San Joaquin County
Behavioral Health Services
Mental Health Services Act (MHSA)
Three-Year Program and Expenditure Plan
FY 2014/15, 2015/16, 2016/17

Final

Approved by San Joaquin County Board of Supervisors:
September 9, 2014

The Public Hearing was convened:

Wednesday August 20, 2014
6:00pm – 8:00pm

San Joaquin County Behavioral Health Services
1212 North California Street
Conference Room B
Stockton, CA 95202

TABLE OF CONTENTS

Introduction

In 2004 California voters approved the enactment of the Mental Health Services Act (MHSA). In San Joaquin County, great advances have been made to enhance mental health services and to increase opportunities for recovery and well-being in the community. There are five different component plans that describe the use of MHSA funding and to lay out a vision and a framework for improving services.

I. Prevention and Early Intervention (PEI)
II. Community Services and Supports (CSS)
III. Workforce, Education and Training (WET)
IV. Innovation (INN)
V. Capital Facilities and Technological Needs (CFTN)

The Prevention and Early Intervention Services plan addresses the identification of the early signs and symptoms pertaining to the emergence of a mental illness and the early interventions necessary to prevent a mental health challenge from becoming severe or disabling. The Community Services and Supports plan provides *general system development* funding to expand and enhance community based mental health services as well as *full service partnership* funds to provide very intensive services to those individuals whose illnesses are most severe and difficult to treat; including those with challenging life circumstances such as homelessness, frequent law enforcement contact, and co-occurring substance use disorders. The Workforce, Education and Training plan component addresses the training and staff development needs necessary to support the professional growth and capacity of the public mental health workforce in order to support the vision and intention of the MHSA to provide the best possible services in a manner that is consumer and/or family directed, data driven, and guided by a belief in recovery. The Innovation component plans have served as an opportunity for San Joaquin County Behavioral Health Services to test-pilot "new and novel" approaches to mental health service delivery to determine if there are better ways to help consumers on their pathway to recovery. Finally, the Capital Facilities and Technological Needs component funds facility and technology upgrades to support all initiatives.

All MHSA component plans address the needs of children and transitional age youth (TAY) with serious emotional disorders or mental illnesses and adults and older adults with serious mental illnesses, as well as address specific needs related to cultural competency and in serving the needs of those previously unserved or underserved. Further, at least 50% of CSS funding must be allocated to Full Service Partnerships programs and at least 51% of PEI funding must be spent in support of programs and activities that address the needs of children, youth, and transitional age youth.

The implementation of MHSA has been the impetus for a tremendous amount of change – in San Joaquin County BHS has redesigned its system of care to provide a larger menu of services for the mentally ill with a range of new community-based programs and services. The System Redesign and Expansion of 24-Hour Services resulted in more options for crisis services and fewer inappropriate hospitalizations. The Redesign and Expansion will enter its Second Phase in 2014/15 with the construction of a Crisis Stabilization Unit for children and youth and expanded mobile crisis services.

San Joaquin County has also leveraged state and federal initiatives to further support community based mental health services in accordance with the principles and vision of the MHSA. The implementation of California's Public Safety Realignment presented more opportunities to help individuals involved in the criminal justice system work towards recovery and crime-free lives and the Affordable Care Act made access to mental health and substance abuse services feasible for more San Joaquin County residents.

This document updates the five MHSA Component Plans. Over the past two years, San Joaquin County consumers, family members, service providers, and community leaders have reexamined goals and objectives of the five existing plan elements and the programs that have been designed to implement those goals. Program staff and stakeholders have conducted a careful assessment to determine program strengths, opportunities to be leveraged, and areas requiring continuing improvements. While this process is ongoing, this plan reflects an increasing movement towards a continuous quality improvement process through the use of evidence based practices, standardized measurement tools and data driven benchmarks of success.

The current Three Year Program and Expenditure Plan for San Joaquin County includes: Section One, an Overview of the 2013-14 MHSA Planning Process and the findings that drove the planning recommendations; Section Two, the Program Summaries with projected expenditure reports; and Section Three, which describes the implementation and evaluation strategies for the plan.

