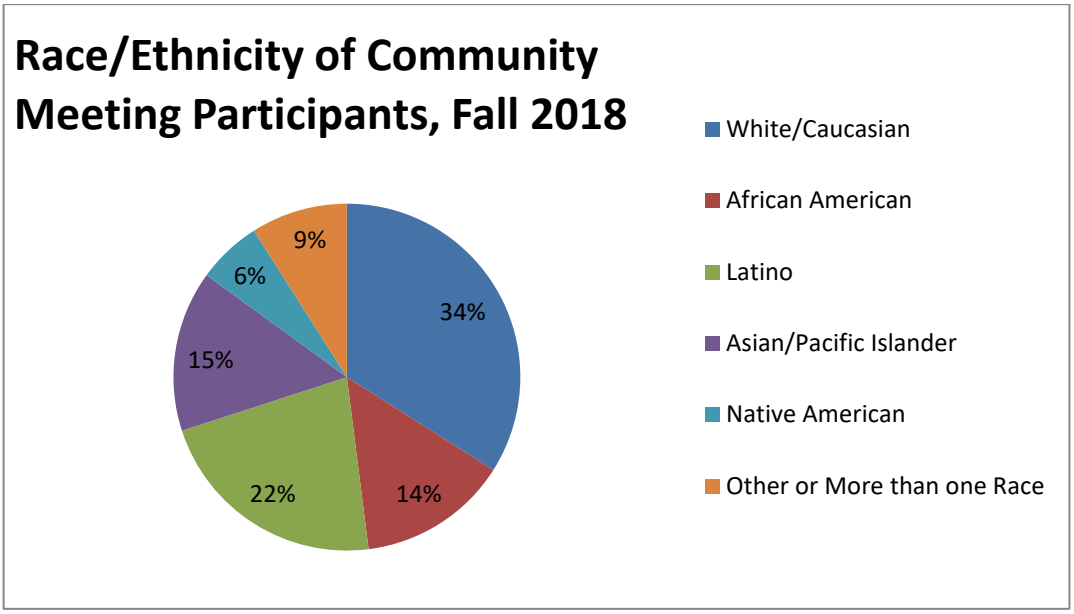
Community Meetings were also attended by the following types of individuals:

- County mental health department staff
- Substance use disorder treatment provider
- Community-based organization staff
- Children and Family Services
- Law Enforcement
- Veterans Services
- Senior Services
- Housing Providers
- Health care Providers
- Advocates for people with Serious Mental Illness

Community meetings included a diverse array of stakeholder participants. Sixteen percent (16%) of meeting participants reported speaking a language other than English at home; this compares favorably to the overall BHS population served during FY 2017/18, in which 13% of clients served spoke a language other than English.

This year also saw a greater proportion of individuals self-identifying as transgender (n=4) than in previous years which typically only included one or two individuals self-identifying as transgender. It is unknown if these increases are due to improved outreach efforts or due to community-wide reductions in stigma allowing more people the safety to self-disclose.

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



Survey Input and Stakeholder Feedback

BHS distributed two surveys to consumers and family members in January 2019 to learn more about the perspectives, needs, and lives of the clients served through mental health programs. Over 800 individuals completed the surveys. The ***MHSA Adult Consumer Survey*** was distributed through BHS Crisis Services and various Outpatient Clinics; 501 adults completed this survey. An additional 335 family members or youth completed the ***MHSA Youth or Family Member of Children and Youth Survey*** in conjunction with services received through BHS Children and Youth Services. Survey questions were relatively the same across both questionnaires, with slight differences in the phrasing of the questions depending on the target audience. Surveys were paper-based surveys with limited choice answers. Responses were scanned into a software program that uses a proprietary technology to match checked answers with corresponding data fields. Survey instruments can be reviewed in the Appendix.

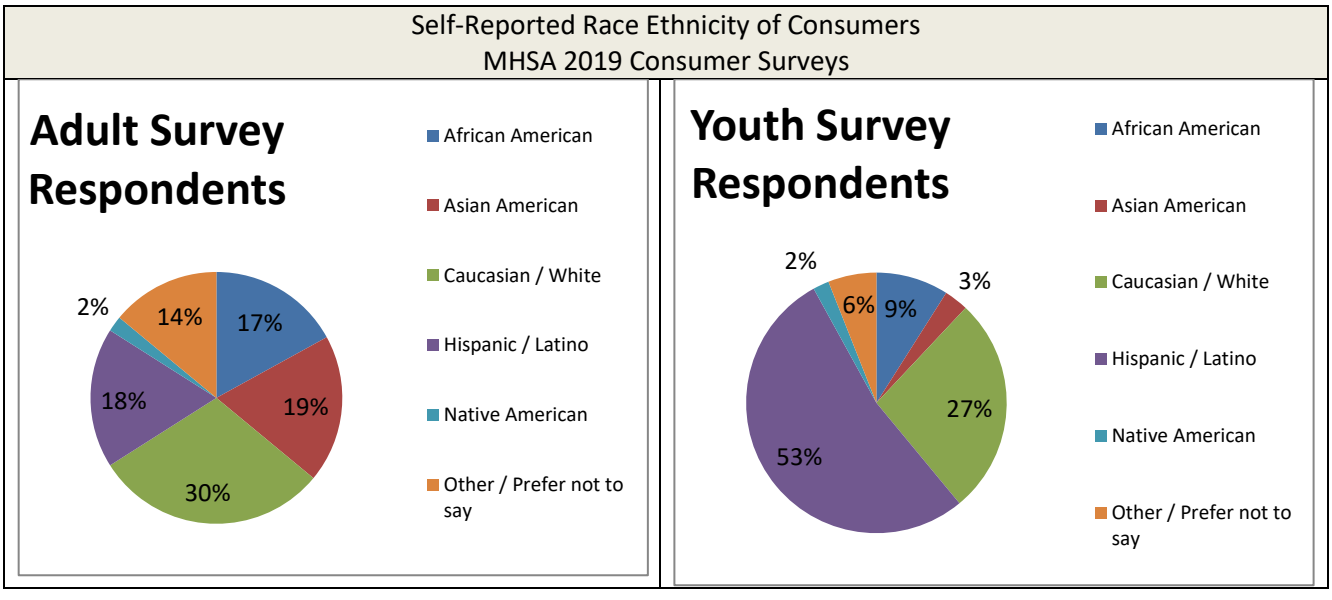
Overall BHS consumers and their family members report high levels of satisfaction with the services provided to address mental health and/or substance use disorder concerns with 85% of the respondents reporting that they would recommend BHS services for others. In terms of challenges, respondents from both surveys

reported that the greatest service challenge is the length of time it takes to get an appointment. Satisfaction for all respondents was highest in the area of thoroughness of services provided. In terms of cultural competency respondents of both surveys reported that the more work is needed to make the lobbies and reception areas feel welcoming and friendly; but report the highest levels of agreement with statements regarding staff courtesy and professionalism, respect of cultural heritage, and capacity to explain things in an easily understood manner. In one area of discrepancy between the respondents, consumers in the adult system of care were far more likely to describe BHS interpretation services as needing improvement than those served in the children and youth system of care (amongst those that have ever used interpretation services). Within the children and youth system, 92% of respondents described interpretation services as good or better, vs. only 76% of those served in the adult system of care. More work is needed to understand this discrepancy as BHS has just one set of protocols to respond to interpretation needs of clients, regardless of the system of care.

BHS was also interested in learning more about the types of people that use mental health services and used the survey tool as a way to ask clients to anonymously self-report demographic information, in the hope of getting a more nuanced understanding of the clients served separate from the data stored and reported in standardized intake forms. Survey data revealed interesting findings about client demographics, criminal justice experiences, and living situations that has not been consistently reported elsewhere.

Race/ethnicity data for the two surveys is depicted below. Race/ethnicity data is reflective of the BHS client population. Notably children and youth are more likely to be Hispanic /Latino than adult survey respondents. Adult survey respondents were more likely to be African American, Asian, or Native American than is reflective of the general population. Again, this aligns with the population served by BHS.

More detailed summaries for each population subset follows.



Summary of Adult Consumer Demographic Data (as self-reported on the survey) N=501

Age Range	Percent
18-25	11%
26-59	63%
60 and over	23%
Other or decline to state	3%

Gender	Percent
Male	42%
Female	56%
Non-binary	1%
Transgender	1%

The 500 Adult consumers surveyed represent the broad diversity of clients served by Behavioral Health Services. Most consumers have children, with 55% describing themselves as parents. Consistent with the general population, 11% self-identified as lesbian, gay, bisexual, transgender, queer/questioning, or intersex (LGBTQQI). Many have a disability, with 48% describing themselves as having a physical or developmental disability. Few are military veterans, with only 6% reporting that they had served in the US armed forces. Finally a quarter of clients reported experiencing homelessness more than four times or being homeless for a at least a year (25%); and a significant portion (40%) reported having been arrested or detained by the police.

Summary of Children and Youth Consumer Demographic Data (as self-reported or declared by a parent or guardian on the survey) N=335

Age Range	Percent
0-5	5%
6-11	29%
12-15	31%
16-21	17%
22-25	7%
Prefer not to say	10%

Gender	Percent
Male	33%
Female	60%
Non-binary	0%
Transgender	1%
Prefer not to say	5%

The child's parent or guardian completed approximately half of the Children and Youth Surveys. Parents were instructed to complete surveys from the perspective of their child, but there may be some error in asking parents to complete surveys on behalf of their children. Amongst children and youth 12% self-identified at LGBTQQI and 24% reported having a disability. Veteran status was not asked on the children and youth survey. Children and youth served by Behavioral Health Services also face challenges with their living situation and in their interactions with the criminal justice system; several had been homelessness (n=31) or been detained by the police (N=40).

Community Mental Health Issues

Key Issues for Children and Youth

Strengthening services and supports for children, youth and their families remains a major concern in San Joaquin County. Stakeholders recognize the increase coordination between Behavioral Health Services and Child Welfare Services in addressing the needs of children and youth touched by the foster care system, but argue 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 meetings convened, stakeholders discussed the importance of uniform screening processes and earlier interventions for children and families.

- Early Education providers and schools appear to be doing a sufficient job at conducting early screening and detection for social emotional concerns among young children. However additional work is needed to engage family practice physicians and pediatricians in identifying children and families in need of additional support services.
- The biggest gap in services are early interventions for children and families following the identification of a social-emotional risk factor. Schools are seeking more behavioral health consultations in the classroom to assist teachers in working with students (including pre-school age students) that are displaying behaviors suggestive of an emerging emotional disorder.
- Many stakeholders also identified family supports such as parenting classes, family strengthening activities, and family peer partners as being pivotal early interventions to help empower parents, stabilize families, and reduce tension/anxiety among children. In particular, stakeholders suggested targeting resources towards (1) parents with self-identified behavioral health concerns of their own, and (2) young parents, particularly young parents with more than one child under 5 in the home.

Recommendations to Strengthen Services for Children and Youth:

- All adults, with children in the home, who are receiving services from BHS Adult Outpatient Clinics should be offered services or supports pertaining to family strengthening; and referred to PEI funded parenting classes.
- BHS should work with San Joaquin Child Welfare Services to review case files of young families with multiple children under 5 in the home; offer parenting classes, services, or supports; engage families and make referrals to existing parenting classes funded through PEI programming.
- The PEI school-based interventions program providing behavioral health interventions on school campuses should be available to all children, including those in pre-school or transitional kindergarten programs.

Key Issues for Transitional Age Youth

In general, stakeholders expressed the most concern for transition age youth who are easily missed by system partners – including those that have been in the military, have exited the foster care system, are college age, or are from communities that are historically unserved or underserved by mental health services. Stakeholders identified some existing resources for transition age youth, but overall stated that outside of a few specialty treatment programs, most interventions target either children and youth, or adults. Despite these gaps, stakeholders remain optimistic that current resources can be leveraged in a better way to serve transitional age youth.

- Both UOP and Delta College have student mental health programs. However, programs are not well articulated to off-campus services and supports, especially those available through the primary health care system to address mild to moderate behavioral health concerns. More linkages and articulating are needed to prevent the escalation of illnesses that can benefit from early interventions such as depression and anxiety.
- Numerous partners are working to reach returning veterans, and new services such as the veteran's court are identifying at-risk veterans and engaging them into services and supports, including alcohol and drug treatment programs.

- 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 towards their sexual identity. LGBTQI youth have few resources or supports in San Joaquin County, though an emerging allies movement is increasing awareness of the need for more deliberate and integrated approaches to supporting LGBTQI youth in San Joaquin county.

Recommendations to strengthen services for transition age youth 16-25

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

Key Issues for Adults

Consumers and community allies discussed the challenges of being homeless while seeking recovery from a mental illness and the need to develop more housing opportunities for people with mental illnesses. Criminal justice partners played an active role in the community program planning meetings and echoed the frustrations of consumers and family members regarding the need for better housing options to avert homelessness. Consumers also expressed frustration that it is still difficult to find reliable information on the services and supports that are available and asked BHS to consider different approaches to talking about mental health and the services available in the community.

- Too many clients are homeless and/or justice involved. BHS needs to work collaboratively to develop comprehensive treatment approaches to prevent the criminalization of the mentally ill. This should include a focus on strengthening services for those dually diagnosed with both a mental illness and a substance use disorder.

- Individuals with mental illnesses, who have been arrested and charged with offenses, are at high risk of homelessness and re-offending upon re-entry in the absence of coordinated services and supports. More efforts are needed to strengthen re-entry services for people with serious mental illnesses to avert homelessness and prevent decompensation from an untreated illness. More coordination is needed to assess all individuals exiting custody for mental illnesses and link them to existing community services prior to release.
- More information is needed regarding access to services. Public information messages should be tailored for consumers, family members, and partner service providers. Information should be developed that is responsive to diverse cultural communities – understanding that clients come from diverse backgrounds and have a range of experiences – many are parents, many are LGBTQ, and many have a first language other than English.
- More education is needed regarding mental health in general. Veterans and Latino communities are underrepresented in the adult mental health service system. Education is needed to reduce stigma towards mental illness that may prevent 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. BHS has 42 staff that are proficient in Tagalog, 8 who are proficient in Hmong, and 4 who are proficient in Cambodian. However there are no direct service staff that are proficient in either Laotian or Vietnamese.

Recommendations to strengthen services for Adults.

- Continue to strengthen the housing continuum for people with serious mental illnesses.
- Strengthen outreach and engagement to underserved populations including Latinos and military veterans. Consider adopting new public information and education strategies that are more broadly received and more specifically target stigma and discrimination.
- Expand suicide prevention efforts (beyond school-based prevention efforts). Develop public information and education campaign for adults with a focus on adult men and veterans.
- Create more treatment teams or residential programs that work specifically with individuals diagnosed as having co-occurring disorders.

Key Issues for Older Adults

Older adults with mild to moderate mental health concerns remain at-risk for untreated depression and suicide ideation. More articulation is needed with senior centers and other programs serving older adults to provide specialty 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 also needed; particularly focusing on adult men who are at the highest risk for suicide in San Joaquin County. Stakeholders identify increase use of alcohol as a coping mechanism for depression and suggest that behavioral health programming should be (1) better targeted to older adults, (2) more urgently address alcohol and depression as co-morbid conditions, (3) 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. Finally stakeholders identified the biggest risk to be among older adults living independently and who are socially isolated. Community members in the Tracy area stated that there are few resources for older

adults in South County. The director of the Larch Clover Community Center in Tracy, which hosted the meeting, encouraged more behavioral health services being co-located at local community centers which provide arrange of senior activities, services, and supports in locations 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, this is of serious concern because alcohol abuse is strongly correlated with older adult depression.
- Expanded prevention services should work in partnership with local community centers.
- Vulnerable older adults include those that are homeless (which account for 10% of the total homeless population) and those that are isolated and living alone.

Recommendations to strengthen services for Older Adults:

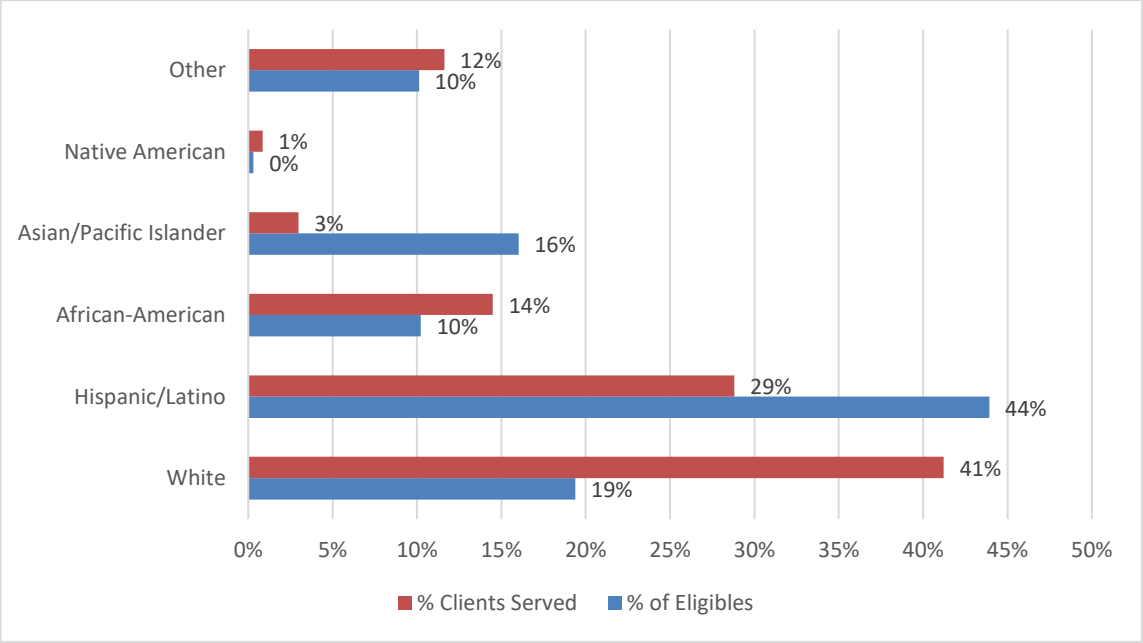
- Co-locating senior peer counseling program in local community centers one day a week to provide information on the mental health services and supports available to older adults in the community. Ensure that senior peer partners have training in recognizing signs and symptoms of alcohol abuse and have an array of tools and resources to offer older adults requesting assistance with behavioral health concerns, including co-occurring disorders.
- Work with Adult Protective Services to identify older adults with escalating mental health symptoms. Convene workshops for Adult Protective services counselors in the prevention and early interventions services available in the community and tips for accessing mental health interventions for mild to moderate behavioral health concerns.
- Strengthen and enhance suicide prevention efforts to target the entire community. Include targeted prevention information for middle age and older adult men. Include a focus on handguns and firearm safety precautions when living with loved ones experiencing depression.

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

CALEQRO PERFORMANCE MEASURES FY19-20 – SAN JOAQUIN MHP

Table 1: Medi-Cal Enrollees and Beneficiaries Served in CY 2018, by Race/Ethnicity San Joaquin MHP				
Race/Ethnicity	**Average Monthly Unduplicated Medi-Cal Enrollees**	**% Enrollees**	**Unduplicated Annual Count Beneficiaries Served**	**% Served**
White	50,914	17.2%	3,526	29.7%
Latino/Hispanic	135,669	45.7%	3,590	30.2%
African-American	28,654	9.7%	1,779	15.0%
Asian/Pacific Islander	42,745	14.4%	1,106	9.3%
Native American	813	0.3%	54	0.5%
Other	37,817	12.7%	1,833	15.4%
Total	**296,611**	**100%**	**11,888**	**100%**
The total for Average Monthly Unduplicated Medi-Cal Enrollees is not a direct sum of the averages above it. The averages are calculated independently.				

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



Attachment 6: Cultural Competency Committee Recommendations

Cultural Competency Committee – Latino Subcommittee Focus Group – Notes from Subcommittee Meeting(s)
June 3rd, June 10th, July 2nd

Cultural Competency Plan Strategies:

1. *Criterion 3 – Dedicate efforts of the BHS – Cultural Competency Committee to the development of additional strategies for outreach and engagement to Latino/Hispanic Communities by making it a permanent agenda item on monthly meetings.*

2. *Criterion 4 – Elicit, suggest, review, monitor and support at least two new strategies to increase penetration and retention rates for identified community groups.*

Attendees:

Antonio Gutierrez – CYS
Lucy Lopez – Golden Valley Health
Jennifer De Polanco – Whole Person Care/JDD
Angelo Balmaceda – Administration

*Additional Feedback from general Cultural Competency Committee on July 9th.

Recommendations:

1. Alternative/Extended clinic hours to meet the needs of Latino Families that are currently working.
    a. Explore option of 4/10's to accommodate this effort.

2. Outreach Information Tables:
    a. Universities (for recruitment efforts)
    b. Flea Market
    c. Activate/Education Leaders in the Latino Community
    d. Advertising Campaign targeted to Latino Population
    e. Working with the Health Plans (HPSJ and HealthNet) on Community Events
    f. Faith Based Communities (Latino)

3. Outreach Team from each Program (Are Outreach Workers going out to community events?) –
    a. Pilot Outreach Team from 2 programs to provide Outreach and Engagement Services in a targeted Latino Community Outreach approach

4. Explore the option of expanding BHS Prevention Program:
    a. Create an In-House Cultural Broker Team (Lead Outreach Team/Community Health Workers) similar to the Promotoras Model for Latino Community Engagement
        i. Community Education (MH First Aid, Suicide Prevention)
        ii. Community Presentations
        iii. Linkage to Services
        iv. Awareness of Historical Trauma

5. Collaboration with Public Health for Community Engagement and Outreach

Attachment 7: 2019 Workforce Needs Assessment -

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							
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							

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

Housing Services Staff	4.50	0	0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ⬇						
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							
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**

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							

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

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 and Total Only)

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**

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							
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									

(Managerial and Supervisory; Sub-Totals Only)

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**

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__

Attachment 8: 2019-20 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 9: Contract Monitoring Tool – Annual Site Review Checklist – 6d.

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

MHSA Prevention and Early Intervention Component Program and Evaluation Report

San Joaquin County Behavioral Health Services

Fiscal Year 2019/20

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Introduction

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

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

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

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

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

This report includes a brief description of each SJCBHS Project along with the required information for each Program and Strategy as specified in Section 3560.010 of the CCR. In addition, this report includes interim evaluation findings for Fiscal Year 2018/19, which will be expanded upon in a Three-Year Program and Evaluation Report due December 31, 2022 (check) per Section 3560.020 of the CCR. It is important to note that no significant qualitative findings or interpretations are included in this preliminary report.

MOQA (Measurements, Outcomes, and Quality Assessment) Reports.[3]

This report includes excerpts from San Joaquin County's Stigma and Discrimination Reduction and Suicide Prevention MOQA reports. The complete Stigma and Discrimination MOQA reports can be found in Tab 8.c and Tab 8.d of the supplemental file. The MOQA Suicide Prevention report can be found in tabs 9.b. and 9.c.

[3] *[3] For more information about the MOQA initiative see https://www.cibhs.org/measurements-outcomes-and-quality-assessment-moqa*

Highlights of Outcomes from FY 2018/19

Under regulation, SJCBHS must conduct an evaluation of PEI programs every three years. In order to support data-driven decision-making, San Joaquin has chosen to do an interim evaluation every year. The following are highlights from Fiscal Year 2018/19. The report provides more detailed findings in each Project section.

Prevention Programs:

Skill-building for Parents and Guardians programs collected 967 matched pre post tests for 1854 participants using various measurement tools. Across all measures, 746 (77%) demonstrated improvements in parenting skills.

TAY Mentoring programs served 330 youth and collected 296 matched pre post modified CANSAs, and 188 (66%) demonstrated positive strengths and needs results. In addition, among the 84 participants with self-identified emotional and wellbeing goals, 77 (92%) reported progress towards achieving their goals.

The Coping and Resilience Education Services (CARES) program served 295 individuals (179 children and 116 parents/guardians). Parents/guardians completed 105 matched pre and post Pediatric Symptom Checklist instruments of which 89 children (85%) demonstrated a reduction in symptoms.

Early Intervention Programs:

The Early Intervention and Recovery Services (TEIR) program served 60 transitional age youth experiencing initial onset of psychosis. During that period, the program collected 25 matched intake and 6-month SIPS/SOPs assessments, and 19 (76%) demonstrated one full scale level decline in symptoms. Of the 17 who had remained in the program for 12 months, 16 (94%) demonstrated one full scale level decline in symptoms.

The Human Trafficking program served 144 individuals and collected 25 matched pre post CANSAs. Of those, 11 (44%) showed improvements in combined Traumatic Stress Symptom, Sexual Exploitation, and Risk Behavior Domains.

The Family Therapy program served 14 families, of which 5 Youth Outcome Questionnaire (YOQ) Self Reports were collected, of which, all 5 (100%) showed improved overall scores.

Prevention and Early Intervention Programs:

The Mental Health Services for High Risk Youth at the Juvenile Justice Center provided voluntary early intervention and prevention services to detained youth, depending on their level of care need. 267 youth received a psychosocial assessment. 84 youth (deemed eligible for prevention) were detained long enough to receive a 60-day followup 13-item modified CANSA (items that were deemed most likely to be impacted by prevention services while in custody). Of those youth, 50 (60%) demonstrated a reduction in overall scores for the 15 items.

Stigma and Discrimination Reduction Program

NAMI's Stigma and Discrimination Program provided trainings and presentations to 694 participants and 559 (81%) completed outcome surveys. Of those, 432 (77%) demonstrated positive changes in attitudes, knowledge, and/or behavior associated with mental illness, and 467 (82%) demonstrated positive changes related to seeking mental health services.

Access and Linkage to Treatment Strategy

All Prevention and Early Intervention Programs were required to implement an Access and Linkage to Treatment Strategy. The following table provides a breakdown of referrals to treatment, referrals to County MHPs in particular, and known linkages to treatment, as defined by having attended at least an intake assessment. In total, there were 450 referrals to treatment, of which 384 were to SJCBHS administered programs, and 108 known linkages to treatment from prevention and early intervention programs.

Program	Treatment Referrals	Referrals to SJC MHP	Known Linkages
Skill building for Parents and Guardians	20	20	5
Mentoring for Transitional Age Youth	29	28	7
Coping and Resilience Education Services (CARES)	16	16	12
Early Interventions to Treat Psychosis (TEIR)	8	5	3
Family Therapy	0	0	0
Recovery Services for Victims of Human Trafficking	0	0	0
High-Risk Youth at Juvenile Justice Center	170	125	34
Community Trainings	0	0	0
Suicide Prevention Program	207	164	35
LEAD - Recovery Services for Nonviolent Offenders	unk	26	3
Whole Person Care	unk	unk	9
Totals	**450**	**384**	**108**

Prevention Programs

Skill Building for Parents and Guardians Project

Project description: Community-based organizations facilitate 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 2018/19, the Skill Building for Parents and Guardian Project was delivered by three community-based providers:

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

Project Outputs

A total of 1,854 parents/guardians were served in FY 2018/19, of whom 971 (52%) graduated (i.e., completed the program). (Graduation rates were misleadingly low because some classes rolled over to FY 19/20, and graduates from these classes were not reported. Attempts are being made to identify this data prior to the three-year evaluation.)

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

Skill-Building Output FY 2018/19				
	CAPC-PC	CC-NPP	PBC - Triple P	Total
Unduplicated parent/guardian participants	774	565	515	**1854**
Number of unduplicated individuals who completed/graduated from the group/class during the reporting period?*	317	222	432	**971**
Total number of groups delivered	42	21	48	**111**
Total number of sessions delivered	525	250	288	**1063**
Average number of participants per group (group size)	18.4	26.9	10.7	**16.7**
Average number of sessions delivered per group (dosage offered)	12.5	11.9	6.0	**9.6**
Average number of sessions attended per participant (dosage received)	5.3	5.6	5.4	**5.4**

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

Participant Demographics

Across all three programs, participants identified their race as Other (34%) and White (24%); all other races represented 5% or less of the population. More than half (57%) identified as Mexican or Mexican American, and 58% were predominantly Spanish speaking. Two-thirds (66%) were assigned female at birth, 16% male, and 18% declined to answer. Current gender identities varied little from sex assigned at birth. Thirteen percent (13%) identified as gay or lesbian, with the remainder declaring heterosexual or decline to state. Participants were predominantly adults between 26-59. Veterans accounted for 3%, and 5% were homeless.

For a more detailed description of participant demographics, see Tab 1 of the supplemental report

Participant Outcomes

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

Outcomes: Child Abuse Prevention Council - Parent Cafés FY 2018/19

Instrument: Protective Factors Survey Freq. of admin: First and last session		
Unduplicated individuals served	774	
Number of graduates	317	*41%*
Number of graduates w/ matched pre/post	317	*100%*
Number who showed improvement in:		
Knowledge of parenting skills	297	*94%*
Access to support	281	*89%*
Parental resiliency	274	*86%*
Social connections	267	*84%*
Parent/child relationships	217	*68%*
Total participants who showed improvement*	**267**	*84%*

* Based on average number who showed improvement in each domain

Outcomes: Catholic Charities FY 2018/19		
Instrument: Adult Adolescent Parenting Inventory (AAPI)		
Freq. of admin: First and last session		
Unduplicated individuals served	565	
Number of graduates	222	*39%*
Number of graduates w/ matched pre/post	218	*98%*
Number who showed improvements in:		
Inappropriate expectations	146	*67%*
Low level of empathy	178	*82%*
Belief in corporeal punishment	172	*79%*
Reverse family roles	122	*56%*
Restricts power and independence	117	*54%*
Total participants who showed improvement*	**147**	***67%***

* Based on average number who showed improvement in each domain

Outcomes: Parents by Choice - Triple P FY 2018/19
Regular Triple P classes: Parenting Tasks Checklist (PTC) & Parenting Scale (PS)

Parents of Teen classes: Conflict Behavior Questionnaire (CBQ) & Parenting Scale (PS) Family Transitions: Acrimony Scale & Depression Anxiety Stress Scale (DASS)		
Unduplicated individuals served	515	
Number of graduates	432	*84%*
Number of graduates w/ matched pre/post:	432	*100%*
Triple P Regular Graduates	265	
Triple P for Parents of Teens Graduates	37	
Family Transitions Graduates	130	
Number (regular participants) who showed improvement in:		
Setting self-efficacy (PTC)	211	*80%*
Behavioral self-efficacy (PTC)	210	*79%*
Laxness and Over-reactivity (PS)	217	*82%*
Total participants who showed improvement*	**213**	*80%*
Number (parents of teens) who showed improvement in		
Conflict behavior (CBQ)	22	*59%*
Laxness and Over-reactivity (PS)	27	*73%*
Total participants who showed improvements*	**25**	*66%*
Number (Family Transitions) who showed improvement in		
Acrimony Scale	86	*66%*
DASS (Depression, Anxiety, Stress) Scale	96	*74%*
Total participants who showed overall improvements*	91	*70%*
Total participants for all programs who showed overall improvement*	**328**	***77%***

* Based on average number who showed improvement across each domain

Cost/Benefit Analysis

The following table shows several key indicators of performance for each provider and for the Skill Building Project as a whole, including: costs of the project (represented by amount invoiced), cost per participant, cost per graduate, and cost per individual who showed reduced risk factors and/or increased protective factors.

The programs cost $233 per individual served; $445 per graduate and $559 per graduate who demonstrated improvement in parenting skills.

Skill-Building Cost/Benefit FY 2018/19				
	CAPC-PC	**CC-NPP**	**PBC-PPP**	**Total**
Program Costs	$150,177	$136,057	$145,988	$432,222
Unduplicated individuals served	774	565	515	1,854
Cost per individual served	*$194*	*$241*	*$283*	$233
Number who graduated	317	222	432	971
Cost per graduate	*$474*	*$613*	*$338*	$445
Number who showed improvement*	267	178	328	773
*Cost per individual who showed improvement**	*$562*	*$764*	*$445*	$559

* CAPC: Based on average number of individuals who showed improvement across all domains of the Protective Factors Survey; CC: Based on average number of individuals who showed improvement across all domains of the Adult Adolescent Parenting Inventory; PBC: Based on average number of individuals who showed improvement across all domains of the Parenting Tasks Checklist, the Parenting Scale, the Conflict Behavior Questionnaire, the Acrimony Scale, and/or the Anxiety Stress Scale.

Comparative Analysis

- Child Abuse Prevention Council offered the most group sessions and served the greatest number of participants. Less than half (41%) graduated but this was in part because Child Abuse Prevention Council had the highest graduation expectation (50% of 15 sessions). For those who did graduate and complete a pre post survey, 84% showed increased protective factors, which was significantly better than the two other programs.

- Catholic Charities provided the fewest groups and correspondingly the fewest number of sessions and had the largest class size. However, their participants on average attended nearly the same number of sessions (11) as Child Abuse Prevention Council (13), suggesting that in spite of the large class size, participants were satisfied with the program. Graduation rates were low, but the program reported that this was due to the fact that some sessions rolled over to FY 19/20. Among those who did graduate, 78% showed reduced risk factors. Cost per graduate and cost per individual who showed improvement were less than average but significantly higher than two other providers.

- Parents by Choice had the highest number of graduates and the highest graduation rate (84%), with a significantly lower cost per graduate than the other two programs. Among graduates 77% showed improvement, making the program the most cost effective in terms of the cost per individual who demonstrated improved parenting skills.

- The average number of sessions attended per participant for each program was nearly the same (5.3 for Child Abuse Prevention Council; 5.4 for Parents by Choice; and 5.6 for Catholic Charities).

Access and Linkage to Treatment Strategy

The following is a summary of data on referrals from the LEAD Project. Detailed data on referrals, including demographic information, is provided in the attachment.

- The project as a whole referred 20 individuals to treatment. All were referred to San Joaquin County MHP programs. Catholic Charities referred the greatest number of individuals (14) whereas Parents by Choice referred none.

- Of the 20 referred individuals, 25% engaged in treatment, defined as attending at least an intake assessment. The average duration of untreated mental illness was 27 months. The average interval between referral and treatment was 90 days.

Timely Access to Services for Underserved Populations Strategy

San Joaquin County has identified the following underserved populations[4]: A) Hispanic/Latino; B) Asian; C) Black/African American; D) American Indian; E) Transitional Age Youth; F) Older Adult; G) Homeless; H) Veterans; I) LGBTQ: J) Non-English speaking.

The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file.

- Thirty-two (32) Hispanics/Latinos were referred to mental health treatment or a different PEI program. Of those, there were 4 known linkages to treatment. At this time, it was not possible to track linkages to other PEI programs, so ostensibly, more could have received the services to which they were referred. The average interval between referral and participation was 38 days.

[4] These include populations that have been underserved, underserved or historically inappropriately served.

- Twenty-six (26) non-English speakers were referred to mental health treatment or a different PEI program. Of those, there were 4 known linkages to treatment. The average interval between referral and participation was 38 days.

The following are ways in which SJCBHS and the Skill Building Project encourage access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- Participants of Catholic Charities' Nurturing Parenting Program (predominantly Latino/Hispanic) are encouraged toward referrals at all classes during the instruction of sensitive parenting topics, in order to provide additional support to parents in need of specific community services. During the second quarter a weekly late afternoon schedule availability was provided to community members in order to increase the number of participants who might need referral services.

- *Child Abuse Prevention Council's Parent Café* staff encourages participants to come to them if they need any resources on the first day of the program. They actively set the tone that it is a safe place and participants can trust that their personal information will not be violated. Staff also assess their groups throughout the program to make sure any participants do not need a referral for services. If they feel they do, they will ask them. Staff have been trained on signs to look out for when making sure their participants are well functioning. If a referral is made on a participant's behalf, staff will always follow-up to make sure they are receiving the service and that it is benefitting them. Staff walk participants through the steps of following through on referrals.

- *Parents by Choice* staff members emphasize referrals to SJCBHS and other providers and services in the community.

Mentoring for Transitional Age Youth Project

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 risk of developing serious and persistent mental illnesses, which are associated with adverse childhood experiences, severe trauma or ongoing stress, family or domestic violence, and/or self-harm or suicidal thoughts.

In FY 2018/19, 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)

Both providers used the evidence-supported Transition to Independence (TIP) service model.

Project Outputs

In FY 2018/19, the TAY Mentoring Project served a total of 330 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.

TAY Mentoring Outputs: FY 2018/19			
	CAPC	WCYFS	**All TAY Mentoring**
Unduplicated individuals served	185	145*	**330**
Number of sessions delivered	1555	874	**2429**
Average number of sessions delivered per individual	8.4	6.0	**7.4**
Organizational Survey fidelity scores (average)	90%	93%	**92%**
TIP Practice Probes fidelity scores (average)	90%	83%	**87%**

*Totals may be duplicated and include clients who discharged and reopened immediately after

Participant Demographics

Across all three programs, participants identified their race as African American (28%) Other (27%), and White (25%). All other races represented 5% or less of the participant population. Forty percent (40%) identified as Mexican or Mexican American, and 8% were predominantly Spanish speaking. Sixty percent (60%) were assigned female at birth, 39% male. Current gender identities varied little from sex assigned at birth. Ten percent (10%) identified as bisexual, 5% as gay or lesbian, with the remainder declaring heterosexual, other sexual identity or decline to state. All participants were transitional age youth. None (0%) were veterans and 13% (46) were parents with a total of 50 children.

For a more detailed description of participant demographics, see Tab 2 of the attached document.

Participant Outcomes

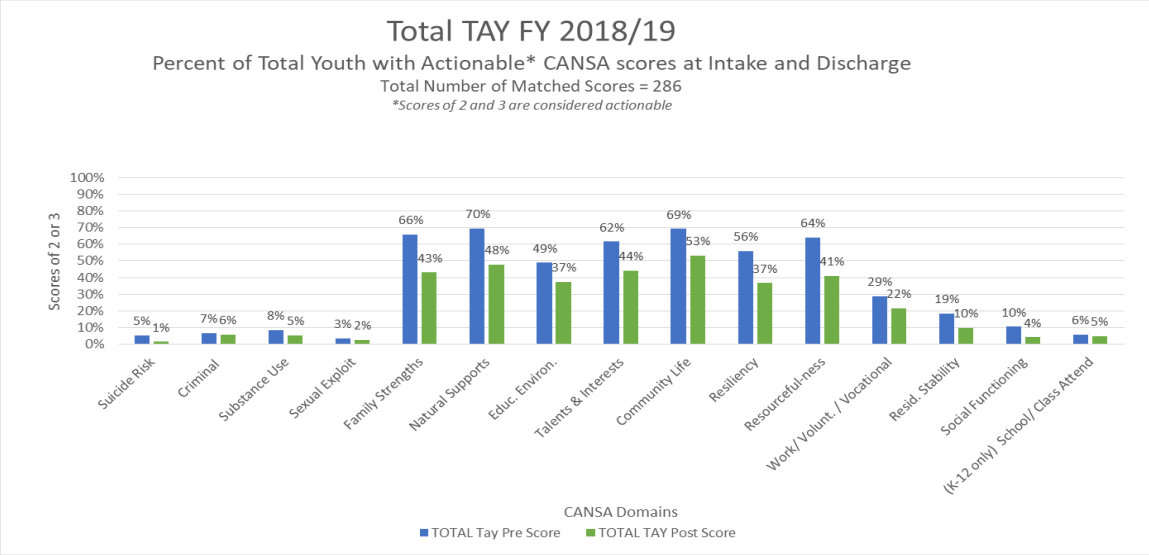
Graduation from this program was defined as participants having completed at least one of their program goals at the program's 90-day discharge. The determination of who graduated was subjective. According to staff, 75% graduated.

The program used two other methods to measure outcomes. The TIP Tracker rated each participant at discharge on progress towards or the completion of their self-identified goals in up to 8 categories. The following table shows the number of participants who had goals in each of the 8 categories and the number and percent who showed improvement in meeting these goals. The bottom row shows a weighted average for the percent of participants who showed improvement towards meeting goals across all 8 categories. Across both programs, 86% made progress towards meeting their goals.

Participant-identified goals FY 2018/18	CAPC TIP			WCYFS TAY			Total TAY		
	# with goals in this category	# who showed improve-ment	*% who showed improve-ment*	# with goals in this category	# who showed improve-ment	*% who showed improve-ment*	# with goals in this category	# who showed improve-ment	*% who showed improve-ment*
Education	90	79	*88%*	56	49	*88%*	146	128	*88%*
Employment and career	107	94	*88%*	82	69	*84%*	189	163	*86%*
Living situation	18	16	*89%*	51	40	*78%*	69	56	*81%*
Social support and connections	48	45	*94%*	26	23	*88%*	74	68	*92%*
Emotional and wellbeing	42	40	*95%*	42	37	*88%*	84	77	*92%*
Physical health	41	18	*44%*	7	6	*86%*	48	24	*50%*
Financial	18	13	*72%*	77	75	*97%*	95	88	*93%*
Parenting	7	7	*100%*	12	9	*75%*	19	16	*84%*
Percent with goals completed			***84%***			***87%***			***86%***

The third method of measuring outcomes involved a modified 15-item CANSA tool, administered at intake and discharge. The 15 items that were selected best represent the risk and protective factors that program managers felt could be addressed through the TIP model.

The following table compare the proportion of youth at intake and at discharge who scored a two or three in each of the 15 CANSA items.



Overall, 66% of clients demonstrated a reduction in CANSA scores (improvement) across all items and 9% showed an increase in CANSA scores (decline) across all items. The following table shows overall improvements and declines for both programs and for the project as a whole.

TAY CANSA Outcomes FY 2018/19						
	CAPC		WC		Total	
Number of matched CANSA scores	186		100		286	
Individuals showing improvement (lower score) in total score	97	52.2%	91	91.0%	188	65.7%
Individuals showing Improvement or no change in total score	161	86.5%	100	100.0%	261	91.3%
Individuals showing decline (higher) total score	25	13.4%	0	0.0%	25	8.7%

Additional CANSA outcome data for each of the programs can be found in the supplemental file.

Cost/Benefit Analysis

The following table shows several key indicators of performance for each CBO provider and for the TAY Mentoring Project as a whole, including costs of the project (represented by amount invoiced), cost per participant, and cost per graduate (individual who met at least one of his/her goals).

TAY Mentoring Cost/Benefit FY 2018/19			
	CAPC TIP	WCYFS TAY	**Total**
Program Costs	$370,449	$356,870	**$727,319**
Unduplicated individuals served	185	145	**330**
Cost per individual served	*$2,002*	*$2,461*	***$2,204***
Number of participants exiting program	186	114	**300**
Number who graduated (exited having completed goals)	125	100	**225**
Cost per graduate	*$2,964*	*$3,569*	***$3,233***

Comparative Analysis

Child Abuse Prevention Council served 40 more participants than Women's Center, resulting in a $459 lower per person cost. While Women's Center reported a higher number of participants having achieved at least one goal at discharge, the program also had fewer graduates. Overall, Child Abuse Prevention Council had a greater number of graduates having completed at least one goal than Women's Center, resulting in a cost differential of $605 per individual.

Women's Center participants were slightly more likely to have achieved progress in their self-identified goals upon discharge (87% for Women's Center, versus 84% for Child Abuse Prevention Council), and Women's Center also showed a greater proportion of youth who demonstrated a reduction in overall CANSA scores between intake and discharge (91% for Women's Center vs 67% for Child Abuse Prevention Council). The supplemental file provides a more detailed description of outcomes for each CANSA item.

Access and Linkage to Treatment Strategy

The following is a summary of data on referrals from the TAY Mentoring Project. Detailed data on referrals, including demographic information, is provided in the attachment. Demographics with fewer than 10 individuals are not made available to the public and are therefore not included in this report.

- The project as a whole referred 29 individuals to treatment, with all but one referred to county MHP programs. Women's Center referred the greatest number of individuals (21) whereas Child Abuse Prevention Council referred 8.

- Of the 28 county-referred individuals, 7 (25%) were known to have engaged in treatment, defined as attending at least an intake assessment. The average duration of untreated mental illness was just over 20 months. The average interval between referral and treatment was 173 days (approximately 6 months).

Timely Access to Services for Underserved Populations Strategy

The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file.

- Eighteen (18) Hispanics/Latinos were referred to mental health treatment or a different PEI program. Of those, there were 0 known linkages to treatment. At this time, it was not possible to track linkages to other PEI programs, so ostensibly, more could have received the services to which they were referred.

- Ten (10) African Americans were referred to mental health treatment or a different PEI program. Of those, there were 3 known linkages to treatment. The average length of time between referral and linkage was 238 days (~7 months).

- Four homeless youth were referred to mental health treatment or a different PEI program. Of those, there were 2 known linkages to treatment. The average interval between referral and participation was 21 days.

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 processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- Child Abuse Prevention Council's TAY Mentoring program provides community resources to and informs youth of their options. Through the assessment process they identify case management/resource needs that can be part of the services

provided to transitional age youth. TAY Coaches regularly check in with clients to ensure they have followed thru on tasks and provided referrals. They started an events 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 access to services.