MHSA COUNTY
COMPLIANCE CERTIFICATION

County/City: SAN JOAQUIN COUNTY

☒ Three-Year Program and Expenditure Plan
☐ Annual Update

Local Mental Health Director		**Program Lead**	
Name:	Victor Singh	Name:	Frances Hutchins
Telephone Number:	209-468-8750	Telephone Number:	209-468-8750
E-mail:	vsingh@sjcbhs.org	E-mail:	fhutchins@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 nonsupplantation 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 annual update and expenditure plan, attached hereto, was adopted by the County Board of Supervisors on September 9, 2014.

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.

Victor Singh
Local Mental Health Director (PRINT)

Signature 9/12/14
Date

MHSA COUNTY
FISCAL ACCOUNTABILITY CERTIFICATION

County/City: SAN JOAQUIN COUNTY

☒ Three-Year Program and Expenditure Plan
☐ Annual Update
☐ Annual Revenue and Expenditure Report

Local Mental Health Director		County Auditor-Controller / City Financial Officer	
Name:	Victor Singh	Name:	Jay Wilverding
Telephone Number:	209-468-8750	Telephone Number:	209-468-3925
E-mail:	vsingh@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.

Victor Singh
Local Mental Health Director (PRINT)

Signature 9/12/14
Date

I hereby certify that for the fiscal year ended June 30, 2014, 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, 2013. I further certify that for the fiscal year ended June 30, 2014, 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.

Jay Wilverding
County Auditor Controller (PRINT)

Signature 9-15-14
Date

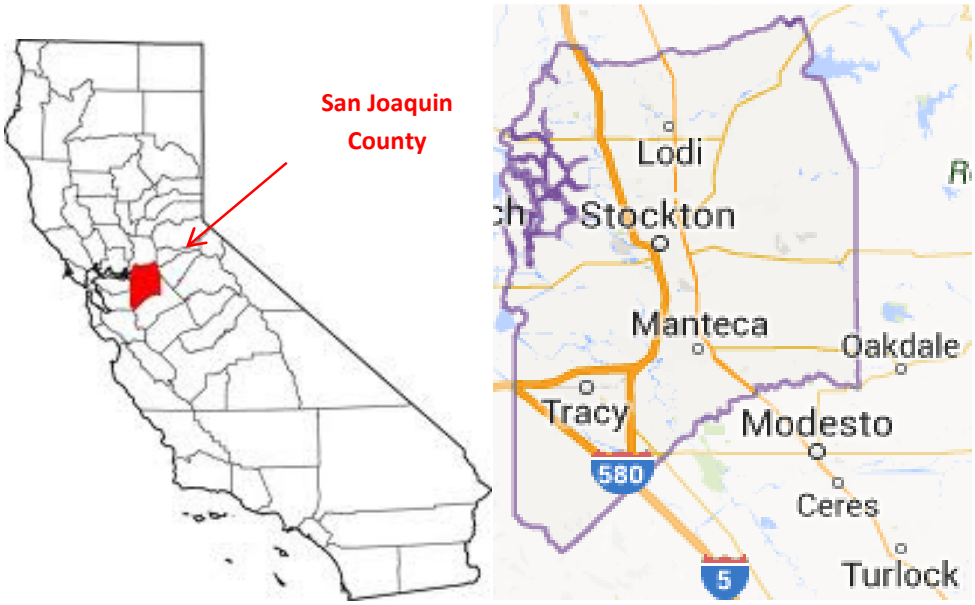
Welfare and Institutions Code Sections 5847(b)(9) and 5899(a)
Three-Year Program and Expenditure Plan, Annual Update, and RER Certification (07/22/2013)

Section One: Community Program Planning Process

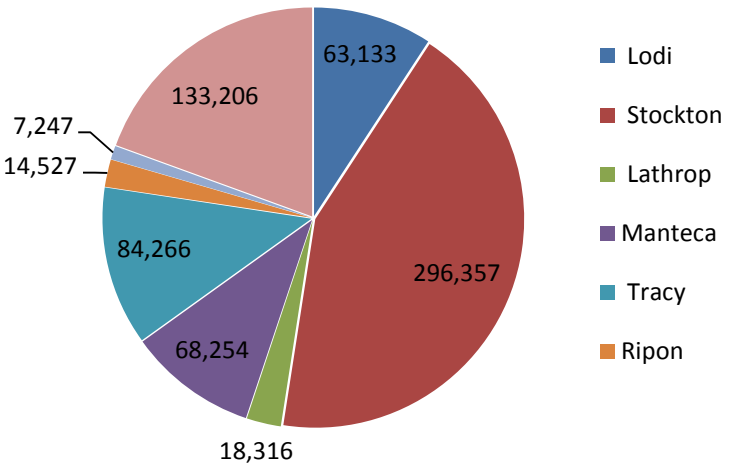
Overview of San Joaquin County

San Joaquin County is located in the heart of California's San Joaquin Valley and encompasses 1,426 square miles stretching from the Sacramento-San Joaquin Delta to the foothills of the Sierra Nevada.

Map

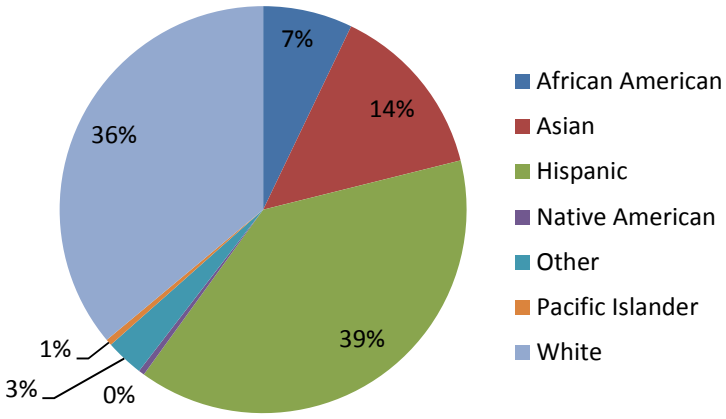


Population by City Area



Nearly 80% of the County's 685,000 residents live in the cities and communities that straddle Interstate 5 and Highway 99.

Population by Race/ Ethnicity



Nearly two-thirds (64%) of the population describe themseles as non-white with no one racial or ethnic group comprising a majority of the population.

The County's diverse population is also characterized by the following trends:

- 50% of County residents are female
- 39% speak a language other than English at home
- 17.5% of individuals live below the federal poverty level
- The median household Income is: $53,895
- 29% of the population is under 18 years of age

MHSA Planning Team

Community program planning for the Three Year Program and Expenditure Plan for FY 2014-15 through FY 2016-17, began in late 2013. The planning team is comprised of Victor Singh, Director; Jean Anderson, Assistant Director; Frances Hutchins, Deputy Director of Administration and MHSA Program Coordinator; and Kayce Rane, of Rane Community Development, a consulting firm with mental health planning expertise. Program evaluation planning and consultation was provided by Jennifer Susskind. Doris Cody provided administrative support. The MHSA Planning Stakeholders Steering Committee provided oversight and recommendations on the planning process and helped ensure that the planning process was representative of all community stakeholders. The MHSA Annual Update's planning process was also a standing agenda item on the weekly BHS Senior Managers team meeting. The BHS program directors provided valuable insight and helped ensure that planning directions aligned with all aspects of MHSA programming within the agency. The Consumer Advisory Committee (CAC) was also notified of the meeting plan, and the CAC consumer coordinator engaged in direct outreach and engagement with consumers.

Local Stakeholder Engagement 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. Between January and June 2014, the following venues were used to: (1) develop the community stakeholder planning process; (2) solicit input on strengths, challenges and opportunities; and, (3) to review and prioritize potential areas of improvement:

- MHSA Planning Stakeholder Steering Committee
- Consumer and Stakeholder Meetings
- Partner and Program PEI Evaluation Planning Meetings

1. MHSA Planning Stakeholders Steering Committee

The MHSA Planning Stakeholders Steering Committee was appointed by the San Joaquin County Board of Supervisors to serve as a standing committee to provide guidance and input on MHSA related planning matters. In three meetings held in November (2013), February, and March, the group met to develop the structure and nature of the community planning process, including:

- Ideal times, location, and stakeholder groups to meet with in focus groups
- Ideal times, location, and number of community planning meetings
- The nature and type of questions that should be asked
- Likely strengths and challenges that should be probed for
- How to improve outreach measures to ensure good stakeholder participation

Upon completion of the DRAFT, members of the MHSA Planning Stakeholders Steering Committee provided invaluable input and assistance in reviewing public comments; recommending improvements and refinements and ensuring that the Plan was reflective of the spirit and intent of the Mental Health Services Act.