- The Women's Center TAY Mentoring program has once a week case management meeting for transitional age youth to provide a supportive environment for staff to share for their client list's and get feedback and assistance with challenging youth situations. Client referrals are distributed by TAY Manager, and contact is attempted and documented at least 3 times before Facilitators put aside a referral. The Women's Center TAY program follows through and monitors all referrals at case management meetings and through Apricot (case management software). They focus on developing a high retention program by providing leadership opportunities, fostering a sense of community and offering more engaging opportunities such as: Building Self Esteem, Game Time, Problem Solving, Job Readiness Workshops etc. Follow up on all referrals and appointments with potential clients are setup within 24 hours. The intake process is clearly outlined in their guidelines. All referrals are followed up by the TAY specialist. Specialists stay in contact with organizations and individuals who refer youth to the program. The peer mentor coordinator has been actively involved in contacting potential referral resources and building relationships within the community at large.

Coping and Resilience Education Services (CARES) Project

The CARES project serves children and youth (ages 6-17) who are CPS-involved, exposed to trauma, or referred by Child Welfare, but who do not meet medical necessity for specialty mental health services, and their caregivers. Children and youth, ages 5 - 18, are screened for trauma-related symptoms and receive a 12- session evidence-based intervention to address previous traumas and sustain them though difficult situations. Resource 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.

In addition, in coordination with the County's Human Services Agency, project staff attended Child Family Team (CFT) meetings with children and family members who are not already to be connected to behavioral health services. The project also facilitated Caring for Children who have Experienced Trauma trainings in the causes and effects of childhood trauma to resource families, teachers, and group home providers.

Project Outputs

In FY 2018/19, the CARES served a total of 295 individuals—179 children and 116 parents. The following table shows number of children referred to the program; number who were screened in, number who began participating in the children and youth curriculum (CRAXES/YRAXES) and parents/caregiver curriculum (PRAXES); and number of resource family trainings delivered.

CARES Output FY 2018/19	#
Number of children/youth referred to program	365
Number of children/youth who were screened into the program	180
Number of children/youth who participated in CRAXES/YRAXES	179
Number of parents who participated in PRAXES	116
Number of trauma informed trainings delivered to resource families, teachers and group home providers	10

Participant Demographics

Forty percent (40%) of participants identified their racial identity as Other, 18% as White, 15% as more than one race; 12% as African American; and 4% American Indian or Alaska Native and 2% Asian. Half (50%) identified as Mexican/Mexican American ethnicity. Of the child/youth participants, 95% were under age 16 and 2% were transitional age youth. The caregivers were 72% between the ages of 26-59, 6% 60 and above, and 4% between the ages of 16-25. Half the children were male assigned at birth and 45% were female. The remainder declined to state. Among the caregivers, 77% were female and 10% male, with the remainder declined to state. Spanish was the principal language for 15% of participants. No participants were veterans and 2% were homeless.

For a more detailed description of participant demographics, see Tab 3 of the attached document.

Participant Outcomes

The CARES program used the Parental Stress Index at intake and discharge. The index has four sub-domains: Parental Distress (PD), Parent-Child Dysfunctional Interaction (P-CDI), and Difficult Child (DC) Eighty-four percent (84%) of the 25 matched pre- and post-tests demonstrated a reduction in stress across all 4 domains.

CARES Parental Stress Index Outcomes FY 2018/19*						
Number of matched pre and post tests	25					
Parental Stress Index	DR	PD	P-CDI	DC	Total Stress	% showing reduced stress
Number of individuals showing reduction in stress (lower score post test)	19	22	18	20	21	84%
Average Pre Score	19.3	32.2	34.3	36.5	102.9	
Average Post Score	15.1	25.0	25.8	29.3	80.2	
Average difference	4.3	7.2	8.5	7.2	22.7	
Standard Deviation of Difference	6.9	10.6	11.2	7.9	25.6	

CARES used the Pediatric Symptom Checklist to measure youth risk. Of the 104 youth who received matched pre and post screenings, 89 (85%) showed a reduction in symptoms.

CARES Pediatric Symptom Checklist Outcomes FY 2018/19		
Number of matched pre and post tests	105	
PSC-35 score		% showing reduced symptoms
Number of individuals showing reduction in symptoms (lower score post test)	89	85%
Average Pre Score	19.9	
Average Post Score	12.9	
Average Difference	7	
Standard Deviation of Difference	8	

*Includes only children who opened and closed in FY18/19 and who had matched pre and post test resul

Cost/Benefit Analysis

The following table shows the program costs, and average cost per individual served. Additional cost/benefit analyses are included in the supplemental file.

CAREs Cost/Benefit FY 2018/19	
Program Costs*	$1,025,222
Unduplicated individuals served	295
Cost per individual served	*$3,475*

** Costs include coordination with HSA, attendance at CFT meetings, and trauma-informed trainings for resource families, etc.*

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the CARES Project. Detailed data on referrals, including demographic information, is provided in the attachment.

- Sixteen (16) individuals were referred to mental health treatment, all to county MHP programs.

- Twelve (80%) were known to have engaged in treatment, defined as attending at least an intake assessment. The average duration of untreated mental illness was just over 12 months. The average interval between referral and treatment was 96 days.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file.

- Eighteen (17) Hispanics/Latinos were referred to mental health treatment or a different PEI program. Of those, there were 6 known linkages to treatment. At this time, it was not possible to track linkages to other PEI programs, so ostensibly, more could have received the services to which they were referred. The average number of days between referral and participation for Hispanic/Latinos was less than a month (26 days).

The following are ways in which SJCBHS and the CARES program, in particular, encourages access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- Each referral received is provided with a screening that utilizes the CANSA tool and is conducted by the clinician. Based on the clinician's evaluation using this tool, minors are screened into services or linked to planned services.

- All referrals are reviewed within three business days of receipt. For minors that do not meet criteria CARES provides information on other programs that may better fit their needs.

- Families are continuously updated by staff of any community events or services available to them.

Early Intervention Programs

Early Intervention to Treat Psychosis (TEIR) Project

The Telecare Early Intervention and Recovery Services (TEIR) program provides an integrated set of promising practices that research indicates will slow the progression of psychosis early in its onset. The TEIR Project follows the evidence-based Portland Identification and Early Referral (PIER) model and provides an integrated set of promising practices designed to slow the progression of psychosis early in its onset. The project goal is to identify and provide treatment to individuals who have experienced their first 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 Outputs

Sixty (60) unduplicated individuals received TEIR intervention services in FY 2018/19. The following table shows the number of psychosis screenings completed during the fiscal year, the number of screenings that resulted in program eligibility, and the number of individuals and family members who participated in the program.

TEIR Output FY 2018/19	
Number of early psychosis screenings completed	62
Number of screenings that resulted in program eligibility	28
Total unduplicated count of individuals receiving early intervention*	60
Number of family members who participated in program*	70

*Includes individuals rolled over from previous Fiscal Year

Participant Demographics

Nearly all (98%) of participants were between the ages of 16-25. With regards to race, 40% identified as Other, 20% as Black/African American, 12% as more than one race, 10% as White, and 8% as Asian. Other races accounted for less than 5% of the participant population. With regards to ethnicity, 25% identified as Mexican/Mexican American ethnicity. None identified as a veteran. Ninety-two percent (92%) identified their primary language to be English. Slightly more than half (53%) were male assigned at birth and 47% were female. Current gender identity varied little from sex assigned at birth. Fifty eight percent (58%) identified as heterosexual or straight and 28% declined to answer.

For a more detailed description of participant demographics, see Tab 4 of the attached document

Participant Outcomes

During the reporting period, 20 participants discharged from services, of those, 14 (70%) completed program objectives and/or successfully discharged to a lower level of care.

SIPS/SOPS Outcomes

The TEIR project measured symptoms at intake, 6-month anniversary, 12-month anniversary and at any discharge and found that 76% demonstrated one full scale level of improvement between intake and 6-months and 94% between intake and their 12-month anniversary in the program. For those who discharged during the fiscal year, 58% had demonstrated one full scale level of improvement.

Outcome Measurement Tool used:		
Structured Interview for Prodromal Syndromes and Scale of Prodromal Symptoms (SIPS/SOPS)		
Outcomes FY 2018/19		
Number of matched baseline/6-month SIPS/SOPS assessments completed for program participants	25	
Number that demonstrate decrease of one full scale level (improvement)	19	*76%*
Number of matched baseline/12-month SIPS/SOPS assessments completed for program participants	17	
Number that demonstrate decrease of one full scale level (improvement)	16	*94%*
Number of matched baseline/discharge SIPS/SOPS assessments completed for program participants	12	
Number that demonstrate decrease of one full scale level (improvement)	7	*58%*

Milestone Assessment Outcomes

The TEIR program measured school/work engagement for participants at intake, 12-month, 24- month, and at discharge (regardless of when participant discharged). At intake, none of the participants were fully engaged in work or school according to their client plan. At 12 months, for those who remained in the program, 41% were fully

engaged, and at 24 months, 55% were fully engaged. For those participants who discharged during the reporting period, 45% were fully engaged in work or school.

Outcome Measurement Tool used:			
Milestone Assessment (Custom tool)			
Outcomes FY 2018/19	#	Fully engaged in work or school per client plan	
Total number of clients served	61	0	*0%*
Number of 12-month assessments completed for program participants	27	11	*41%*
Number of 24-month assessments completed for program participants	20	11	*55%*
Number of discharge assessments completed during reporting period	20	9	*45%*

The Milestone Assessment also measured homeless status, number of hospitalizations and arrests/incarcerations and conversion to psychosis, but interim findings are inconclusive. Data is included in the supplemental file.

CANS/ANSA Outcomes

The program assessed participants at intake,12-month and 24-month anniversaries, and discharge. Overall, 58% of clients showed improvement in overall score after 12 months; 68% showed improvement after 24-month; and regardless of when they were discharged, 72% showed improvement at discharge. The table below shows outcomes in three domains: risk factors; life domain; and strengths, as well as the total combined score across all three domains.

TEIR Outcomes CANS/ANSA FY 2018/19									
	Number of	**Risk Factors**				**Life Domains**			
		Improved		Declined		Improved		Declined	
Intake--12 months	31	17	54.8%	6	19.4%	10	32.3%	14	45.2%
Intake--24 Months	22	12	54.5%	5	22.7%	7	31.8%	13	59.1%
Intake--Discharge	22	15	68.2%	2	9.1%	12	54.5%	9	40.9%
	Number of	**Strengths**				**Combined Total**			
		Improved		Declined		Improved		Declined	
Intake--12 months	31	18	58.1%	9	29.0%	18	58.1%	12	38.7%
Intake--24 Months	22	15	68.2%	6	27.3%	15	68.2%	7	31.8%
Intake--Discharge	22	15	68.2%	5	22.7%	16	72.7%	5	22.7%

Cost/Benefit Analysis

The following table shows the cost per individual served for the TEIR program. Due to the long-term nature of this project, the cost per individual demonstrating improvement will be provided in the three-year evaluation report only.

Outreach for Increasing Recognition of Early Signs of Mental Illness Strategy

The TEIR Project conducted 33 outreach presentations and events reaching a total of 660 potential responders.

TEIR Outreach FY 2018/19	
Number of individuals reached via outreach (i.e., potential responders)	660
Number of individuals who attended a presentation, training, or educational workshop	286
Settings in which potential responders were engaged	
Mental Health/Behavioral Health	2
Other Social Service	9
Primary Health Clinics/Hospitals	1
Educational settings	17
Faith-based	1
Other	3
Total number of outreach presentations/events	33
Types of potential responders: general public; family members; legal support staff; employers	

Access and Linkage to Treatment Strategy

The following is a summary of data on mental health treatment referrals from the TEIR Project. Detailed data on referrals, including demographic information, is provided in the attachment.

- Eight (8) individuals were referred to mental health treatment, 5 of whom were referred to county MHP programs.

- Three (60%) were known to have engaged in treatment. The average interval between referral and treatment was 63 days.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file.

- Seven (7) referrals of members of underserved populations were made to mental health treatment or a different PEI program programs (several met the criteria for underserved population in two or more demographic categories). Due to the small sample size, no demographic data are available to the public.

- Two (2) of the individuals from underserved populations participated in the program to which he/she was referred. The average duration from referral to treatment 40 days.

The following are ways in which SJCBHS and the TEIR Project encourage access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- When receiving a referral, the TEIR team utilize multiple ways of engagement such as phone screening, coordination with referral party to ensure comfort level, and offer the screening to occur in a location and language convenient for the members and their family.

Family Therapy Project

SJCBHS's Children and Youth Services (CYS) provides family therapy with children with recent diagnoses of SED, their siblings and parents. Therapy is provided at CYS and in the community by a team of clinical staff (for children) and outreach workers (for parent support). These family-oriented intervention services are provided concurrent with child-centered specialty mental health services for children who were recently diagnosed with SED.

Project Outputs

In FY 2018/19, the CARES served a total of 14 children and their family members.

Participant Demographics

Due to the small sample size, no demographics are reported. Demographic tables are included in the supplemental file.

Participant Outcomes

The program used three outcome measurement tools: Youth Outcome Questionnaire Self Report (for children 13 and older), Youth Outcome Questionnaire (parent report), and Parent Scale. All youth (100%) demonstrated improvements in functionality according to the Self Report (n=5) and Parent Report (n=4). Of the 5 parents who completed the Parent Scale, 3 (60%) demonstrated improved parenting skills.

YOQ Self Report (only used for age 13+) (Decreased score indicates improvement)	
Number of matched scores	5
Number (%) who showed improvement in total score	5 (100%)
Average Pre-Score Total	121.8
Standard Deviation	26.2
Average Post Score Total	64.4
Standard Deviation	18.8
Average Improvement (change in total score)	57.4
Standard Deviation	25.6

YOQ (Parent Report) (Decreased score indicates improvement)	
Number of matched scores	4
Number (%) who showed improvement in total score	4 (100%)
Average Pre-Score Total	107.8
Standard Deviation	19.2
Average Post Score Total	59.3
Standard Deviation	13.4
Average Improvement (change in total score)	48.5
Standard Deviation	6.6

Parent Scale (Decreased score indicates improvement)	
Number of matched scores	5
Number (%) who showed improvement in total score	3 (60%)
Average Pre-Score **Laxness**	3.3
Average Post Score **Laxness**	3.2
Average Pre-Score **Overreactivity**	3.1
Average Post-Score **Overreactivity**	2.9
Average Pre-Score **Verbosity**	3.9
Average Post-Score **Verbosity**	3.2
Average Pre-Score Total	3.4
Standard Deviation	0.3
Average Post Score Total	3.2
Standard Deviation	0.1

Cost/Benefit Analysis

The following table shows the program costs, and average cost per individual served. Due to the small sample of pre and post outcome assessments, we cannot measure average cost per individual benefitting from the program.

CYS Family Therapy Cost/Benefit FY 2018/19	
Program Costs	$600,596
Unduplicated families served	14
Cost per family served	*$42,900*

Access and Linkage to Treatment Strategy

The program reported no referrals to a higher level of mental health treatment.

Timely Access to Services for Underserved Populations Strategy

The program reported no referrals to treatment or another PEI program

The following are ways in which SJCBHS and the Family Therapy program, in particular, encourages access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

Recovery Services for Victims of Human Trafficking

The Recovery Services for Victims of Human Trafficking identifies and provides mental health treatment to victims of human trafficking and other exploitation. The project involves outreach, screenings, resource navigation, case management and short-term clinical interventions.

Project Outputs:

One hundred forty-four (144) unduplicated individuals received services from the Victims of Human Trafficking program in FY 2018/19. The following table provides more details of program outputs including of individuals engaged in a variety of services and amount of service delivered per individual.

Recovery Services for Victims for Human Trafficking Output FY 2017/18	
Number of Outreach Events	34
Number of Individuals Reached via Outreach	1892
Number of individuals newly enrolled	144
Number of Participating Family Members	5
Number of groups	5
Total number who participated in group services	37
Number of Individuals who Participated in Case Management Services	87
Total number of Hours of Case Management Services Provided	772
Average number of Hours of Case Management Services Provided Per Individual who received case management	21

Participant Demographics

Thirty percent (30%) of participants identified their racial identity as White; 28% as Other; 16% as African American; and 15% as more than one race. All other races represented less than 5% of the participant population. Thirty-two percent (32%) identified as Mexican American, and 12% spoke Spanish as their primary language. More than half (54%) were adults between 26-59, 17% were transitional age youth, and 12% were under age 15. Seventy-eight percent (78%) were assigned female at birth and 9% male. Current gender identity did not vary significantly from that assigned at birth. Seventy-one percent (71%) identified as heterosexual and 11% identified as gay, lesbian, bisexual or questioning. Twenty-two percent (22%) identified as homeless at intake.

For a more detailed description of participant demographics, see Tab 6 of the attached document.

Participant Outcomes

The program reported 25 matched pre- and post-tests, of which 11 (44%) demonstrated a reduction in overall score (improvement); 9 showed no change (20%); and 6 (24%) showed a decline. The following table shows the number of individuals who demonstrated improved score in each of the following three domains: 1) traumatic stress s symptoms; 2) sexual exploitation module; 3) risk behaviors; and 4) strengths.

Human Trafficking CANSA Outcomes FY 2018/19		
Number of matched pre-post tests	25	
Number of individuals showing improvement (lower total score) in CANSA traumatic stress symptoms	3	12%
Number of individuals showing improvement (lower total score) in CANSA Sexual Exploitation Module	6	24%
Number of individuals showing improvement (lower total score) in CANSA Risk Behaviors	6	24%
Number of individuals showing improvement (lower total score) in CANSA Strengths	12	48%
Number of individuals with lower overall score	**11**	44%
Number of individuals with a higher overall score	**6**	24%

Cost/Benefit Analysis

The following table shows the cost of the program per participant who enrolled during the fiscal year. Due to the small number of matched pre post assessments collected, no reliable cost per individual who demonstrated improvement could be calculated.

Recovery Services for Victims for Human Trafficking Cost Benefit FY 2018/19	
Program Costs	$501,863
Unduplicated individuals served (newly enrolled)	144
Cost per individual served	$3,485

Access and Linkage to Treatment Strategy

The program reported no referrals to a higher level of mental health treatment.

Timely Access to Services for Underserved Populations Strategy

The program reported no referrals to treatment or another PEI program

The following are ways in which SJCBHS and the TEIR Project encourage access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- When receiving a referral, the TEIR team utilize multiple ways of engagement such as phone screening, coordination with referral party to ensure comfort level, and offer the screening to occur in a location and language convenient for the members and their family.

Combined Prevention and Early Intervention Projects

Juvenile Justice (JJC) Project

Project description: The Juvenile Justice Project was delivered by San Joaquin County Behavioral Health Children and Youth Services (CYS). CYS provides behavioral health evaluations and transition services for youth detained at San Joaquin County's Juvenile Justice Center (JJC). Upon detention, JJC administers a MAYSI-II screening. CYS evaluates youth with high- and medium-risk MAYSI-II scores within 24 hours and youth with low-risk scores within 5 days. Regardless of MAYSI-II score, if youth agree to participate in CYS services they receive a comprehensive behavioral health assessment. Youth determined to be SMI/SED receive early intervention-oriented mental health services whereas those who are not SMI/SED receive prevention-oriented services. If youth are detained for 60 days or longer, they receive a followup CANSA assessment, which is used to measure outcomes related to mental status, risk and protective factors.

Project Outputs:

In FY 2018/19 CYS staff conducted 603 mental health evaluations of youth. Evaluations were conducted on all youth with high and medium MAYSI-II risk scores who were detained for 24 hours and all youth with low MAYSI-II risk scores who were detained for at least 5 days.

All evaluated youth, regardless of risk score, were offered brief behavioral health interventions while at the JJC. Of the 603 evaluated youth, 267 agreed to participate in behavioral health interventions and were in detention long enough to receive a comprehensive psychosocial assessment. Approximately three-quarters (76%) of these youth were identified as severely emotionally disturbed and were eligible for Early Intervention services. The remaining 24% were had mild to moderate symptoms and were offered prevention services. During the fiscal year 117 youth received Early Intervention and 23 received Prevention services beyond assessment.

JJC Output FY 2018/19			
	#	%	
Number of youth received an evaluation (i.e., youth opened to BHS)	603		
Number who received a comprehensive psychosocial evaluation (i.e., number who were not already open to services, were in detention long enough, and who voluntarily agreed to an assessment)	267	44%	of evaluated youth
Number with SMI/SED who were eligible for early intervention	202	76%	of youth who were SMI/SED and qualified for early intervention
Number without SMI/SED who were eligible for prevention service	65	24%	of youth who were not SMI/SED and qualified for prevention
Number with SMI/SED who received at least one services (Early Intervention) post assessment	117	58%	of youth who qualified received early intervention services
Number w/out SMI/SED who received at least one services (prevention) post assessment	23	35%	of youth who qualified received prevention services
Total receiving PEI services	140	52%	of youth who received a psychosocial evaluation

Participant Demographics

Participants identified their race as Other (44%), Black or African American (29%), White (16%), and more than one race (5%); all other races represent 5% or less of the population. Forty-six percent (46%) identified as Mexican or Mexican American and an additional 6% identified as another Hispanic/Latino ethnicity. Ninety-six percent (96%) reported English as their primary language. Nearly two-thirds (63%) were transitional age youth and 37% were under the age of 16. Eighty-five percent (85%) were assigned male at birth, 15% male. Current gender identities varied little from sex assigned at birth. Ninety-one percent (91%) identified as heterosexual, and 6% as bisexual, with fewer than 5% representing other sexual orientations.