2. Consumer and Stakeholder Discussion Groups

Rane Community Development, a planning and consulting firm with expertise in mental health planning, conducted seven consumer and stakeholder focus groups during March, 2014. Discussion group questions addressed overall behavioral health needs and were structured around the MHSA component areas. BHS is especially grateful to the community- and faith-based organizations that graciously hosted the discussions and encourage their constituents to participate in the planning process.

San Joaquin County Behavioral Health Services
Community Program Planning for the
MHSA 3-Year Program and Expenditure Plan
FY 2014/15, 2015/16, and 2016/17

Stakeholder Focus Group		Discussion Topics	Location/Date/Time
1	General Community	Presentation of Current Programs and BHS Strategic Directions: Strengths, Challenges, Recommendations	Tuesday, March 4th **Tracy Public Library** 3pm – 5pm
2	MHSA Consortium and Contracted Providers	Presentation of PEI Program Guidelines and Anticipated Directions. Strengths, Challenges, and Recommendations	Wednesday, March 5th **Dorothy Chase** 3pm – 5pm
3	PEI Stakeholders	Presentation of PEI Guidelines and Anticipated Directions. Strengths, Challenges, and Recommendations	Monday, March 10th **BHS – Conf. Rooms B&C** 1:00 – 3:00 pm
4	General Community	Presentation of Current Programs and BHS Strategic Directions: Strengths, Challenges, Recommendations	Wednesday, March 12th **BHS – Conf. Rooms B&C** 1:00pm – 3:00pm
5	General Community	Presentation of Current Programs and BHS Strategic Directions: Strengths, Challenges, Recommendations	Thursday, March 13th **Lodi Public Library** 1:30pm – 3:30pm
6	General Community	Presentation of Current Programs and BHS Strategic Directions: Strengths, Challenges, Recommendations	Thursday, March 13th **Central United Methodist Church** 6pm – 8pm
7	Probation & Court Partners	Presentation of Current Activities and Opportunities to Strengthen Services	Wednesday, March 26 **Robert J. Cabral Center** 8am – 12pm

3. Partner and Program PEI Evaluation Planning Meetings

Focused meetings were held with a representative sample of community based partners and contracted public agency providers to develop evaluation strategies for current and ongoing Prevention and Early Intervention Programs. Individual program evaluation meetings led to a deeper understanding of program goals and objectives and clarified desired outcomes. BHS program managers, contracted provider staff, and the evaluator worked collaboratively to develop project specific performance

measures. These conversations were subsequently used to inform the performance measures described in the PEI component section. Discussions were conducted with the following MHSA contracted program providers:

Public Agency Partners

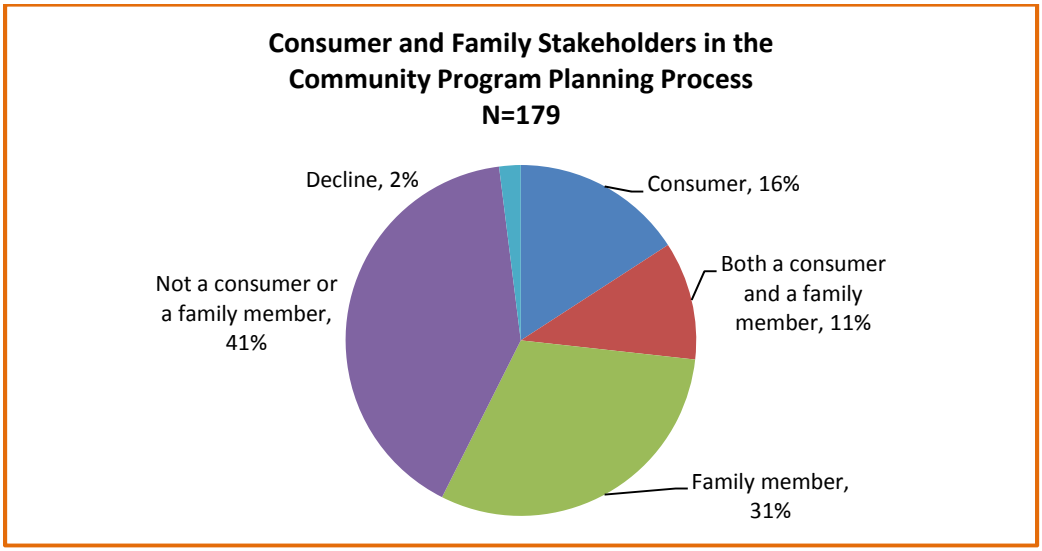
- City of Stockton: April 10, 2014
- City of Tracy: April 17, 2014
- County Office of Education: April 17, 2014

Community Based Providers

- Community Partnership for Families of San Joaquin: April 10, 2014
- El Concilio: April 10, 2014
- Women's Center: April 10 2014

Stakeholder Participants

Outreach to consumers and family-members was a key component of the 2014 Community Program Planning Process. Individuals who self-identified as consumers and/or family members accounted for over half of the individuals providing input.



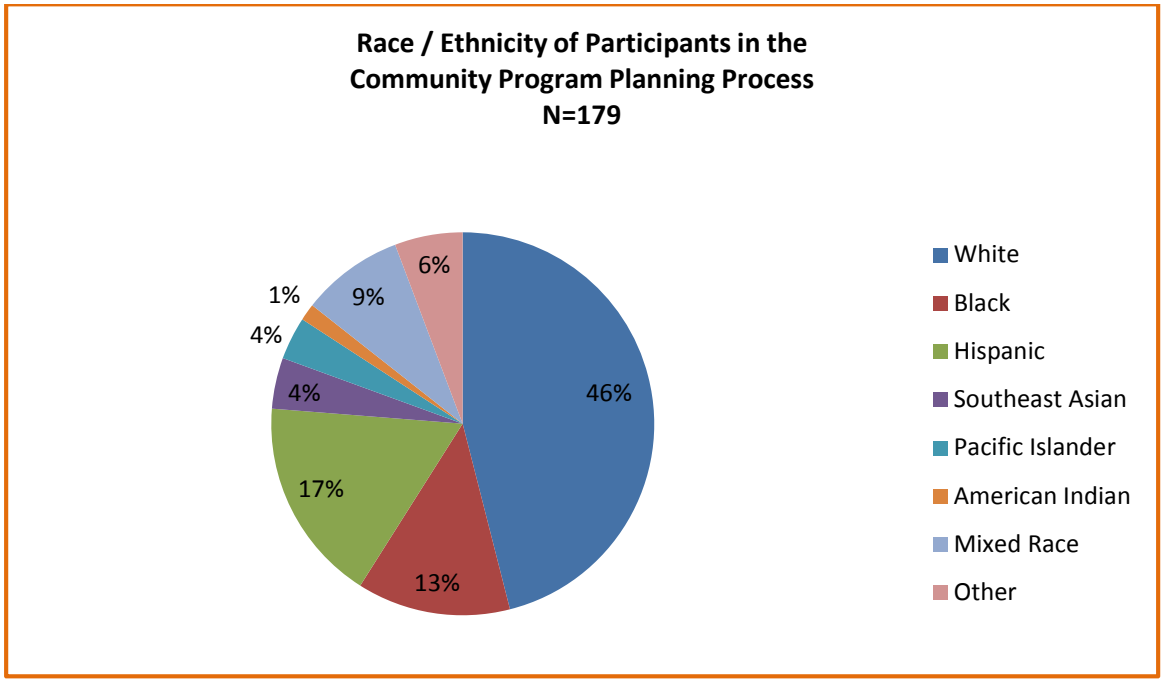
A diverse array of individuals participated in the 2014 MHSA Community Program Planning Process. Nearly 200 unique individuals provided insight and input into program design recommendations. Of the participants, the majority self-identified as consumers and/or family members. Others represented various public and community-based partners, including hospitals, schools, law enforcement, veterans' services, children and family services, and faith based organizations. Thirty-seven percent of participants were affiliated with local community-based organizations.