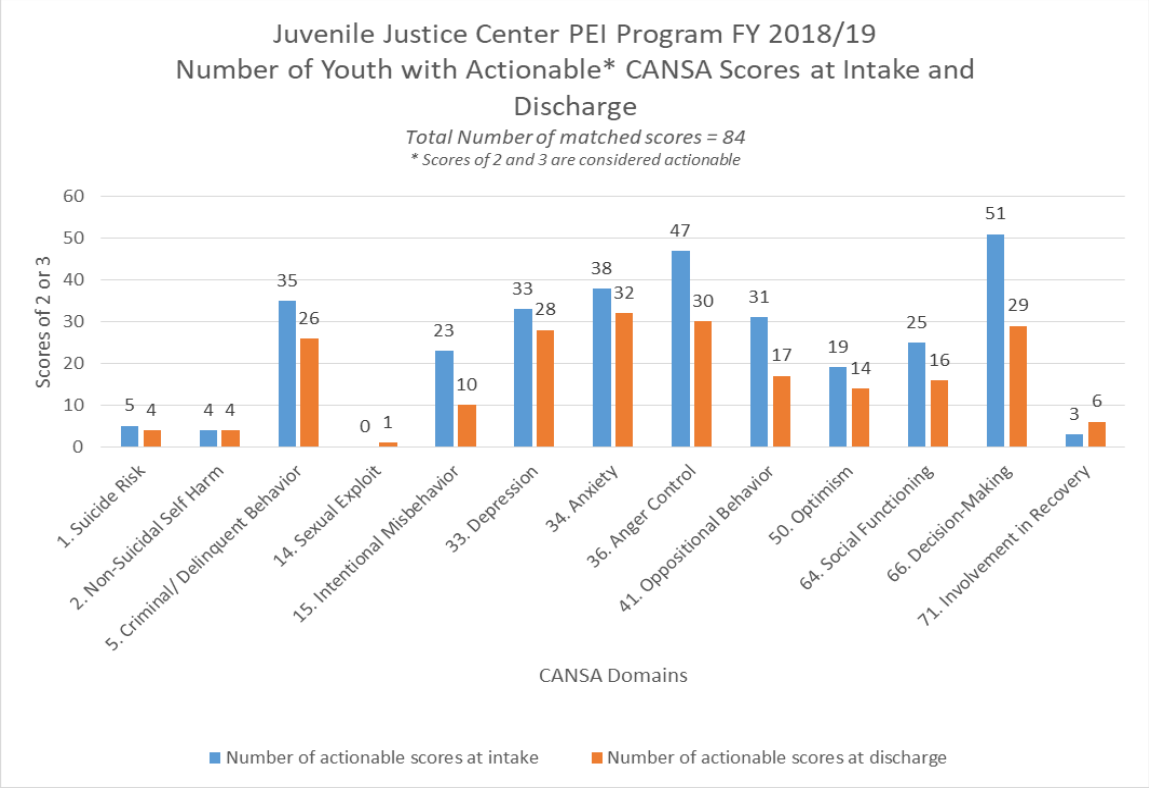
For a more detailed description of participant demographics, see Tab 7 of the attached document.

Participant Outcomes

During FY 2018/19 there were 84 individuals who received a matched 13-item pre post CANSA assessment. The following table shows changes in overall scores. Outcomes for Early Intervention clients who received the comprehensive CANSA are pending.

JJC CANSA FY 2018/19	
Number of participants Discharged in FY 2018/19 w/ matched scores	84
Number of matched assessments that demonstrate improvement (decrease in total score)	50
Percent of matched assessments that demonstrate improvement (decrease in total score)	60%
Number of Matched Assessments that demonstrate decline (increase in total score)	20
Percent of matched assessments that demonstrate decline (increase in total score)	23%
Average pre score	11.9
Standard deviation	4.8
Average Post score	9.9
Standard deviation	5.1

The following chart shows the number of prevention program participants with actionable items (scores of 2 or 3) in each item at intake and discharge. Participants were most likely to have actionable needs related to decision-making upon intake, and the program had the most positive impact on this risk/protective factor



Cost/Benefit Analysis

The following table shows the cost per individual assessed and cost per individual who received at least one prevention or early intervention service following assessment.

JJC Cost/Benefit Analysis FY 2018/19	
Program Costs	$1,442,020
Number of individuals assessed	255
Cost per individual assessed	$5,655
Number of individuals who received at least one PEI service	140
Cost per individual who received at least one PEI service	*$10,300*

Access and Linkage to Treatment Strategy

The following is a summary of data on referrals from the JJC Project. Detailed data on referrals, including demographic information, is provided in the attachment.

- The project as a whole referred 170 individuals to treatment upon discharge from the Juvenile Justice Center. Of those, 125 were referred to county MHP programs.

- Of the 125 referred to MHP programs, 34 (27%) engaged in treatment. The average duration of untreated mental illness was 95 days.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file. Demographics with fewer than 10 individuals are not made available to the public and are therefore not included in this report.

- One hundred nine (109) Transitional Age Youth were referred to mental health treatment or a different PEI program. Of those, there were 38 (35%) known linkages to treatment. At this time, it was not possible to track linkages to other PEI programs, so ostensibly, more could have received the services to which they

were referred. The average interval between referral and participation was 81 days.

- Ninety-one (91) Hispanics/Latinos were referred to mental health treatment or a different PEI program. Of those, there were 46 (75%) known linkages to treatment. The average interval between referral and participation was 82 days.

- Fifty (50) African Americans were referred to mental health treatment or a different PEI program. Of those, there were 15 (30%) known linkages to treatment. The average interval between referral and participation was 120 days.

- Thirteen (13) LGBTQ individuals were referred to mental health treatment or a different PEI program. Of those, there were 3 (23%) known linkages to treatment. The average interval between referral and participation was 26 days.

The following are ways in which the Juvenile Justice project encourages access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- There are frequent contacts with the JJAT program manager to ensure JJC youth are successfully linked to their program

- The program manager reviewed records for the JJAT program to ensure they are attempting contact with youth who are released from JJC and referred to JJAT.

- Attended MDT for youth identified as being at risk for CSEC. During the MDT, linkage to ongoing services is discussed and encouraged.

- CYS works closely with the TAY Mentoring Program and they come out to JJC to engage the youth into their program prior to discharge. CYS makes frequent referrals to that program.

- CYS implemented paper referrals at time of assessment so as not to miss youth who suddenly discharge from JJC. They attend CFT Meetings that take place at JJC to help the team identify appropriate treatment options at discharge from JJC.

Outreach for Increasing Recognition of Early Signs of Mental Illness Program: Community Trainings

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

NAMI Provider Education is a free, 15-hour program of in-service training taught by a team consisting of an adult with a mental health condition, a family member and a mental health professional who is also a family member or has a mental health condition themselves.

Program Outputs

NAMI delivered a total of two 15-hour Provider Education classes. Classes were taught by a team consisting of an adult with mental illness, a family member, and a mental health professional.

In FY 2018/19 the Outreach Project reached a total of 30 unduplicated individuals. Including the 4 instructors, the total number of potential responders was 34 (potential responders refers to both trainers and trainees).

The settings in which potential responders engaged (i.e., classes were held) included behavioral healthcare offices and Disability Resource Agency for Independent Living (DRAIL). The types of responders engaged in both settings all identified as behavioral health providers.

Program Demographics

Of the potential responders, 17% identified as Asian; 17% as White; 14% as another race. Ten percent (10%) identified as Mexican/Mexican American. The majority of responders (70%) were between 26-59 years old. Twenty percent (20%) were older adults and 10% were transitional age youth. Seventy-seven percent (77%) were assigned female at birth and 20% male. Insufficient participants answered current gender identity question to determine if there was variance between sex assigned at birth and current gender identity. At least 87% of participants described their sexual orientation as

heterosexual, and the remainder declined to state. Ninety percent (90%) chose English as their primary language; 3% Spanish and 7% other.

For a more detailed description of participant demographics, see Tab 1 of the attached document.

Cost/Benefit Analysis

The following table shows the amount invoiced for provider education plus an estimated as one sixth of the total administrative fees for NAMI's community training programs (Outreach and Stigma and Discrimination Reduction programs combined). The program cost $381 per individual trained.

NAMI Cost Benefit Analysis for Stigma & Discrimination and Outreach Programs FY 2018/19	
Provider Education	$9,300
Total administration cost for NAMI trainings	$12,691
Estimated proportion of administrative costs dedicated to Provider Education (1/6th of all administrative costs)	$2,115
Total cost of Provider Education	$11,415
Total number of individuals trained	30
Cost per individual trained	$381

Access and Linkage to Treatment Strategy

The program reported no referrals to a higher level of mental health treatment.

Timely Access to Services for Underserved Populations Strategy

The program reported no referrals to treatment or another PEI program.

The following are ways in which SJCBHS and the Outreach program, in particular, encourages access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- NAMI only follows ups with individuals who reach out directly after classes or presentations. Under these circumstances, NAMI follows up by phone and

provides assistance in accessing resources. In addition, the NAMI website, General Membership Meetings, and Newsletter often bring in inquiries for services and or resources.

Stigma and Discrimination Reduction Program: Community Trainings

In FY 2018/19, stigma and discrimination workshops and trainings were delivered throughout the County by National Alliance on Mental Illness San Joaquin (NAMI).

Project Outputs:

A total of 694 individuals were reached through the Stigma and Discrimination Reduction Project in FY 2018/19. The following table shows the type and number of each of training/workshop offered and the number of individuals reached.

NAMI Stigma Reduction Output FY 2018/19			
		Number of trainings/ workshops	Number of individuals reached
In Our Own Voice (IOOV)	60-90 minute presentations by two trained speakers describing personal experiences living with mental health challenges and achieving recovery	37	596
Family to Family (F2F)	12-session educational program for family members of adults living with mental illness taught by trained teachers who are also family members.	3	38
Peer to Peer (P2P)	10-session class to help adults living with mental illness challenges achieve and maintain wellness taught by Peer Mentors living in recovery	4	54
NAMI Basics	6-session class for parents and caregivers of children and adolescents living with mental illness	1	6
TOTAL		45	694

Participant Outcomes

Following each presentation or series of classes, NAMI facilitators distributed evaluation forms with a set of retrospective Likert Scale items asking participants to rate the degree to which they agreed with certain statements. IOOV and F2F used one set of statements whereas P2P and Basics used a different set of questions. These statements were then distributed into two reporting categories identified by state regulations, namely, number of participants who showed positive change in attitudes, knowledge and/or behavior related to *mental illness*; and number who showed positive change in

attitudes, knowledge and/or behavior related to *seeking mental health services.* Our analysis demonstrated that taking a weighted average of those participants who "agreed" or "strongly agreed" with each statement, 432 individuals (77%) showed positive change in statements related to mental illness and 467 (83%) showed positive change in statements related to seeking mental health services.

NAMI Stigma Reduction Outcomes FY 2018/19				
Because of the class or presentation….		# of survey responses	# who "agreed" or "strongly agreed"	%
Items included in IOOV & F2F Survey	A: I am comfortable with the idea of working with someone who has a mental illness	519	400	77%
	B: I do not believe mental illness is anyone's fault	519	383	74%
	C: Recovery from Mental Illness is possible	519	425	82%
	D: individuals have a right and an obligation to actively engage and question their treatment provider	519	428	82%
Items included in P2P & NAMI Basics survey	A: I am better able to recognize the signs and symptoms of mental illness	40	40	100%
	B: I am able to manage the stresses and negative impacts that the stigma of mental illness may cause	40	40	100%
	C: I am better able to understand the type of services people with mental illness need.	40	40	100%
	D: I am able to access the care and support services that I or my family members need	40	40	100%
Number of responses that showed positive change in attitudes, knowledge and/or behavior of items related to mental illness (Items A&B, above)			431.5	77%
Number of responses that showed positive change in attitudes, knowledge and/or behavior of items related to seeking mental health services (Items C &D, above)			467	83%

Outreach for Increasing Recognition of Early Signs of Mental Illness Strategy

The Stigma and Discrimination Reduction Project also involved an Outreach for Increasing Recognition of Early Signs of Mental Illness strategy. Potential responders were defined as those facilitating or teaching the presentations and classes. Since these classes focused primarily on stigma and discrimination, the participants were not

considered potential responders. There were 4 teachers/facilitators. Due to the small sample size, no responder demographics are included in this report.

Potential responders were engaged (i.e., presentations/classes were delivered) in the following settings and with the following types of participants.

NAMI Stigma Reduction Output FY 2018/19	
Settings in which potential responders were engaged	**Total**
Senior centers	1
Schools/Universities	4
Hospital/Medical Center	1
Behavioral healthcare provider offices	33
Residential Substance Abuse Treatment Center	2
Churches or Faith-based organizations	2
Other	2
Total	45
Classes/Presentations targeted the following types of participants	**Total**
Behavioral Health Providers	2
Seniors	1
Faith Leaders	1
Consumers and/or family members	38
College and university students	3
Total	45

Access and Linkage to Treatment Strategy

The program reported no referrals to a higher level of mental health treatment.

Timely Access to Services for Underserved Populations Strategy

The program reported no referrals to treatment or another PEI program

The following are ways in which SJCBHS and the Outreach program, in particular, encourages access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- NAMI only follows ups with individuals who reach out directly after classes or presentations. Under these circumstances, NAMI follows up by phone and provides assistance in accessing resources. In addition, the NAMI website, General Membership Meetings, and Newsletter often bring in inquiries for services and or resources.

Suicide Prevention Program[5]

In FY 2018/19, the Suicide Prevention Program was delivered in 12 San Joaquin County high schools by Child Abuse Prevention Council of San Joaquin County (CAPC). The program involved the evidence-based Yellow Ribbon (YR) Suicide Education Campaign and ancillary Be a Link Adult Gatekeeper and Ask 4 Help Youth Gatekeeper Trainings. In addition, Child Abuse Prevention Council provided SafeTALK workshops to youth over age 15 to assist in the recognition of individuals with suicidal thoughts and to connect them to mental health resources. The Suicide Prevention Project also included depression screenings, referrals, and school-based depression support groups.

Participant count

In FY 2018/19, the Suicide Prevention Project reached a total of 9,573 unduplicated individuals. The following table is a detailed breakdown of the number of individuals reached by various program components:

CAPC Suicide Prevention Output FY 2018/19	
Total reached (duplicated count)	9828
Yellow Ribbon campaign messaging	8616
Depression Screening	511
Be a Link ® Adult Gatekeeper Training	144
Ask 4 Help ® Youth Gatekeeper Training	220
SafeTalk Training	241
CAST Support Groups	56
Break Free from Depression Support Groups	40

[5] Much of the data in this report, most notably that which is represented in grey fields, were compiled by the MOQA project. For more information see https://www.cibhs.org/measurements-outcomes-and-quality-assessment-moqa

Suicide Prevention Community Education/Outreach Events

Suicide Prevention Community Education/Outreach Events

Yellow Ribbon Ask for Help

On behalf of San Joaquin County Behavioral Health Services (BHS), Child Abuse Prevention Council of San Joaquin County (CAPC) implements the evidence-based Yellow Ribbon Campaign in 12+ high schools throughout San Joaquin County. As part of the campaign, student gatekeepers provide classroom presentations and distribute Ask for Help cards. The campaign aims to increase public awareness of suicide prevention, decrease suicide risk and promote help-seeking behaviors.

Target Populations

Children (12 and over)
TAY (16-25)

Settings

High School

Number of Participants

8,616

Number of Consumers, Peers, Family Members, or Youth Involved in Facilitating the Training

220

Number of Trainers/Facilitators Trained

220

Number of Non-MOQA Surveys Collected (% of Participants)

8,616 (100%)

Percentage of Individuals with Improved Attitudes, Knowledge, and/or Behavior Regarding Suicide Related to Mental Illness (Duplicated)

83%

Outcomes (non-MOQA questionnaire)	N	% Agreeing/ Strongly Agreeing	Average 5-pt Likert Score	*St. dev.*
Increased recognition of suicide risk	8,616	83%	n/a	*n/a*
Increased knowledge in responding to suicide risk	8,616	82%	n/a	*n/a*

Yellow Ribbon Ask for Help

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Outcomes (non-MOQA questionnaire)	N	% Agreeing/ Strongly Agreeing	Average 5-pt Likert Score	*St. dev.*
Increased recognition of suicide risk	8,616	83%	n/a	*n/a*
Increased knowledge in responding to suicide risk	8,616	82%	n/a	*n/a*

Safe TALK				
Safe TALK was offered in high schools and other locations throughout San Joaquin County. Safe TALK 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. Safe TALK helps bridge the gap between short suicide awareness sessions and longer suicide intervention skills training.				
Target Populations				
TAY (16-25) Adults (26-59) Law Enforcement Teachers/School Personnel				
Settings				
High School Colleges/university				
Number of Participants				
302				
Number of Non-MOQA Surveys Collected (% of Participants)				
238 (79%)				
Percentage of Individuals with Improved Attitudes, Knowledge, and/or Behavior Regarding Suicide Related to Mental Illness (Duplicated)				
88%				
Outcomes (non-MOQA questionnaire)	**N**	**% Agreeing/ Strongly Agreeing**	**Average 5-pt Likert Score**	***St. dev.***
Increase in ability to understand the dynamics of suicide, identify people who have thoughts of suicide and apply the TALK steps (Tell, Ask, Listen, and Keep Safe)	238	88%	n/a	n/a

Suicide Prevention Hotlines/Crisis Lines/Screenings and Brief Interventions
School-Based Depression Screening and Referral

School-Based Depression Screening and Referral	
Mental Health Specialists provide depression screenings and referrals to adolescents in 12 high schools throughout San Joaquin County who are self-referred or referred by school staff or Alert Helpers. Depression screenings use the Patient Health Questionnaire (PHQ-9). Following the screenings, students may be referred to depression support groups, individual therapy, and/or medication	
Target Populations	
Teens/Youth	
Total Number of Suicide Risk Screenings/Assessments Completed	508
Number of suicide risk assessments showing significant risk or intent	276
Number of contacts referred to additional services	502
Comments	
Of the 508 screenings; 138 demonstrated high or severe risk; 138 moderate risk; 231 mild risk. 502 referred to school-based depression support groups; 315 referred to therapy or treatment.	

Suicide Prevention Support Groups and Individual Counseling
CAST support group
Break Free from Depression

CAST support group
Following depression screening, students may be referred to CAST support groups. 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. 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. 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.
Group or Individual
Group
Counselors/Facilitators
Non-clinical staff
# of Participants
56
Target Populations
People at risk of suicide
Outcomes Measured
Reduced depressive symptoms
Greater healthy coping attitudes/behaviors
Improved social competency and emotional regulation
Increased problem solving and conflict management skills
Increased treatment engagement and medication adherence

Break Free from Depression
Following depression screening, students may be referred to Break Free from Depression (BFD) support groups. BFD is 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. 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. Students discuss stigmas often associated with depression, their symptoms, the course of their illness, and the methods they have used to manage their depression. Each of the 4 sessions lasts 45 to 60 minutes.
Group or Individual
Group
Counselors/Facilitators
Non-clinical staff
# of Participants
40
Target Populations
People at risk of suicide
Outcomes Measured
Reduced emotional distress Reduced suicide risk behaviors Reduced suicidal ideation Reduced suicide attempts Reduced depressive symptoms Greater healthy coping attitudes/behaviors Increased help seeking behaviors

Participant Demographics

Across all components, participants identified their race as Other (28%), more than one race (19%); Asian (15%) and White (44%), African American (7%). All other races represented 5% or less of the population. Thirty-four percent (34%) identified as Mexican or Mexican American, and 16% were predominantly Spanish speaking. Six percent (6%) identified their primary language as something other than Spanish or English. Forty-eight percent (48%) identified as female at birth, 42% male, and 10% declined to answer. Current gender identities varied little from sex assigned at birth. Seventy-one percent (71%) identified as heterosexual, 6% as bisexual, 2% gay or lesbian, 2% questioning, and 1% another sexual orientation. Participants were children aged 0-15 (55%), transitional age youth (33%). Approximately 1% were adults and older adults (and represented those who participated in adult gatekeeper program).

For a more detailed description of participant demographics, see Tab 9 of the attached document.

Cost/Benefit Analysis

The following table shows the cost per individual reached by the Suicide Prevention program as well as the cost per individual who demonstrated improvement.

CAPC - Suicide Prevention Cost/Benefit FY 2018/19	
Program Costs	$505,915
Total Reached (Duplicated Count)*	9828
Cost per individual served	*$51.48*
Number who showed improvement/positive change*	7503
*Cost per individual who showed improvement/positive change***	*$67.43*

* Based on average number of individuals who showed improvement in each domain

** Based on 94.7% of total budget. 5.3% of total individuals served were given depression screenings with no measurable outcomes.

Access and Linkage to Treatment Strategy

The following is a summary of data on referrals from the Suicide Prevention Project. Detailed data on referrals, including demographic information, is provided in the attachment. Demographics with fewer than 10 individuals are not made available to the public and are therefore not included in this report.

- In addition to referrals to depression groups, Child Abuse Prevention Council reported having made 207 referrals to treatment programs, including 164 to County MHP programs.

- Of the 164 referrals 35 (21%) engaged in treatment. The average number of days between referral and treatment was 90, and there was no reliable data on duration of untreated mental illness.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file. Demographics with fewer than 10 individuals are not made available to the public and are therefore not included in this report.

- One hundred twenty (120) Hispanics/Latinos were referred to mental health treatment or a different PEI program. Of those, there were 19 known linkages to treatment. At this time, it was not possible to track linkages to other PEI programs, so ostensibly, more could have received the services to which they were referred. The average interval between referral and participation was 79 days.

- Twenty-six (26) Asians were referred to mental health treatment or a different PEI program. Of those, there were 2 known linkages to treatment. The average interval between referral and participation was 157 days.

- Twenty-nine (29) African Americans were referred to mental health treatment or a different PEI program. Of those, there were 3 known linkages to treatment. The average interval between referral and participation was 94 days

- One hundred fifty-five (155) transitional age youths were referred to mental health treatment or a different PEI program. Of those, there were 19 known linkages to treatment. The average interval between referral and participation was 89 days

- Seventy (70) LGBTQ participants were referred to mental health treatment or a different PEI program. Of those, there were 8 known linkages to treatment. The average interval between referral and participation was 53 days

- Thirty-four (34) participants whose primary language was not English were referred to mental health treatment or a different PEI program. Of those, there were 8 known linkages to treatment. The average interval between referral and participation was 53 days

The following are ways in which SJCBHS and the Suicide Prevention Program encourages access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- As a result of a positive screening, youth are referred to a variety of mental health services, ranging in intensity from group to individual to crisis services. Child Abuse Prevention Council staff follow up with students 30, 60, and 90 days after a referral is made to ensure they receive the services and support they are in need of and that they are not forgotten about while they navigate the mental health system.

- Each staff member is encouraged to attend monthly staff meetings at their school sites to ensure that they are well known by school staff on campus.

Timely Service for Underserved Populations Program: Recovery Services for Nonviolent Offenders (LEAD)

BHS works with San Joaquin County Courts, District Attorney, and local law enforcement agencies to provide targeted outreach and engagement, screening and assessment, and linkage to appropriate services and supports. Brief interventions 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 Outputs:

In FY 2018/19, LEAD served a total of 63 individuals, 33 of whom were opened into the electronic health record and billing systems, which allowed us to measure the number of minutes/hours of service delivered per individual. The following table shows total minutes of service provided to each individual.