The race and ethnicities of participants was also quite diverse, over 50% self-identified as non-white, and 8% reported speaking a language other than English at home. More females than males participated in the planning process and 1% of participants self-identified as transgender. Adolescents

and transitional age youth were actively engaged in the planning process (6% of all participants) including presentations by several youth who described themselves as youth leaders with lived experience in the juvenile justice and child welfare systems who came to meetings to advocate on behalf of prevention and early intervention services for other youth in the community.

Age Range of Participants	
18-25	6%
26-59	56%
60 & Older	15%

Gender of Participants	
Male	34%
Female	65%
Transgender	1%



2012/13 Planning Process

In addition to the nearly 200 individuals who participated in planning activities in 2014, BHS conducted 20 public discussions with over 300 individuals in 2013; of which 61% were consumers or family members. These community discussions strongly informed the Three-Year program and Expenditure planning process which has, in large part, consisted of strategic conversations on how to implement the changes recommended in by consumers, family members, program staff, and local service partners over the past couple years. More information on the 2012/13 planning process can be found in the 2013 MHSA Annual Update, see www.sjmhsa.net.

Community Stakeholder Input: Key Findings and Recommendations

1. Community Feedback – Our Voices

Over the past two years, hundreds of community members have participated in community discussions regarding mental health services. Consumers and their family members have provided poignant and thoughtful feedback and recommendations. The following statements provide a sample of the some of the comments made:

Provide housing environment and support for those who fail … there are no throw away consumers of mental health services.

Make calls from law enforcement a priority. When a family member calls law enforcement, they have exhausted all other resources. Do all possible to keep ill people out of jail and court system.

Look at train the trainer models so that community based organizations are trained as well as extended members of the supporting community.

Address treatment in more collectivistic (family focus/family treatment) vs. individualistic (client only without family) focus of treatment.

The system should have more funding channeled to better staff education, so housing programs can address the whole person every day, beyond food, shelter and basic needs.

When something happens to us, out on the streets, there is no one we can turn to for help, because they think we are delusional or criminals.

There is a lot of talk about cultural competence, but I think there should be more training on LGBT. Sometimes I feel like my mental health issues get confused with my sexual orientation. It's like "Oh, you're gay, well no wonder your depressed," rather than addressing the root causes of my anxiety and depression.

I noticed that things have changed at the PHF. They have a 24 hour service now so they can wait before putting you in the PHF – I think it is a good thing. [referring to the new 23-hour Crisis Stabilization Unit]

We need a different kind of housing program: where medication can be distributed; they can stay for a long time; and there are engaging activities. Where people can't run away and there is a clinician to work with. And they will talk with parents.

When I took my daughter to crisis she got really upset in the waiting room. She said, "Am I going to grow up and be like that?" [indicating to a homeless, mentally ill consumer].

What really works is a warm atmosphere, support groups and warm line available in multiple languages, and really good outreach to let people know services are available – also in multiple languages.

2. Summary of Local Challenges and Barriers

Several notable challenges or barriers to service delivery were identified. Challenges ranged from staff shortages to a need for more universal training in evidence based approaches. Stigma against mental health continues to be the largest barrier to accessing early and timely mental health services, especially for vulnerable populations who have experienced severe traumas or anxieties, but for whom there remain access barriers to services.

Demand exceeds capacity for the Mobile Crisis Response Team

Consumers, family members, staff, and community partners all described situations in which the MCRT has been too busy on a prior call to respond to a new request for service. The MCRT receives approximately 4,000 calls for assistance each year, significantly more than the 500 consumers planned for in the original program design in 2006. According to Vic Singh, BHS Director, the increasing demand for MCRT services has resulted in periodic delays in response time to law enforcement and hospital emergency rooms. Family members also noted lengthy wait times when seeking assistance for a loved one. BHS staff members also commented that a 24/7 warm line is an uncommon resource for counties to support and that the warm-line phone number has been published in several out-of-area resource directories – resulting in numerous calls from non-county and out-of-state residents. Further, law enforcement and hospital emergency room personnel indicated a need for more dedicated and deliberate coordination of services, with one department stating frankly, "we don't call anymore because last time it took too long to get a response."

After-hours crisis response for children is limited

Parents of children and youth described particular challenges when seeking after-hours help on weekends or evening for their child. In particular parents expressed frustration that only "a couple staff on the crisis unit really know how to work with kids." BHS program staff also expressed frustration that there were not "better options" for family members than to bring their children to an emergency psychiatric unit that principally serves adults, many of whom display symptomology disturbing to the children and youth waiting to be seen in the waiting area. Parents and BHS staff all agreed on the need for more child-specific capacity within the crisis unit and for 24-hour alternatives for children and youth with urgent mental health needs.

More intensive services are needed for hardest to serve consumers

The vast majority of consumers are able to maintain stability in their treatment regime through prescribed outpatient services, including case management, supportive housing, and other more intensive full-service partnership options. However, a small proportion of consumers are "harder to serve successfully." These "harder to serve" consumers often have co-occurring disorders and have had multiple housing placements. In implementing the just completed Residential Learning Communities project, BHS learned that targeted, flexible, consumer driven, and intensive services can help provide a pathway to stabilization, housing permanency, and recovery. Critical to success is a "no fail" approach that never gives up on an individual.

Access to services may be delayed if service providers do not recognize mental health related needs or have the training to make an effective referral

Teachers, health care workers, police, firefighters, and spiritual leaders are often the "first responders" when an individual or family member seeks assistance for a mental health related concern. Community meeting participants expressed a desire for more universal training in core mental health related competencies, including signs and symptoms, knowing how to make a referral, and impacts of trauma. Consumers and law enforcement (in separate conversations) were united in their sentiment that all police officers need more training in recognizing the signs and symptoms of mental illness and having regularly updated trainings or briefings on when and how to contact the CCRT or homeless outreach team for intervention versus making an immediate referral for mental health crisis or emergency room services. In addition to requesting both basic and advanced training courses in mental health for patrol officers, local law enforcement departments also requested access to a mental health liaison for phone consultations.

There are limited resources for vulnerable populations to either ameliorate behavioral health needs or serve as a warm entry into higher level mental health interventions

Providing early interventions and access to mental health services to ameliorate or prevent a mental health disorder from emerging is a core component of the MHSA. Services for some vulnerable populations, at risk of escalating mental health disorders, are limited in San Joaquin County. Specifically, the following vulnerable population groups have high incidence for PTSD, depression, anxiety, and suicidality:

- Veterans
- Refugees, who have fled conflicts in war-torn regions of the world
- Youth, who have witnessed or experienced violence within family or neighborhood environments; especially crossover youth - those dually involved in juvenile justice and foster care systems
- Lesbian, gay, bisexual, and transgender (LGBT) individuals, who have experienced bullying and harassment for their identity or who have experienced depression or anxiety as a result of the (lifelong) "coming-out" process
- Socially isolated or homebound older adults and disabled who experience anger and depression regarding loss of mobility, functionality, or status

Uniformly, members of these communities expressed reservation in talking to a mental health provider either due to stigma with seeking mental health services and/or a perceived stigma against themselves as a population group. More overt indicators of welcome such as diversity messages, rainbow flags, and language appropriate services were recommended to reduce barriers accessing services. Other recommendations included convening more community and peer-based groups to help support those with mild and short-term symptomology and to serve as a safe referral source for individuals with more serious symptomology, including trauma.

3. MHSA Three Year Program and Expenditure Plan Strategies to Address Challenges

BHS has developed several strategies to address barriers to service delivery in response to the input received from consumers and family members. All strategies have been developed with a goal of reducing stigma and discrimination as a barrier to accessing services. Strategies include:

Increase Capacity of the Mobile Crisis Support Team

BHS has applied for and received funding to increase its mobile crisis support team. MHSA funding will also be leveraged. The team will expand from one unit operating Monday through Friday, 8am – 5pm, to three teams, operating seven days a week and into the evening. The teams will be trained in the mental health needs of diverse populations and be dispersed throughout the county. One team will have special training in mental health crisis responses to children and youth.