LEAD Output FY 2018/19	
Number of individuals served	63
Individuals opened into Clinicians Gateway	33
Total Minutes of service	26,026
Average minutes per individual	789
Average hours per individual	13

Program Demographics

Demographic information was available for 29 LEAD program participants. They identified as White (41%), Black/African American (28%), and more than one race (24%), and all other races represented less than 5% of the population. Seventeen percent (17%) identified their ethnicity as Mexican or Mexican American, with 3% speaking Spanish as their primary language. Participants were predominantly (76%) between the ages of 26 – 59; the remaining 24% were 60 years or older. Forty-five percent were male and 41% female, with 14% unreported. There was no variance between sex assigned at birth and current gender identity. Sixty nine percent (69%) of participants identified as Heterosexual and 10% as bisexual or questioning. Ten percent were veterans.

For a more detailed description of participant demographics, see Tab 1 of the attached document.

Cost/Benefit Analysis

The following table shows costs of the project, the cost per individual referred to treatment, and cost per individual who engaged in treatment.

LEAD Cost/Benefit FY 2018/19	
Program Costs	$44,996
Unduplicated individuals served	63
Cost per individual served	*$714*
Number Individuals who were referred to Tx	29
Number of Individuals who engaged in tx	3
Cost per individual who engaged in tx	*$14,999*

Access and Linkage to Treatment Strategy

The following is a summary of data on referrals from the LEAD Project. Detailed data on referrals, including demographic information, is provided in the attachment.

- LEAD reported having made 29 referrals to treatment, of which 26 referrals to treatment, of which 26 were to County MHP providers.

- Of the 26 referrals 3 (12%) engaged in treatment. The average number of days between referral and treatment was 13, and there was no reliable data on duration of untreated mental illness.

Timely Access to Services for Underserved Populations Strategy

The following is a summary of data on referrals to treatment and PEI programs for underserved populations. Additional information, including the detailed demographics of those from underserved populations who are referred to treatment and PEI services, is included in the supplemental file. Demographics with fewer than 10 individuals are not made available to the public and are therefore not included in this report.

- Fourteen (14) Homeless participants were referred to mental health treatment or a different PEI program. Of those, there was one known linkage to treatment. The interval between referral and participation was 6 days

The following are ways in which SJCBHS encourages access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- The Whole Person Care and LEAD projects provides intensive case management, navigation and warm handoffs to all referral destinations. Case management involves helping clients schedule or reschedule appointments and transportation as needed. Case managers build trust and rapport in order to convey the importance and benefits of services. The program addresses a wide array of psycho-social stressors, including food, clothing, and shelter, since Maslow's Hierarchy of Needs suggest they these concerns may inhibit clients' ability to engage in services. Clients in crisis are immediately linked to services.

Access and Linkage to Services Program: Whole Person Care

This project provides match funding for San Joaquin County's Whole Person Care Pilot Project, approved by DHCS in 2016. The purpose of San Joaquin County's Whole Person Care pilot project is to test interventions and create a care management infrastructure to better support individuals who are at high risk of untreated mental illness and are high utilizers of health care services. Program services target adult Medi-Cal beneficiaries who over-utilize emergency department services, have a mental health and/or substance use disorder, or are currently, or are homeless or at risk for homelessness upon discharge from an institution.

Project Outputs:

In FY 2018/19, Whole Person Care served a total of 93 individuals, including clients who entered into service during the previous fiscal year. The following table shows the total number of new admissions, total participant count and average minutes of service provided to each individual during FY 2018/19.

WPC Output FY 2018/19	
Number of new admissions during the fiscal year	39
Number of Individuals served including rollover clients from previous year	93
Number of Service hours and minutes per client	10 hrs and 20 minutes

Cost/Benefit Analysis

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

WPC Cost/Benefit FY 2018/19	
Program Costs	$451,553
Unduplicated individuals served	93
Cost per individual served	*$4,855*

Access and Linkage to Treatment Strategy

Referrals from this program were not reliably tracked, however, linkages were tracked by identifying the first billable to a BHS treatment program following intake into WPC. Of the 39 clients admitted 9 linked to treatment, 8 to a crisis service and one to an outpatient clinic.

Timely Access to Services for Underserved Populations Strategy

The following are ways in which SJCBHS encourages access to services and follow through.

- All PEI provider organizations are trained in referral processes, including for crisis services, outpatient treatment, other PEI programs, and how to document referrals per State regulations.

- The Whole Person Care and LEAD projects provides intensive case management, navigation and warm handoffs to all referral destinations. Case management involves helping clients schedule or reschedule appointments and transportation as needed. Case managers build trust and rapport in order to convey the importance and benefits of services. The program addresses a wide array of psycho-social stressors, including food, clothing, and shelter, since Maslow's Hierarchy of Needs suggest they these concerns may inhibit clients' ability to engage in services. Clients in crisis are immediately linked to services.

XII. Appendix: Community Planning Documents

MHSA Public Meeting Flyer

MHSA Consumer Meeting Flyer

Community Planning Presentation

Input and Recommendations Form

Stakeholder Information Form

Stakeholder Demographic Form

Consumer and Stakeholder Survey, Summary Results

Public Hearing Presentation

Letters Received During 30-Day Public Review and Comment Period

SAN JOAQUIN COUNTY
Greatness grows here.

Behavioral Health Services
A Division of Health Care Services Agency

Tony Vartan, MSW, LCSW, BHS Director

San Joaquin County mhsa

Transforming Mental Health Services

Community Planning Meetings
Mental Health Services Act (MHSA)

The Mental Health Services Act (MHSA), intended to transform public mental health care for children, youth, adults and seniors. MHSA provides funding allocations for community mental health services in five program areas:

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

Please join us at one of the following community meetings to discuss the needs and opportunities to strengthen mental health services in San Joaquin County. These meetings will include an update on how MHSA funds are currently being used, as well as a chance to share your opinion and recommendations on how to expand or enhance programs and services. Your feedback is needed to inform next year's Three Year 2020-23 Program and Expenditure Plan.

We are counting on your voice to help guide us!

January 8, 2020	January 15, 2020	January 21, 2020	January 28, 2020	February 11, 2020
3:00 – 5:00 pm **BHS** 1212 N, California St. Conference Room A&B Stockton CA 95202	5:00-7:00 pm **Behavioral Health Board** 1212 N, California St. Conference Room A&B Stockton CA 95202	3:00 – 5:00 PM **Larch Clover Community Center** 11157 W. Larch Road Tracy, CA 95304	5:00 -7:00 PM **El Concilio meeting in Spanish** 445 N. San Joaquin Street, Stockton, CA 95202	4:00-6:00 PM **Lodi Police Station** 215 W. Elm St. Lodi, CA 95240

Meeting accessibility is important. Please contact us at 209-468-8750 to discuss accessibility questions. All meetings are held in accessible locations. Translation assistance is available upon request. Families are welcome.

Please post this notice in a public location and distribute via your mailing lists. Thank you for passing this invitation along.

SAN JOAQUIN COUNTY
Greatness grows here.

Behavioral Health Services
A Division of Health Care Services Agency

Tony Vartan, MSW, LCSW, BHS Director

San Joaquin County mhsa

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We are counting on your voice to help guide us!

January 7, 2020	**January 14, 2020**
10:00 – 12:00 pm **Wellness Center** **1109 N. California Street** **Stockton, CA 95202**	10:00 – 12:00 pm **Martin Gipson Center** **405 E. Pine Street** **Stockton, CA 95204**

Meeting accessibility is important. Please contact us at 209-468-8750 to discuss accessibility questions. All meetings are held in accessible locations. Translation assistance is available upon request. Families are welcome.

Please post this notice in a public location and distribute via your mailing lists. Thank you for passing this invitation along.

SAN JOAQUIN COUNTY

Greatness grows here.

San Joaquin County Behavioral Health Services
Mental Health Services Act - Overview

Community Program Planning for Fiscal Year 2020-2021

Part 1: Overview of BHS

WELCOME AND INTRODUCTIONS
BHS MISSION, VISION, AND VALUES

Mission and Vision

Mission Statement

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

Vision Statement

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

Core Values

SERVICE:

We are dedicated to serving our community through the promotion of behavioral health and wellness.

RESPECT:

We value diverse experiences, beliefs, and backgrounds and strive in our interactions to keep everyone's dignity intact.

RECOVERY:

We share a belief that all individuals can find a path towards health and well-being.

INTEGRITY:

Our values guide us as individuals and as an organization to be responsive and trustworthy.

Providing our clients with the same quality of care that we all would want our families to receive.

Part 2: Mental Health Services Act

OVERVIEW OF MHSA
COMMUNITY INVESTMENT
NEW MHSA PROGRAMS

Mental Health Services Act (MHSA)

Purpose of MHSA Funding

- Expand and enhance mental health services for individuals with serious mental illness.
- Provide prevention and early intervention services for those at risk of developing a mental illness.
- Promote innovative solutions that will advance the field of mental health.
- Strengthen the personnel, technology, and facilities through which services are offered.

Common Acronyms

(MHSA) Mental Health Services Act, Prop. 63

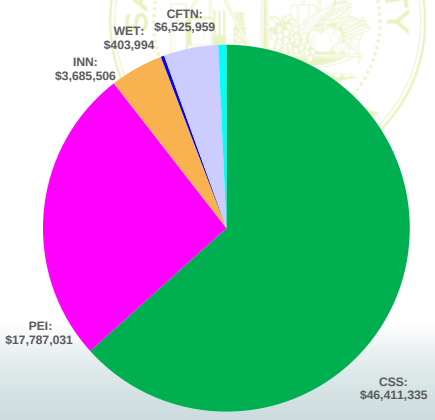
(CSS) Community Services and Supports
(PEI) Prevention and Early Intervention
(INN) Innovation
(WET) Workforce Education and Technology
(CFTN) Capital Facilities and Technology

MHSA 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**

2019-20 MHSA Planned Expenditures



27% of CSS Expenditures are from Leveraged Funds

SAN JOAQUIN COUNTY

Building Community Through the MHSA

- 25% of MHSA funded direct program services are provided by contracted community partners.
- 10% of MHSA funds are being used to expand housing and acute care services for the mentally ill.

Cranes Landing Apartments
Eden Housing Management, Inc.
80 Senior Units
Lodi, CA 95242
Phone:(209) 400-2070
8 Units reserved for MHSA Clients

Zettie Miller's Haven
Buckingham Property Management
82-units
Stockton, CA 95207
Office: (209) 475-9827
20 units reserved for MHSA clients.

SAN JOAQUIN COUNTY

New and Expanded MHSA Programs

2019 New and Expanded Programs

- Housing Coordination Services (CSS)
- Recovery Services for Non-Violent Offenders (PEI)
- Two Intensive Adult Care FSP's (CSS)
- Two Intensive Justice Response FSP's (CSS)
- Forensic Access and Engagement for Repeat Court Offenders (PEI)

Program Operations have Begun

2020 New and Expanded Programs

- School Based Interventions for Children and Youth (PEI)
- High-Risk Transition Team (CSS)
- Peer Navigation (CSS)
- Community Trauma Services for Adults (PEI)
- Information and Education Campaign (PEI)
- Suicide Prevention in the Community (PEI)

Community Program Planning

Purpose: *To assess the mental health needs of the entire community, including those that are currently served, and those that are unserved, underserved, or inappropriately served.*

Feedback Requested:

1) What is working?
2) What needs improvement?
3) Identify key needs and concerns by age groups.
4) Prioritize needs or concerns.

Definitions:

Gap or Need – Services do not exist, or does not exist for a specific population.

Issue or Concern – Services exist, but there is an issue or concern to be addressed.

Planning Activities for this Annual Update

- **MHSA Showcase**
- **Community Planning Meetings**
- **Consumer Discussion Groups**
- **Stakeholder Surveys**
- **Key Informant Interviews**
- **MHSA Consortium**
- **Behavioral Health Board**
- **Draft Plan for 30-day Public Review (March or April)**
- **Public Hearing (April or May)**
- **Presentation to the Board of Supervisors (May or June)**

Collecting your Feedback!

- **Please make sure to:**
  - Sign-in to the meeting.
  - Complete a green demographic form.
  - Use the blue form to tell us what you thought of today's meeting.
  - Consider sending additional feedback, suggestions or ideas to:

Mail:

MHSA Comments
c/o MHSA Coordinator
1212 N. California St.
Stockton CA 95202

E-mail:

mhsacomments@sjcbhs.org

Angelo Balmaceda
MHSA Coordinator
abalmaceda@sjcbhs.org

San Joaquin County Mental Health Services Act (MHSA) Community Program Planning Process

2019-20 Stakeholder Input and Recommendation Form for the

2020-2023 Three Year Program and Expenditure Plan

Group Brainstorm

1. What is working?

2. What needs improvement?

*SHARE YOUR IDEAS IN THE LARGE GROUP DISCUSSION

San Joaquin County Mental Health Services Act (MHSA) Community Program Planning Process

2019-20 Stakeholder Input and Recommendation Form
2020-2023 Three Year Program and Expenditure Plan

Small Group Discussion

1. Identify key needs and concerns by age group.

2. Identify type of issue or concern.

3. Identify population with the greatest needs.

*GROUP SPOKESPERSON REVIEWS NEEDS OR CONCERNS DISCUSSED – COMMON THEMES AND PRIORITIES ARE IDENTIFIED

Proceso de Planificación para Programas Comunitarios de la Ley de los Servicios de Salud Mental del Condado de San Joaquín (MHSA)
Forma de Recomendaciones y Aportes de Participes del 2019-20 para el
Programa de 3 Años y Plan de Gastos del 2020-2023

Aportación de Ideas en Grupo

1. Que está funcionando?

2. Que necesita mejoramiento?

*COMPARTA SUS IDEAS EN LA DESCUSIÓN DEL GRUPO GRANDE

Proceso de Planificación para Programas Comunitarios de la Ley de los Servicios de Salud Mental del Condado de San Joaquín (MHSA)
Forma de Recomendaciones y Aportes de Participes del 2019-20 para el
Programa de 3 Años y Plan de Gastos del 2020-2023

Discusión del Grupo Pequeño

1. Identifique necesidades y preocupaciones claves por grupo etario.

2. Identifique el tipo de problema o preocupación.

3. Identifique la población con las necesidades más grandes.

*EL PORTAVOZ DEL GRUPO REVISA LAS NECESIDADES O PREOCUPACIONES DISCUTIDAS – TEMAS Y PRIORIDADES COMUNES SON IDENTIFICADAS

Feedback Form:
San Joaquin MHSA Planning 2019/20
2020-2023 Three Year Expenditure Plan

Overall, how well did this meeting meet your expectations? (Please check one) ☐ Very Well ☐ Well ☐ Slightly ☐ Not At All
What about this meeting worked well?
How would you improve this meeting?

Feedback Form:
San Joaquin MHSA Planning 2019/20
2020-2023 Three Year Expenditure Plan

Overall, how well did this meeting meet your expectations? (Please check one) ☐ Very Well ☐ Well ☐ Slightly ☐ Not At All
What about this meeting worked well?
How would you improve this meeting?

Forma de Comentarios:
Plantificación de San Joaquin 2019/20
2020-2023 Plan

¿En general, que tan bien a cumplido con sus expectativas esta junta? (Por Favor Marque Uno) ☐ Muy Bien ☐ Bien ☐ Un Poco ☐ Para Nada
¿Qué parte de esta junta funciono bien?
¿Cómo mejoraría usted esta junta?

Forma de Comentarios:
Plantificación de San Joaquin 2019/20
2020-2023 Plan

¿En general, que tan bien a cumplido con sus expectativas esta junta? (Por Favor Marque Uno) ☐ Muy Bien ☐ Bien ☐ Un Poco ☐ Para Nada
¿Qué parte de esta junta funciono bien?
¿Cómo mejoraría usted esta junta?

San Joaquin County MHSA Planning
2019/20 Demographics

San Joaquin County Behavioral Health Services
2020-2023 Three Year Program and Expenditure Plan

Per State of California guidelines, we must report demographic information on planning participants. This information will be kept confidential and used for reporting purposes only. You may decline to answer these questions.

☐ **I decline to answer the demographic questions**

Please indicate your age range:
- ☐ **Under 18**
- ☐ **18-25**
- ☐ **26-59**
- ☐ **60 and older**

Please indicate your gender:
- ☐ **Male**
- ☐ **Female**
- ☐ **Transgender**

Please indicate the primary language spoken in your home:
- ☐ **English**
- ☐ **Other:** _____

Consumer Affiliation (check all that apply)
- ☐ Mental health client/consumer
- ☐ Family member of a mental health consumer

Stakeholder Affiliation (check all that apply)
- ☐ County mental health department staff
- ☐ Substance abuse service provider
- ☐ Community-based/non-profit mental health service provider
- ☐ Community based organization (not mental health service provider)
- ☐ Children and families services
- ☐ K-12 education provider
- ☐ Law enforcement
- ☐ Veteran services
- ☐ Senior services
- ☐ Hospital/ Health care provider
- ☐ Advocate
- ☐ **Other:** _____

What is your race ethnicity?
- ☐ **White/Caucasian**
- ☐ **Black/African American**
- ☐ **Hispanic/Latino**
- ☐ **Southeast Asian**
- ☐ **Other Asian or Pacific Islander**
- ☐ **American Indian/Native American/First Nations (including Hawaiian and Alaskan Native)**
- ☐ **Mixed Race:** _____
- ☐ **Other:** _____

Please return to facilitator upon concluding the meeting. The demographic information is confidential. Your name WILL NOT be connected to your response.
San Joaquin County Behavioral Health Services

San Joaquin County MHSA Planning
2019/20 Demographics

San Joaquin County Behavioral Health Services
2020-2023 Plan

En acuerdo con las directrices del estado de California, debemos reportar información demográfica de participantes del plan. Esta información se mantendrá confidencial y se usara con fines informativos. Usted puede negarse a responder estas preguntas.

☐ **Yo me niego a responder estas preguntas demográficas.**

Por favor indique su rango de edad:

- ☐ **Menor de 18**
- ☐ **18-25**
- ☐ **26-59**
- ☐ **60 o mayor**

Por favor indique su genero:

- ☐ **Masculino**
- ☐ **Femenino**
- ☐ **Transgenero**

Por favor indique el idioma principal que es hablado en su hogar:

- ☐ **Ingles**
- ☐ **Español**
- ☐ **Otro:** _____

Afiliación de consumidor (marque todos los que apliquen)

- ☐ Cliente de salud mental/consumidor
- ☐ Familiar de un consumidor de salud mental

Afiliación de Intereses (marque todas las que aplican)

- ☐ Personal del condado del departamento de salud mental
- ☐ Proveedor de servicios de abuso de sustancias
- ☐ Proveedor de servicios de salud mental comunitarios/ sin fines lucrativos
- ☐ Organización comunitaria (no un proveedor de servicios de salud mental)
- ☐ Servicios de 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
- ☐ Defensor
- ☐ **Otro: _____**

¿Cuál es su raza etnica?

- ☐ **Blanco/Caucasico**
- ☐ **Negro/Afro-Americano**
- ☐ **Hispanic/Latino**
- ☐ **Asiatico Sudeste**
- ☐ **Asiatico o Isleno del Pacifico**
- ☐ **Indígena Americano/Indio Americano/Primeras Naciones (incluyendo Hawaiano y Nativo de Alaska)**
- ☐ **Raza Mesclada: _____**
- ☐ **Otro: _____**

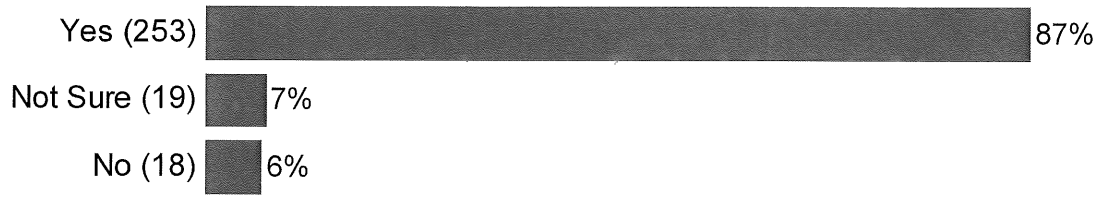
Por favor regreses al facilitador una vez que haiga concluido la junta. La información demográfica es confidencial. Su nombre NO sera conectado a su repuesta.

2019 MHSA Consumer and Stakeholder Survey

This report was generated on 03/09/20. Overall 327 respondents completed this questionnaire. The report has been filtered to show the responses for 'All Respondents'.

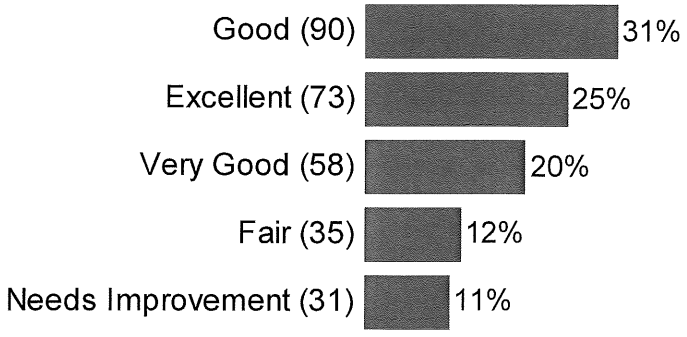
The following charts are restricted to the top 12 codes. Lists are restricted to the most recent 100 rows.

Do you identify as someone who is receiving, or who needs, mental health treatment services?



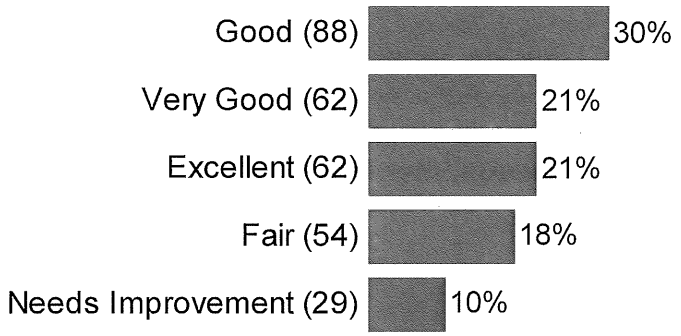
Please rate the quality of our services. Your feedback will help us identify what is working well and areas that we can improve upon. (1. The location our services are provided.)

Please rate the quality of our services. Your feedback will help us identify what is working well and areas that we can improve upon. (2. The information available in flyers, pamphlets , or on our website that describes our services.)

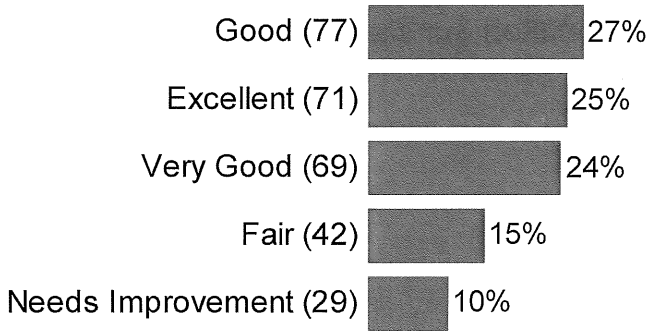


2019 MHSA Consumer and Stakeholder Survey

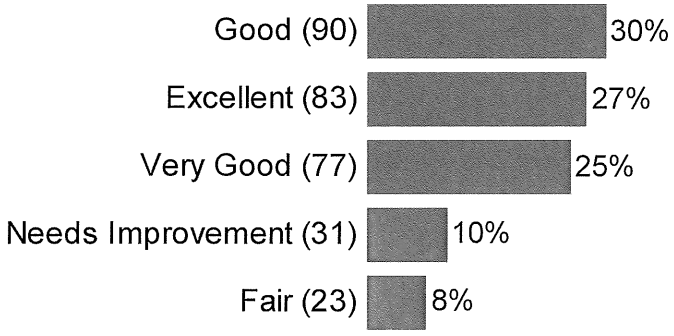
Please rate the quality of our services. Your feedback will help us identify what is working well and areas that we can improve upon. (3. The length of time it takes to get an appointment.)



Please rate the quality of our services. Your feedback will help us identify what is working well and areas that we can improve upon. (4. The types of individual or group interventions that are offered.)

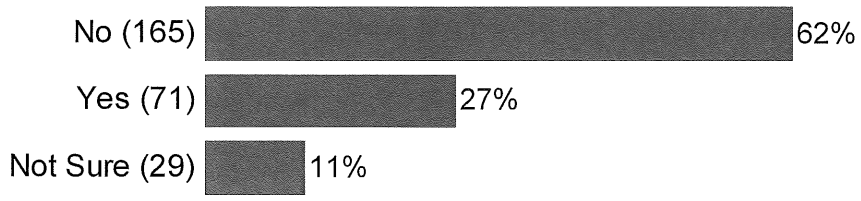


Please rate the quality of our services. Your feedback will help us identify what is working well and areas that we can improve upon. (5. The thoroughness of the services that are provided.)



2019 MHSA Consumer and Stakeholder Survey

Have you or a family member ever used BHS interpretation services?



If you've used BHS interpretation services, how would you describe the quality of the interpretation services?

What is the MOST important factor that contributes to wellness and recovery?

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2019 MHSA Consumer and Stakeholder Survey

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2019 MHSA Consumer and Stakeholder Survey

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2019 MHSA Consumer and Stakeholder Survey

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What is the SECOND most important factor that contributes to wellness and recovery?

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2019 MHSA Consumer and Stakeholder Survey

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2019 MHSA Consumer and Stakeholder Survey

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2019 MHSA Consumer and Stakeholder Survey

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2019 MHSA Consumer and Stakeholder Survey

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2019 MHSA Consumer and Stakeholder Survey

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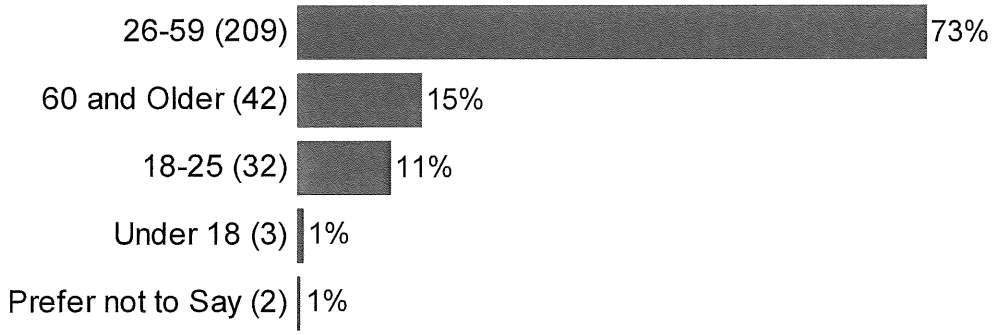
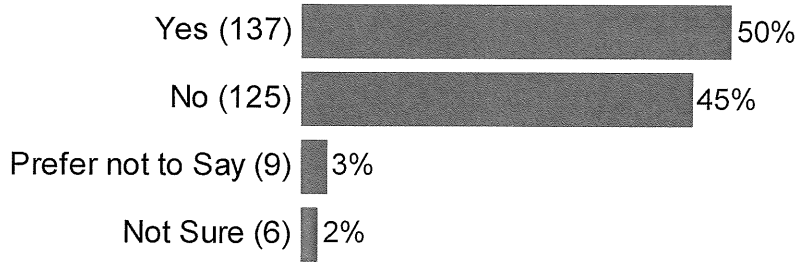
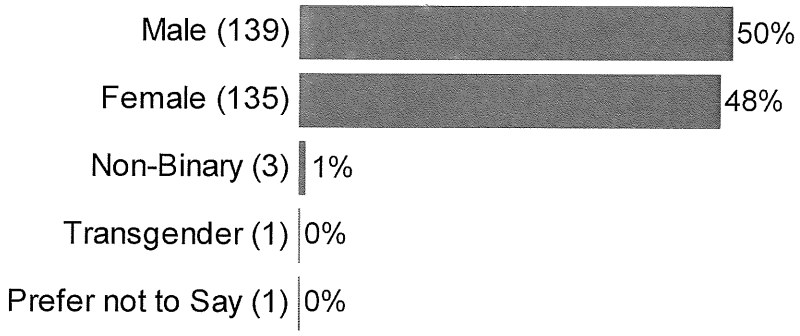


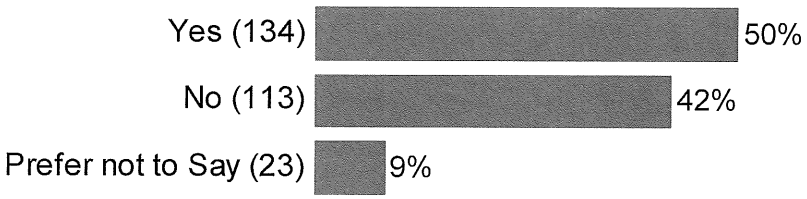
Are you a parent or are you about to be a parent?



Please indicate your gender:



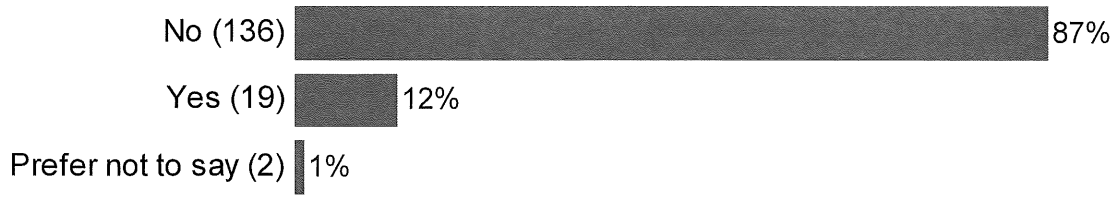
Do you self-identify as someone with a physical or developmental disability?



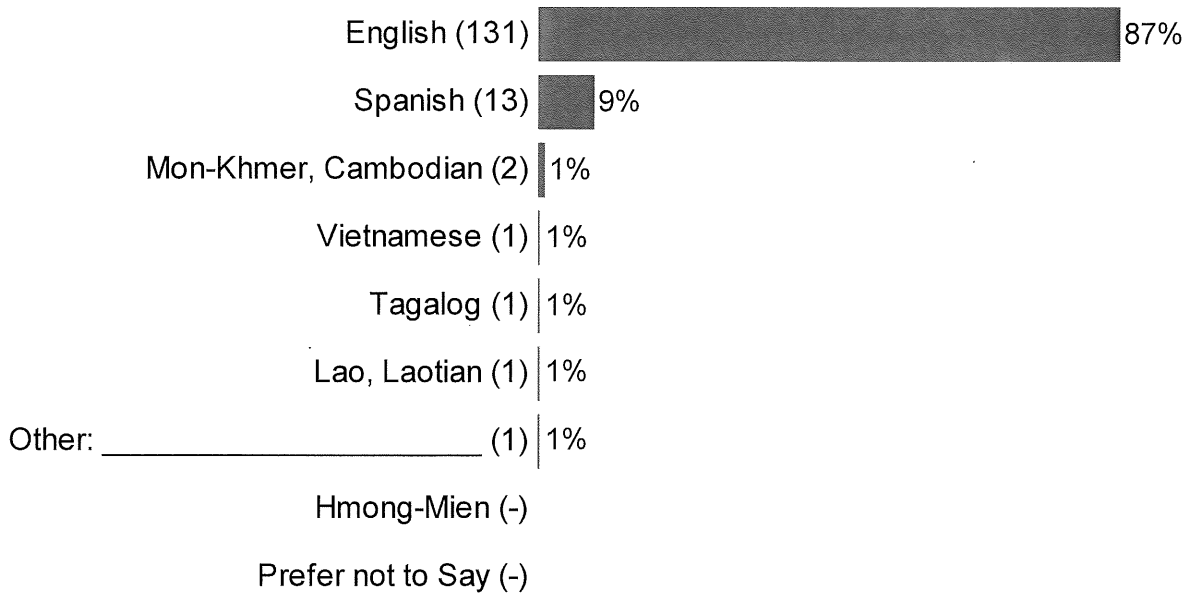
Are you a U.S. Military Veteran of the Army, Navy, Marines, Air Force, or Coast Guard?

2019 MHSA Consumer and Stakeholder Survey

Do you self-identify as Lesbian, Gay, Bisexual, Transgender, or Queer/Questioning (LGBTQ)?

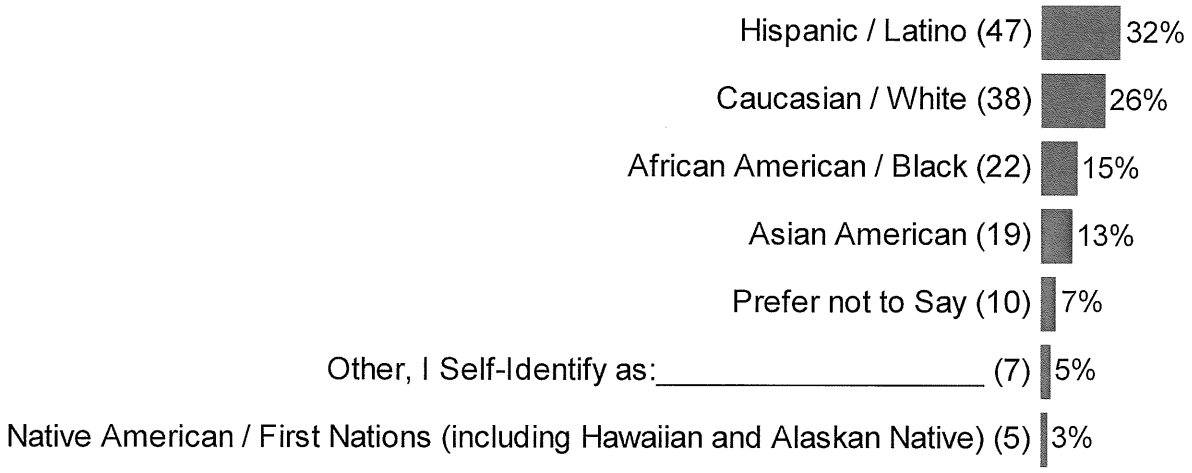


Please indicate the language that is most frequently spoken in your home (please choose only one):

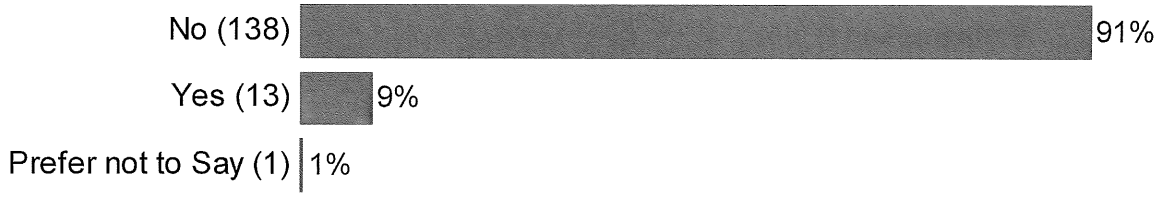


2019 MHSA Consumer and Stakeholder Survey

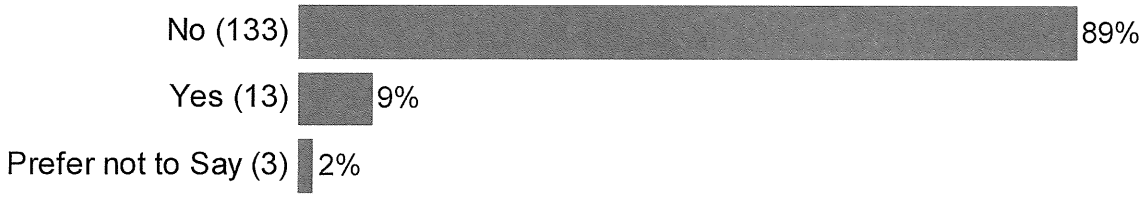
What is your race ethnicity?



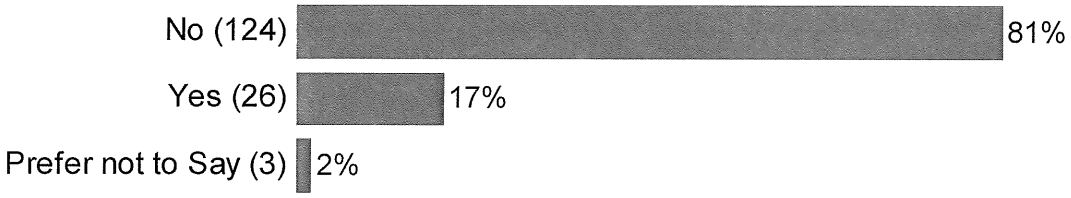
Are you currently homeless or at risk of homelessness?



In the past three years have you been homeless for more than a year or experienced homelessness more than four times?

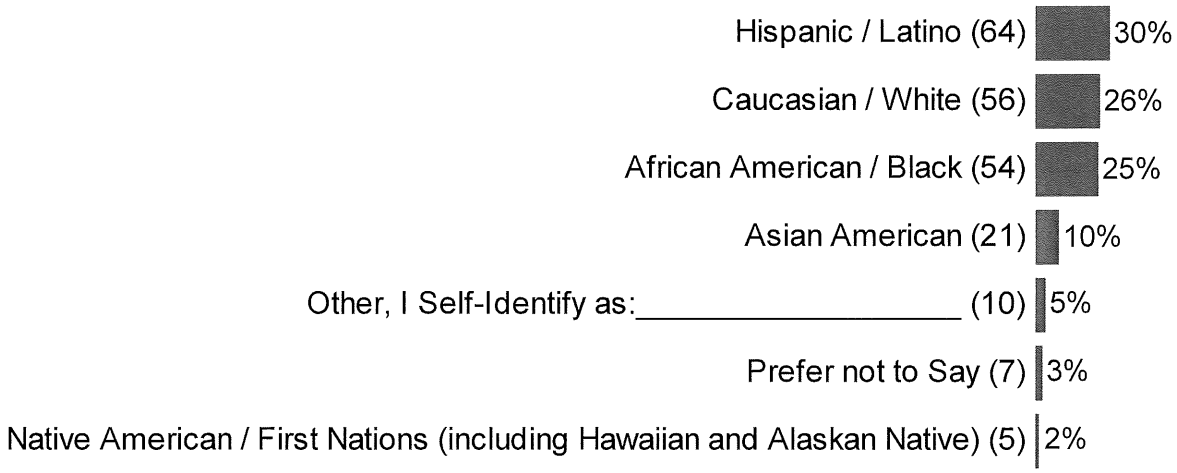


Have you ever been arrested or detained by the police?



2019 MHSA Consumer and Stakeholder Survey

What is your race ethnicity?



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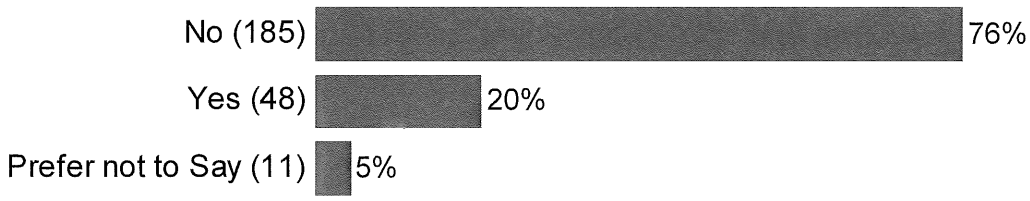

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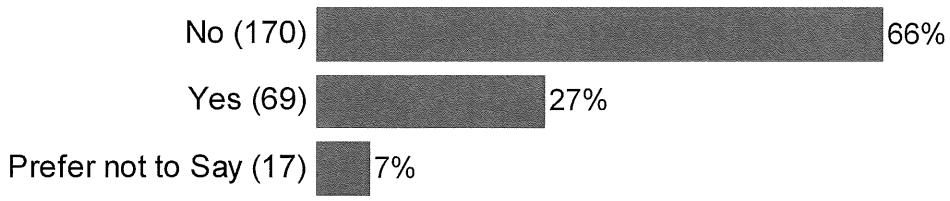
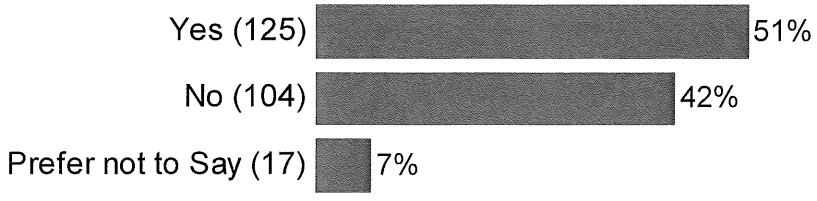
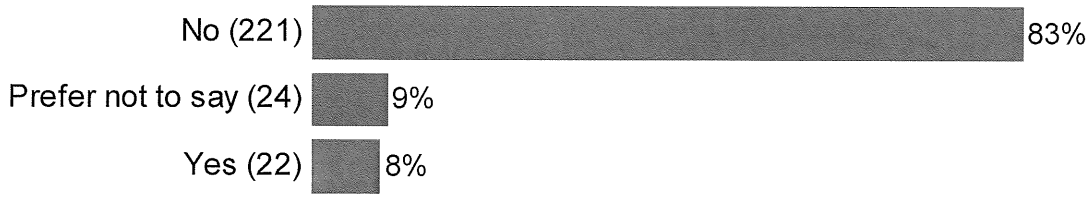


Have you ever been arrested or detained by the police?

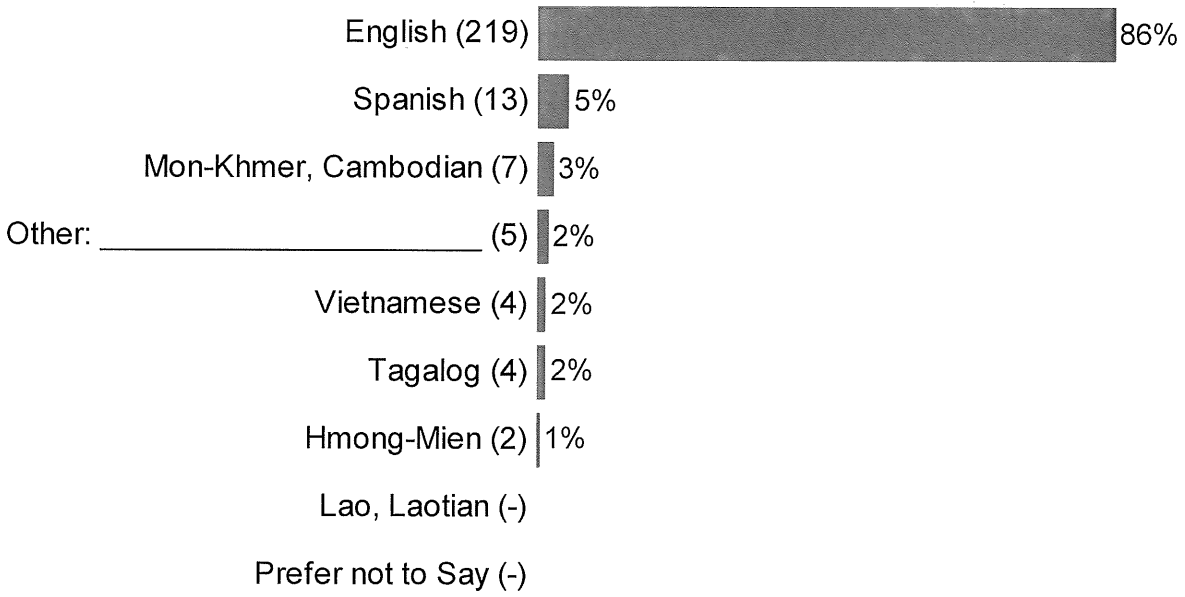


2019 MHSA Consumer and Stakeholder Survey

Do you self-identify as Lesbian, Gay, Bisexual, Transgender, or Queer/Questioning (LGBTQ)?



Please indicate the language that is most frequently spoken in your home (please choose only one):

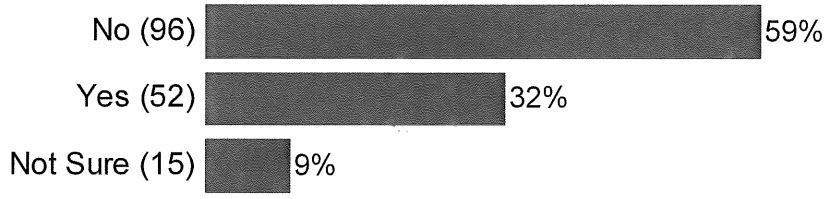


2019 MHSA Consumer and Stakeholder Survey

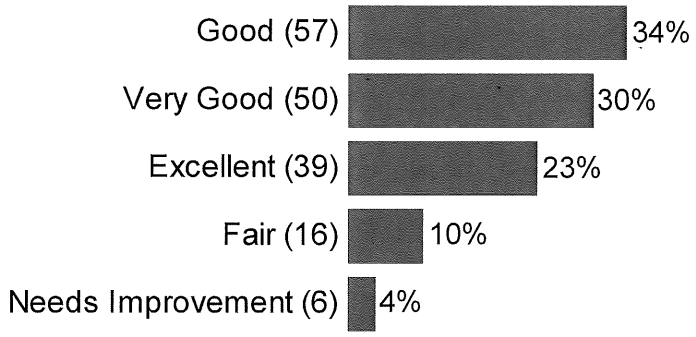
This report was generated on 03/09/20. Overall 175 respondents completed this questionnaire. The report has been filtered to show the responses for 'All Respondents'.

The following charts are restricted to the top 12 codes. Lists are restricted to the most recent 100 rows.

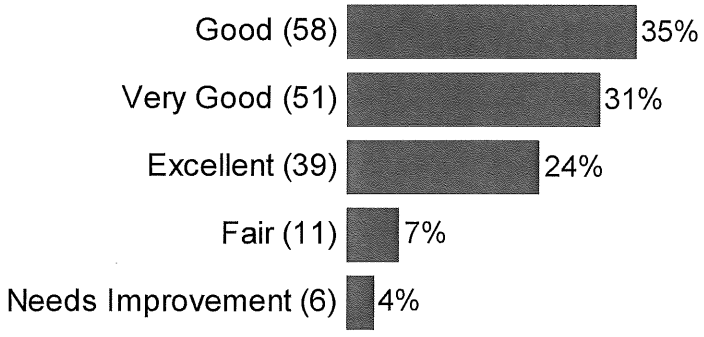
Do you identify as someone who is receiving, or who needs, mental health treatment services?



Please rate the quality of our services. Your feedback will help us identify what is working well and areas that we can improve upon. (1. The location our services are provided.)

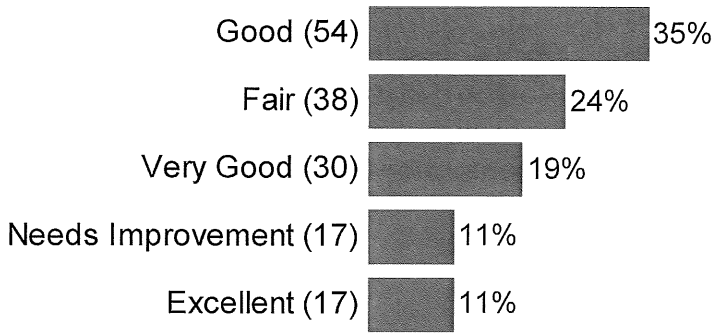


Please rate the quality of our services. Your feedback will help us identify what is working well and areas that we can improve upon. (2. The information available in flyers, pamphlets, or on our website that describes our services.)

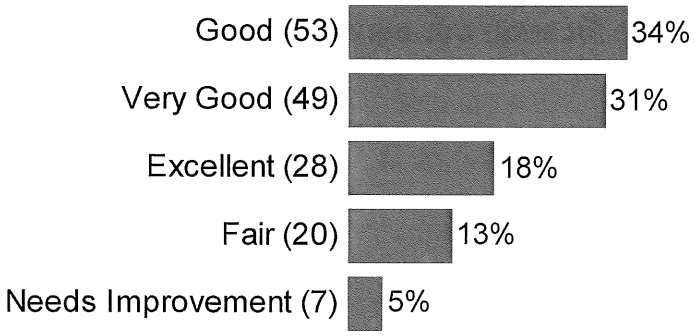


2019 MHSA Consumer and Stakeholder Survey

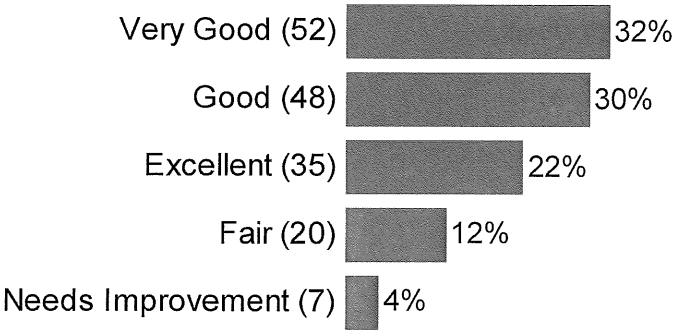
Please rate the quality of our services. Your feedback will help us identify what is working well and areas that we can improve upon. (3. The length of time it takes to get an appointment.)



Please rate the quality of our services. Your feedback will help us identify what is working well and areas that we can improve upon. (4. The types of individual or group interventions that are offered.)



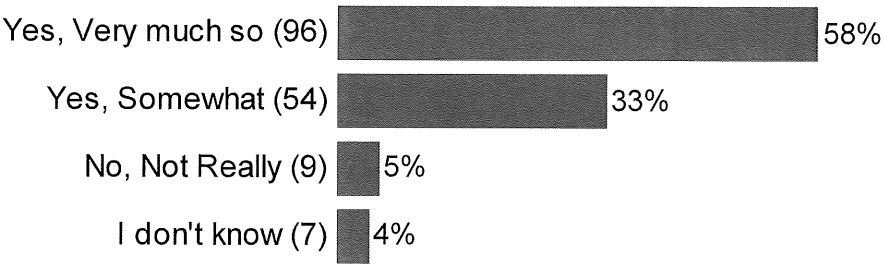
Please rate the quality of our services. Your feedback will help us identify what is working well and areas that we can improve upon. (5. The thoroughness of the services that are provided.)



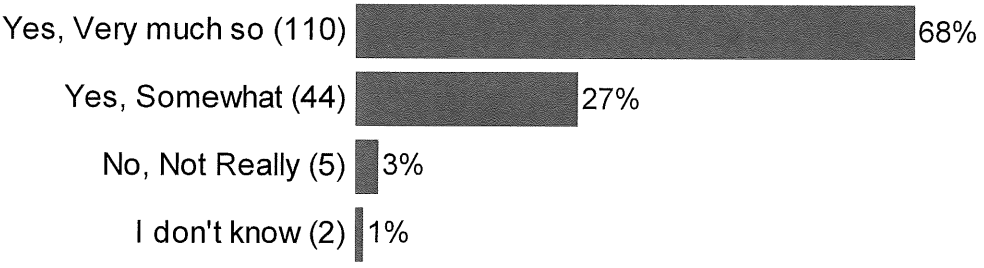
2019 MHSA Consumer and Stakeholder Survey

Would you recommend our services to people who need help for a mental health or substance use concern?

Please let us know whether you think that BHS program services are meeting the cultural and linguistic needs of the community (1. Lobby and reception areas are friendly and welcoming.)

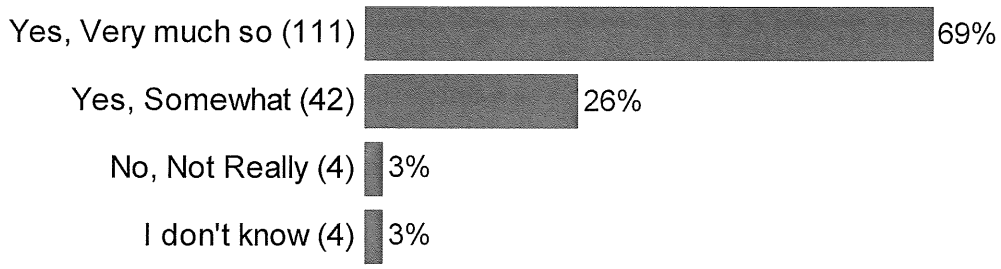


Please let us know whether you think that BHS program services are meeting the cultural and linguistic needs of the community (2. BHS staff members are courteous and professional.)

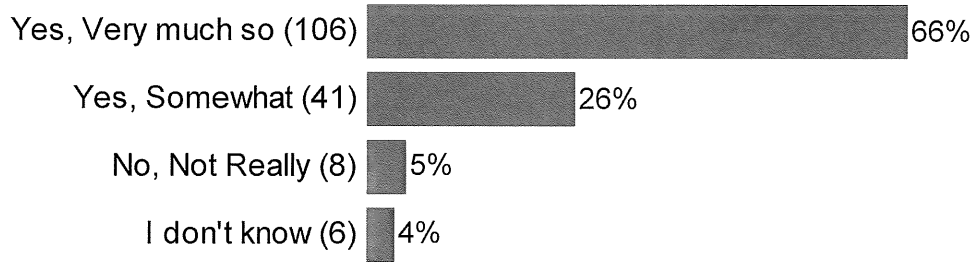


2019 MHSA Consumer and Stakeholder Survey

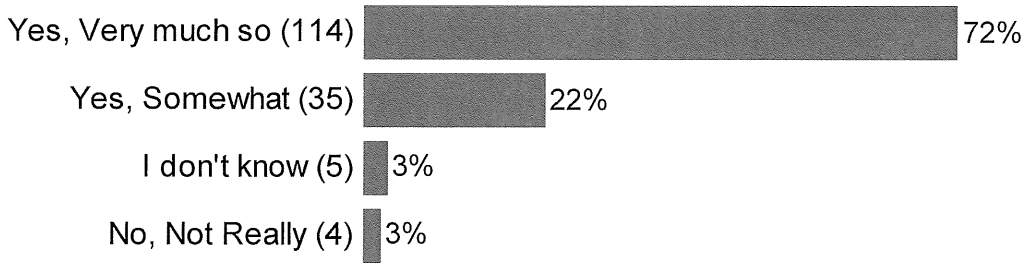
Please let us know whether you think that BHS program services are meeting the cultural and linguistic needs of the community (3. BHS staff members are respectful of your cultural heritage.)



Please let us know whether you think that BHS program services are meeting the cultural and linguistic needs of the community (4. BHS staff members explain things in a way you like and understand.)



Please let us know whether you think that BHS program services are meeting the cultural and linguistic needs of the community (5. BHS programs are helpful for many different types of people.)



2019 MHSA Consumer and Stakeholder Survey

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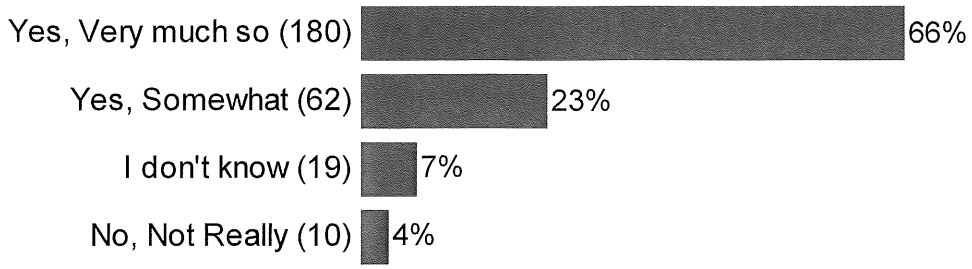

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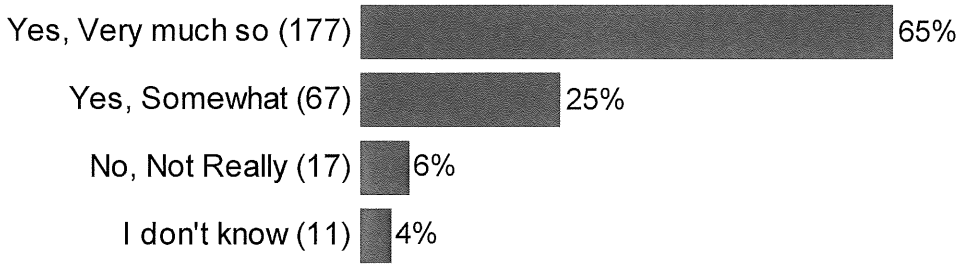

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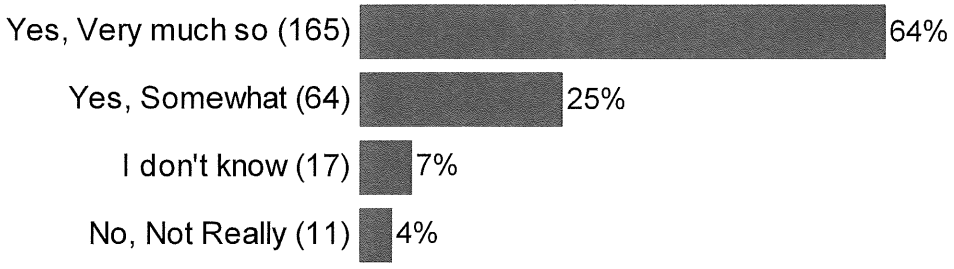
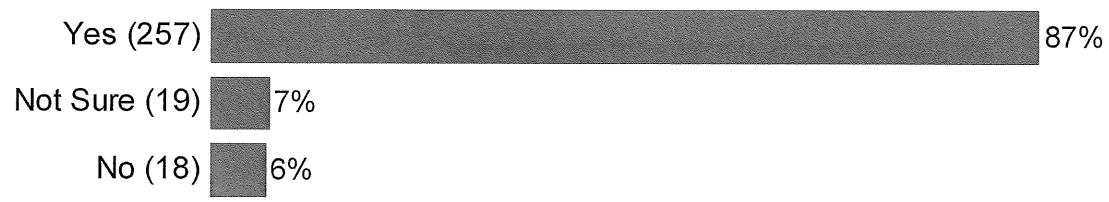
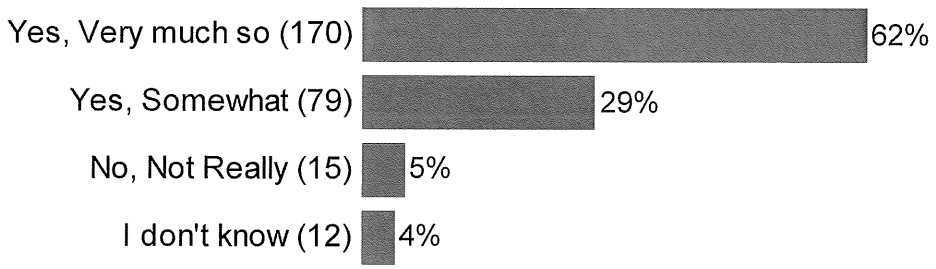


2019 MHSA Consumer and Stakeholder Survey

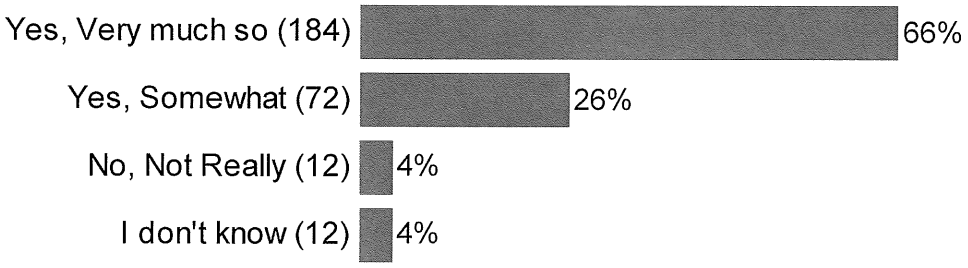
Would you recommend our services to people who need help for a mental health or substance use concern?



Please let us know whether you think that BHS program services are meeting the cultural and linguistic needs of the community (1. Lobby and reception areas are friendly and welcoming.)

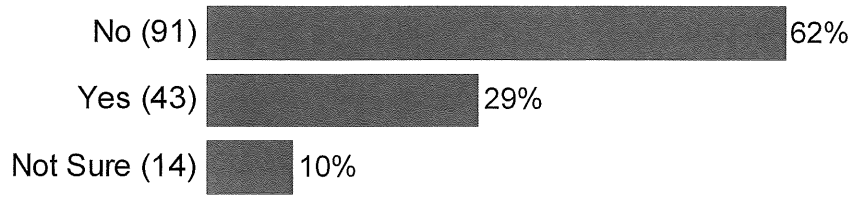


Please let us know whether you think that BHS program services are meeting the cultural and linguistic needs of the community (2. BHS staff members are courteous and professional.)



2019 MHSA Consumer and Stakeholder Survey

Have you or a family member ever used BHS interpretation services?



If you've used BHS interpretation services, how would you describe the quality of the interpretation services?

What is the MOST important factor that contributes to wellness and recovery?

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2019 MHSA Consumer and Stakeholder Survey

What is the MOST important factor that contributes to wellness and recovery?

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2019 MHSA Consumer and Stakeholder Survey

What is the MOST important factor that contributes to wellness and recovery?

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2019 MHSA Consumer and Stakeholder Survey

What is the MOST important factor that contributes to wellness and recovery?

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What is the SECOND most important factor that contributes to wellness and recovery?

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2019 MHSA Consumer and Stakeholder Survey

What is the SECOND most important factor that contributes to wellness and recovery?

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2019 MHSA Consumer and Stakeholder Survey

What is the SECOND most important factor that contributes to wellness and recovery?

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What is the THIRD most important factor that contributes to wellness and recovery?

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2019 MHSA Consumer and Stakeholder Survey

What is the THIRD most important factor that contributes to wellness and recovery?

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2019 MHSA Consumer and Stakeholder Survey

What is the THIRD most important factor that contributes to wellness and recovery?

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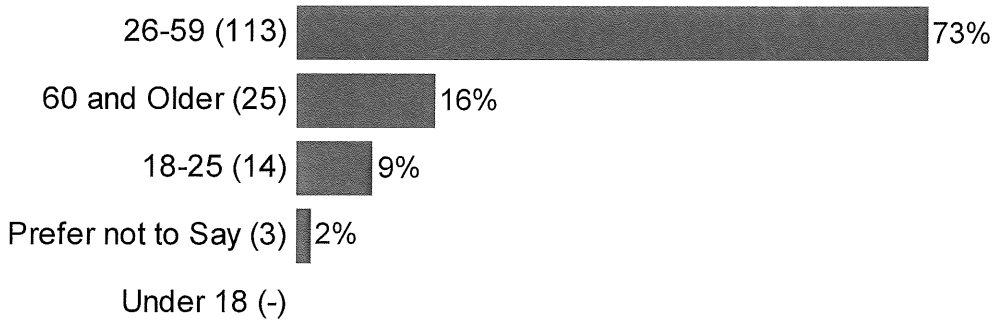
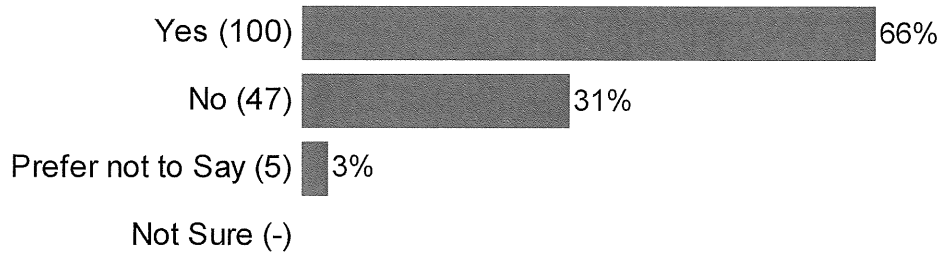
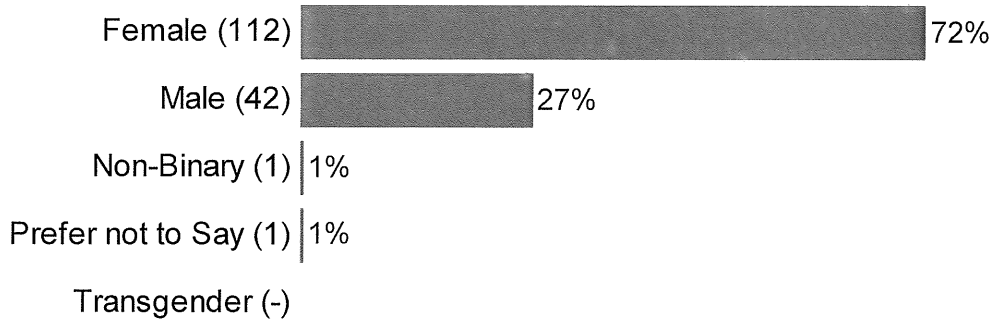


2019 MHSA Consumer and Stakeholder Survey

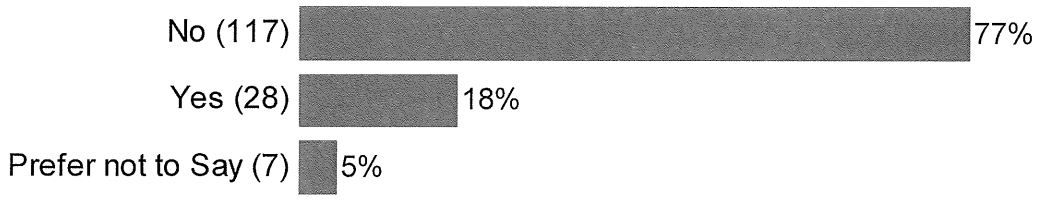
Are you a parent or are you about to be a parent?



Please indicate your gender:



Do you self-identify as someone with a physical or developmental disability?



Are you a U.S. Military Veteran of the Army, Navy, Marines, Air Force, or Coast Guard?

Balmaceda, Angelo [BHS]

From: Jami Alexander <jalexander@nochildabuse.org>
Sent: Monday, June 15, 2020 2:54 PM
To: mhsacomments
Subject: Public Hearing Comments

I would like to share the importance of funding for youth in foster care programs. Funding for programs such as CASA would address different areas of the strategic plans- such as Mental Health and Justice Collaborations and access to treatment and housing stability. 1 in 5 foster youth will be homeless by age 18 however statistics have shown that youth that have a caring adult such as a CASA have significantly better outcomes overall. Additionally, CASAs advocate for youth in foster care in regards to their mental health needs, educational needs and have assisted and supported the youth in regards to justice issues and dual dependency. The CASA program has proven to work and aligns very well with many aspects of the BHS strategic plans and goals. CASA, however is never fully funded and relies of grants and other funding opportunities to be able to continue these services. There are over 1700 youth in foster care in SJC alone with CASA only serving 6% of these youth. It is our goal and hopes to increase this to 20% youth served over the next 5 years and it takes other agencies to invest in the foster youth programs such as CASA.

Thank you

Jami L Alexander, M.S.
Director of Family Services
Child Abuse Prevention Council
CASA
209-851-3486
209-227-7255- Fax

You can Change A Child's Story. Click the CASA logo below to watch a short video.

CASA
Court Appointed Special Advocates
FOR CHILDREN

Balmaceda, Angelo [BHS]

From: B. Trieu <bthtrieu@gmail.com>
Sent: Tuesday, May 26, 2020 10:08 AM
To: Vartan, Tony [BHS]; Balmaceda, Angelo [BHS]
Cc: Tham Le; Bao Trieu
Subject: Request Support for VIVO's intention to apply Grant for BHS 3-Year Plan MHSA
Attachments: VIVO Q4 A18 105 Service Report.PDF

Follow Up Flag: Follow up
Flag Status: Flagged

Dear Mr. Tony Vartan (SJC-BHS Director)
and Mr. Angelo Balmaceda (SJC Manager Analyst II),

I would like to introduce myself as Bao Trieu, Chairman of the Board for VIVO (Vietnamese Voluntary Foundation). VIVO is a non-profit 501-C3 agency working with with Diverse Racial and Ethnic Communities in San Joaquin County and Santa Clara County.

I have had chances to meet the BHS Directors, Analysts, as well as other County Supervisors a few times last year during my trips to the County together with Ms. Tham Le, Branch Director of VIVO at Stockton. Ms. Tham Le had been working directly with both of you and others during VIVO's prior BHS Grants for the last 12 years.

With this email VIVO would like to request your support for renewal of collaboration opportunities to work with the SJC-BHS in the 2020-2023 three-year plan of providing services for the community, with the following data:

* In the three-year plan, it appears that most of the agencies that collaborated with SJC-BHS since 2007 are going to continue to receive funding from SJC-BHS. The exceptions noted to be the Southeast Asian group (VIVO, Lao Family and APSARA) which worked under GOALS (Gain Older Adult Service) and SEARS at the Trans Cultural Service programs.

* There is a thriving and dense Asian population within the San Joaquin County, however they are still very limited in terms of receiving treatment services from the community. Even after the end of last BHS Grant to VIVO Stockton since July 1st, 2019, we have been continuing to receive phone calls from the community informing us of clients' frustrations in receiving treatment. The statements were that clients found it difficult to find reliable support who can speak their languages and who are readily available to provide mental health treatment or advice to these clients.

* VIVO has had 12 plus years of experience in providing this type of support to the Asian community that requires mental health services. However, VIVO was unable to renew the grant in July 2019 due to some administrative changes within collaborating organizations. VIVO provided suicide prevention workshops in 2016- 2018 to reach out those who were at risk within their homes. The suicide workshops were performed at home, within the community, and at high schools. VIVO also developed information for adults on how to approach traumas in their life as well as keeping an open mind regarding PTSD treatment. As a community service provider in the San Joaquin County since 1986, VIVO has provided translation, social work, and case management services for non-English speakers that continue to struggle from their traumas, mental health issues, and/or transition into the work force.

Attached is the VIVO Mental Health Report which shows VIVO's successful contributions in the SJC-BHS collaboration of the 18-19 contract.

Please let me know if you would like any other historical information to help with your decision in renewing your collaboration with VIVO.

Thank you and have a nice day.

Bao Trieu, VIVO
Chairman of the Board
(408) 507-3192

Balmaceda, Angelo [BHS]

From: Nicholas Hatten <nicholasmhatten@gmail.com>
Sent: Tuesday, June 16, 2020 2:43 PM
To: Vartan, Tony [BHS]; Hutchins, Frances [BHS]; Balmaceda, Angelo [BHS]
Subject: Responding To MHSA From An African American Perspective

Upon review of this year's MHSA plan and budget, these are the recommended changes the San Joaquin County African American population will be demanding in response to the Black Live Matter protests, the deaths that have occurred by law enforcement and by the systemic racism that has held back black people of San Joaquin County from thriving equitably as others in the county.

As I said during the zoom meeting, I would strongly suggest as a show of solidarity, scheduling a zoom meeting to meet with the African American community to address the systemic racism of black people and how that's impacted providing mental health care locally. I will be more than happy to help organize leaders and community to attend,

Action Items:

Form an African American Cultural Competency Committee that is composed of community, clients and BHS representation that meets on a monthly basis.

End the practice of online cultural competence training and hire African American Culturally Competent CBO's to offer these training.

Create an African American crisis rapid response policy, in partnership with the African American community, all police departments and all school districts, and hire African American Culturally Competent CBOs & faith-based organizations to participate in mobile crisis responses.

Increase PEI funding and diversify your CBO & faith- based organizations portfolio that is funded to provide services for the African American community.

There is currently 10 million dollars not accounted for within this year's budget. We demand that those funds go to preventative mental illness services for the demographics (African American, Latinx, Asian/Pan Pacific, Native American and LGBT+) that these funds are encouraged to be used for.

Outside of MHSA
We also call on San Joaquin County to develop a Small, Local and Emerging Business, Diversity and Inclusion program, funded with staff, that promotes and monitors race and gender neutral contracts and addresses this County's decades long history of underfunding programs that impact the African American community, women, LGBT+ and all people of color; nor awarding commensurate contracts to these same demographics that would have allowed for a more equitable community for all within San Joaquin County.

Respectfully submitted,

Nicholas Hatten

--
nicholasmhatten@gmail.com
Pronouns: he, him, his
(209) 406-6133 [mobile]

FIRST 5 San Joaquin

P.O. Box 201056
Stockton, CA 95201

102 S. San Joaquin St.
Stockton, CA 95202

(209) 953-KIDS (5437) • sjckids@sjgov.org • www.sjckids.org

June 17, 2020

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

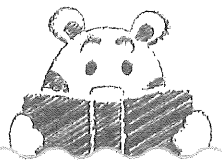
Attn: MHSA Planning Coordinator

In reviewing the MHSA Three Year Program and Expenditure Plan FY 2020-2021 through 2022-2023, it is exciting to see the growth of mental health services and outreach to the community over the past several years. It is even more exciting to see the forward thinking approach of reaching children and youth who may be "at risk" for various reasons, including, but not limited to, "adverse childhood experience, chronic medical conditions, experience of severe trauma or ongoing stress, poverty, family conflict or domestic violence, etc." (pg. 106) Recognizing and addressing the need for prompt intercessory action to prevent children and youth from progressive physical, emotional and mental challenges or Prevention and Early Intervention (PEI) (pg. 105) has been a goal of First 5 California and First 5 San Joaquin (F5SJ) for over 20 years. F5SJ has laid the foundation for PEI by designing and implementing a collaborative Help Me Grow (HMG) network system with developmental screenings as one of the main components of the framework in San Joaquin County.

Despite the increased recognition of the important role that screenings plays in detecting developmental, behavioral and physical delays, California continues to be **30th in the nation** for ensuring early identification and linkage to intervention. California has some of the lowest developmental screening and early intervention rates in the country. Failure to identify developmental delays and behavioral concerns puts children at a higher risk for lifelong problems that can affect their health and development throughout their lives, and their chances for successful independence.

Even when there is an identified delay, families struggle to navigate California's complex early identification and intervention system (EII) due to barriers such as:

- incomplete lists of resources



- long waiting lists for services
- inconsistent use of screening tools
- "wait and see" approach that leave too many children without the early support they need. (HMG CA)

Help Me Grow call centers provide:

- screening (offered in simplified online format for easy parent access 24 hours/day)
- enhanced referrals
- client follow-up and tracking
- care coordination
- education
- outreach to parents and providers
- training for pediatricians and other providers
- data collection and systems building
- partner convening for effective collaboration

The Help Me Grow system leverages existing resources to ensure communities identify vulnerable children, establishes linkages to community-based services, and empowers families to support their child's healthy development through the implementation of four interconnected Core Components:

1) **Centralized Point of Access**: Streamlined access to child development information, support and referrals to help families navigate San Joaquin Count's complex intervention system

2) **Family and Community Outreach**: Building awareness and linkage across support systems

3) **Healthcare Provider Outreach**: Collaborating with healthcare professionals to ensure children receive developmental screenings

4) **Data Collection and Analysis**: Identifying gaps in service and opportunities for greater collaboration and systems improvement

The exhaustive community research reported in the MHSA three-year plan states, "Strengthening services and supports for children, youth and their families remains a major concern in San Joaquin County." (pg. 15) In the vein of strengthening services and supports for children, it is critical to engage partnerships with agencies that are already doing this work. Some of the recommendations from the stakeholder meetings in the plan include collaborating with Human Services Agency (HSA) to, "review child welfare cases of families with children under five in the home; offer parenting classes, services and supports to families of young children; engage families of young children and make referrals to existing parenting classes funded through PEI programming." (pg. 15).

In addressing the recommendation, F5SJ asks for consideration for funding of the already existing F5SJ HMG Call Center, which addresses the stakeholder recommendations and would be able to expand services through additional funding. F5SJ HMG already receives referrals from HSA programs (an identified source for referrals in the BHSA recommendations). HMG staff are qualified to conduct appropriate assessments and work with families to outline an action plan to ensure their children (ages 0-5) receive all the services and supports necessary to thrive. It seems a natural progression to include the MHSA component to the HMG system as a coordinated system of overall mental and physical wellness resources.

The HMG model is a comprehensive, county-based system for early identification, referral, and care coordination for children at risk for developmental delays and behavioral concerns. The approach is systemic and is changing the way counties respond to the needs of young children and their families. F5SJ and its county partners have used the HMG framework to design new approaches to address parent and provider needs and family engagement, and innovate ways to strengthen connections between systems. (HMG CA) The San Joaquin County HMG program identifies and makes appropriate referrals to addresses PEI/EII using the nationally recognized Ages and Stages Questionnaire (ASQ) and the Ages and Stages Questionnaire – Social Emotional (ASQ-SE), which are both validated tools that help to identify early intervention needs. Referrals to HMG come from any point of contact with the child (family, preschool/child care, nurse/doctor, social worker, mental health professional, etc.).

Although they provide great value to their local communities, HMGs in California lack a designated funding source and have largely been supported by county First 5s, whose Proposition 10 revenues continue to decline (HMG CA). An additional consequence of the current state of California's budget is

that children may not be able to receive developmental assessments from their Pediatrician, as the state repealed reimbursements to doctors for administering critical assessments for their young patients in the May Revise of the Governor's budget. HMG fills a massive service gap in San Joaquin County by making referrals, linking resources and providers and ensuring needs are met by following up with clients to address concerns that would otherwise be overlooked without the program and F5SJ funding. Collaborating with MHSA as an additional funding stream would give San Joaquin County's most vulnerable clients more access to seamless support with a single point of contact and additional connections to mental health services.

Funding HMG will broaden the program reach to vulnerable San Joaquin County families. With the additional funding, F5SJ can maintain the established intensive services to the highest risk children and families with the added benefit of providing linkage to essential preventative and early mental health support (PEI) to clients who would not typically receive mental health services until behaviors become problematic and/or disruptive to their lives.

Please include the above recommendation to fund F5SJ Help Me Grow as a Community Service and Support partner in the Public Comments and for funding consideration, as MHSA extends its reach into Prevention and Early Intervention.

Sincerely,

Lani Schiff-Ross

Lani Schiff-Ross, LCSW
Executive Director

Balmaceda, Angelo [BHS]

From: Amy Portello Nelson <amyportello@hotmail.com>
Sent: Wednesday, June 17, 2020 5:00 PM
To: mhsacomments
Subject: MHSA 3-Year Plan Public Comment

Follow Up Flag: Follow up
Flag Status: Flagged

Good evening BHS Board and staff,

My name is Amy Portello Nelson. I am an independent consultant working with San Joaquin County nonprofits to improve their capacity to serve communities with the highest health disparities and community trauma. Before that I worked on improving community public health issues for over a decade. I am also a mother who is raising my children in Stockton and a survivor of domestic abuse who struggles with PTSD, depression, and anxiety. From all of those experiences, I am very familiar with the complexity of addressing and preventing mental illness and trauma.

I am also very familiar with the policies and investments that CA has put in place to help counties support this work within their community. MHSA funding is one of the sole sources of sustainable funding that has the flexibility to address wellness and healing beyond the scope of the doctor's office or clinical setting. Although a large majority of the funding must be allocated to Community Services and Supports for direct care of those with serious mental and emotional disturbances, there is still 24% of revenue that can be allocated for Prevention and Early Intervention, as well as Innovative projects. These are incredible sources of sustainable funding that can be used to support individual and community healing in San Joaquin county.

Over the last 3 years, I have worked directly with residents and community organizations who are facing violence, incarceration, poverty, lost jobs, school expulsions, domestic abuse, racism, and other community trauma. I've also spoken to families who live with chronic stress and anxiety because they have low paying jobs, can't afford transportation to get their kids to school, are caregivers to their parents, have no support system, and don't know how to find help.

Our communities are facing layer upon layer of challenges and need support. Some don't know how to navigate our behavioral health system, some can't afford co-pays, some don't feel comfortable in a clinical setting, some don't feel comfortable talking about their struggles at all. And yet, all of these people still need help. MHSA funding can't solve all of these issues, but it CAN begin to address it.
I'm here today with three asks:

1. Please dedicate time and funding to have a robust, ongoing community engagement strategy that is as diverse as San Joaquin County. We need conversations that are led by our community leaders (not county staff) so they can be adaptive, culturally relevant, and follow up with direct support as residents bravely share their struggles and needs around this issue. We need more communication about what resources are available and how people can engage in conversations around this issue. It takes a deep level of trust and vulnerability to share about these issues publicly. The county can't expect large numbers of people to share to strangers at open forums a few times a year.

2. Please invest in more local organizations that are serving the community with clinical and non-clinical forms of healing. Again, the diversity of cultures, ages, genders, sexual orientation, religious views, and economic groups means that people need a variety of options. And they are also at different levels of comfort about what that service looks like. One person might be comfortable in a FQHC clinic. Another might want counseling from a person of their same gender and racial background in a community setting they are familiar with. Another might need a group healing circle led by indigenous leaders. Getting services to those most in need, which are often the hard-to-reach populations, means meeting them where they are. You won't need to allocate $1.7 million to a stigma reduction campaign if you fund the organizations that are already connected with this community to help them find a service that feels safe and welcoming to them. Fund more community-based organizations to do this work as your partners. Instead of simply trying to hire a more diverse BHS staff, invest in the community that is already listening to their voices, speaking their languages, and know their stories.
3. Invest funds into community projects that will help address social determinants of health, including more counselors and nonprofits focused on restorative justice in schools, more job opportunities for youth at a variety of organizations committed to trauma-informed services, community-led activities in parks and community centers, and community outreach workers based at CBOs who can refer to social or health services as needed. All of these things heal the community, but they also give our residents a sense of purpose and connection.

Based on your three year plan, there is an estimate of over $7 million in PEI and $11 million in Innovation funding that has not yet been allocated for 20-21. Please consider investing in these ideas and especially in connecting with community partners on an ongoing basis to give them the opportunity to prioritize investments, not just advise on them. I'd also highly recommend using the CA Reducing Disparities Project's Strategic Plan to Reduce Mental Health Disparities as a guide for investment priorities moving forward.

Sincerely,

Amy Portello Nelson
amyportello@hotmail.com
415-424-9149
She - Her - Hers

Balmaceda, Angelo [BHS]

From: Kimberly Warmsley <kwarmsley@rsscoalition.org>
Sent: Wednesday, June 17, 2020 4:04 PM
To: Balmaceda, Angelo [BHS]
Subject: MHSA Proposals

Hi Angelo,

I hope all is well and you are prepared for tonights meeting.

Just sending in some reminders of the topics we discussed during our listening session. The priorities includes the following:

Improve and open the line of communication within marginalized communities.

Formulate a community lead coalition of stakeholders in order to engage BHC staff surrounding quality of services.

Increase and expand opportunities for other culturally specific CBO ability to apply for RFP's. Also improve BHC outreach when RFP's come out.

Innovation fundings should seek to improve innovative means of providing services to communities that have or impacted through environmental trauma, homelessness and cultural/subcultural barriers.

The implications of COVID 19 have compromised BHC's ability to expand and gather insight, suggestions and feedback from stakeholders. Due to the implications of COVID 19, can BHC ask for an extension to submit the proposal so that more information can be sought out from the community and stakeholders.

More discussion surrounding funding allocations for preventative substance abuse services and interventions.

Consideration for community based organizations and targeted communities to provide educational services and preventative programming in order to create rapport, and then hand off to BHC for more intensive interventions. (The allocation of more funding).

Allocation for affordable housing to include wrap around services.

Expand contractual opportunities for other CBO's that are also dong the work.

Has the county official terminated contractual MHSA services that were once provided by El Councilo, ASPRA, Mary Magadlene?

I look forward to speaking to you all in the very near future, and will be watching tonight's meeting per via ZOOOM.

--

Kim Warmsley, Senior Project Coordinator
Reinvent South Stockton Coalition
kwarmsley@rsscoalition.org
(209) 905-8809

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Click here to schedule a meeting or view my calendar availability.

Balmaceda, Angelo [BHS]

From: Wimmer, Virginia [VSO]
Sent: Wednesday, June 17, 2020 5:38 PM
To: Balmaceda, Angelo [BHS]
Subject: MHSA Public Comment
Attachments: PUBLIC COMMENTS VSO MHSA 2021_2023 increase COMMENTS.docx

Follow Up Flag: Follow up
Flag Status: Flagged

San Joaquin County Veterans Service Office requests an $200,000 to continue providing services and support to the Veterans and families of San Joaquin County.

Virginia A. Wimmer, SMSgt USAF (Ret), MSW, CVSO
Deputy Director, Veterans Service Office
San Joaquin County
209 468-2917

San Joaquin County Veterans Service Office (VSO) provides mental health outreach services that promote programs that encourage early intervention of mental health needs for veterans and their families. The VSO assists veterans in applying for, receiving Federal VA benefits. VSO serves and advocates for 32,000 veterans and their dependents. We educate the community about the mental health issues that can affect transitioning service members from military life. We identify underserved veterans and their families to provide referrals that enhance access to mental and physical healthcare. We are the frontline workers and liaisons who connect veterans and their families to the benefits, entitlements, and services that they deserve. We exist to reduce eligibility and enrollment barriers to federal, state, and local benefits by providing timely and effective advocacy services. This fiscal year alone we have served 6,528 individual veterans and/or family members. We have filed 2,286 monetary benefit claims and brought in over $3M to those families. We have saved $92K in Medi-Cal assistance by effectively enrolling 164 new family members in CHAMPVA (which is health insurance for veteran family members).

In 2015 VSO co-founded the Veterans Treatment Court which offers alternatives to incarceration for veterans by linking participants with vital rehabilitation and treatment resources. The VTC provides structured services and support based upon research and evidenced based interventions that links substance misuse and combat-related mental illness. To date we have had a zero recidivism rate and have graduated 67 veterans. All of whom have either secured stable housing, jobs, went back to school, maintained employment, and/or reconnected with estranged family members. Additionally, VSO collaborates with community based veteran service organizations to ensure they are afforded the opportunity to participate in Mental Health First Aid and Applied Suicide Intervention Training Workshops. Through increased training opportunities – the veteran's community is better equipped to mitigate suicide, and provide support during a mental health crisis.

As part of the collaboration of federal, state, community, and County agencies VSO is able to carry out these duties and actions on a limited and stifled budget and with part time temporary staffing levels. To further support VSO in providing these invaluable services and expand capacity within the VTC, a new position is required to provide intensive case management. Local general funds have not been made available for enhanced staffing levels; therefore, VSO would benefit from an increase in MHSA funding to fully support mental health outreach, intensive case management, and supportive social services for our county's veterans. Connecting local veterans to substance abuse treatment, VA benefits, and behavioral health services are necessary in reducing the long-term and adverse impacts of untreated mental illness as well as to reduce recidivism. VSO will do this by engaging the veterans where they live, work and play, through community outreach, participating in local benefits fairs, civic events, and partnering with community based, faith based, non-profit organizations, and mental health agencies including Vet Centers and the Department of Veterans Affairs.

In addition to the services provided through VTC, mental health outreach, and benefits advocacy the VSO is the lead agency on Mental Health First Aid (MHFA) and Applied Suicide Intervention Skills Training (ASIST) workshops. These evidence based trainings increase the utilization of mental health care and substance abuse treatment through education, assessment, and engagement of the veteran population living in San Joaquin County. BHS has benefited immensely from VSO's MHFA and ASIST workshops. In fact, BHS is one of the largest agencies within the County that benefits most from these trainings. Our community based organizations find these trainings to be effective in recruiting, retaining, and maintaining their workforces and volunteer forces. Veterans and their families also benefit from these trainings. These trainings require VSO to partner and contract with certified and accredited facilitators to present these trainings 4-6 times per year. To continue this effort VSO requires additional funding.

For the County VSO to increase targeted outreach to the veteran populations that include justice involved veterans and service members from all socioeconomic statuses such as minorities, LGBTQ, women, homeless, and veterans living in the underserved, rural, and outlying communities surrounding the County.

The aligned program priorities include serving veterans through the MHSA program by expanding and enhancing the County mental health services to veterans for treatment and other related recovery programs. However, there was no consideration of increasing funding to expand and enhance these services and programs. BHS vows to work with VSO to strengthen services and expand suicide prevention efforts. The current MHSA plan does not reflect that commitment. The total proposed budget for ALL veteran's services and support is $238,305 while the VSO's proposed grant $160,000 of that. There are more than 32,000 veterans and their families living in San Joaquin County and the VSO is staffed at 4 full time and 3 part time staff to care for those veterans and their families. MHSA Plan allots the lowest amount of funding to support veterans – of all the wonderful programs outlined within.

San Joaquin County Behavioral Health Services must ensure all funds provided through the MHSA are expended in an effective manner to ensure the services provided are in accordance with recommended best practices but the plan should also administer those funds to ensure veterans are properly cared for in the manner that they deserve. An increase from $160,000 to $200,00 from the MHSA funding will ensure VSO continues to provide professional and timely advocacy services, intensive case management, mental health outreach services, reduce eligibility and enrollment barriers, and continue as lead agency on MHFA and ASIST in order to reduce the long-term, adverse impact of an untreated, serious mental illness and suicide.

Balmaceda, Angelo [BHS]

From: Wimmer, Virginia [VSO]
Sent: Wednesday, June 17, 2020 5:44 PM
To: mhsacomments
Subject: Please add these comment to the Public Comments for the MHSA Plan

The current plan proposes $160,000 for VSO to carry out the duties of serving 32,000 veterans and their families. VSO is requesting an increase from $160,000 to $200,000 (although $250,000 would be better). Currently the County Veterans Service Office has 4 full time staff and 3 part time staff to carry out the duties of serving 32,000 veterans. VSO is proud of the work we do with the diligence and efficiency in which we do it. We are requesting your support and your voices to encourage Behavioral Health to recognize that their commitment to support VSO and the Veterans in our community is imperative.

The plan allots more than $4 million to serve transitional aged youth – another $2 million for an intensive justice response program. All of these are worthy and important but so are Veteran's programs. Please provide a comment that would encourage Behavioral Health to increase funding to the Veterans Service Office to increase efforts with the Veterans Treatment Court, Mental Health First Aid, outreach to homeless veterans, and to reduce the long-term, adverse impact of an untreated, serious mental illness.

The proposed funding for veteran specific programs total $235,946 out of tens of millions of dollars. Central Valley Low Income Housing will be awarded $75,946 and County Veterans Service Office will be awarded $160,000 for a total of $235K.

Virginia A. Wimmer, SMSgt USAF (Ret), MSW, CVSO
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San Joaquin County
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