Create a Dedicated Crisis Stabilization Unit for Children and Youth

BHS has applied for and received funding to construct a new crisis stabilization unit dedicated to treating children and youth. MHSA and Medi-Cal funding offset operating costs. Initial design and planning is currently underway. Construction is anticipated to begin in 2015, with operations beginning during fiscal year 2016/17. The new crisis stabilization unit will provide a safe and secure facility for children and youth to seek urgent mental health services after hours.

Provide more intensive services for consumers with the highest acuity of treatment needs

BHS will strengthen and redesign FSP services to provide more intensive services for consumers with the highest acuity treatment needs. Changes to the FSP program are described in detail on page 105, and are supported with various new programs and strategies, described throughout this Plan, to increase outreach and engagement services and provide additional training for program staff. Additionally, BHS will explore the feasibility of operating a small residential full service partnership program for ten to fifteen of the most acutely mentally ill consumers who require supportive housing and intensive services and supports in order to stabilize in the recovery process. The feasibility study will be conducted in fiscal year 2014/15.

Convene more mental health trainings for law enforcement and other first responders

BHS will continue its commitment to provide Crisis Intervention Training for law enforcement throughout San Joaquin County. Other trainings, such as the NAMI Provider Education classes will also be offered. Trauma Informed Care Trainings, offered in partnership with the San Joaquin County Probation Department, will train public safety officers and other first responders how to recognize and respond to trauma. BHS will station one mobile crisis support team in downtown Stockton to operate in close partnership with law enforcement and other justice partners.

Convene more mental health trainings for community partners

BHS is creating a train-the-trainer model to conduct widespread Mental Health First Aid Trainings in San Joaquin County. By December 2014, ten partner agencies will have three staff members trained as Mental Health First Aid facilitators. Over the next three years, these Mental Health First Aid facilitators will convene over 100 Mental Health First Aid trainings with 1,500 teachers, health care workers, spiritual leaders, service providers, and community members. San Joaquin County will have more caring and knowledgeable individuals ready to talk with and help consumers struggling with mental health illnesses find the treatment they need in a safe and culturally appropriate manner.

Expand and enhance outreach and engagement services

Stigma against mental health continues to be the biggest barrier to timely access to services. BHS will expand the use of culturally and linguistically competent peer partners in creating a warm entry to recovery at all levels, including specialty mental health care services. Outreach and engagement peer partners shall be trained in competencies that will support a relationship-based care model, principally motivational interviewing, mental health first aid, and wellness recovery action planning.

Public Review Process

1. Dates of the 30 day Review

The document was posted for review and circulation on the *Document Center* of San Joaquin MHSA website on July 16, 2014. The public review closed on August 20, 2014.

Comments were 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

2. 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 the public program areas that the draft plan is available for review on the San Joaquin MHSA website at:

http://www.sjmhsa.net/documentcenter.htm

A summary of the proposed program components in the plan was made on August 5, 2014 at the MHSA Planning Stakeholder Steering Committee Meeting. Thirty-four members of the public attended this meeting, of whom 38% identified as consumers and/or family members. Audience members were encouraged to share the draft plan with others, submit comments, and attend the public hearing.

3. Public Hearing

A public hearing was convened at the August meeting of the Mental Health and Substance Abuse Board. Consumers, family members, mental health and substance abuse stakeholders and concerned members of the public were encouraged to attend. Translation services were available, though not requested. Five members of the public were in attendance:

The meeting was held:

August 20, 2014
6:00 – 8:00pm
1212 N. California St.
Conference Rooms A & B
Stockton, CA 95202

Included in the audience were various consumers, family members, and community based service providers.

4. Substantive Comments

The Three Year Program and Expenditure Plan was reviewed by the Mental Health and Substance Abuse Board at a public hearing on August 20, 2014 and forwarded to the Board of Supervisors for consideration and approval.

The version submitted to the Board of Supervisors includes minor alterations and updates from the version posted for public review, based on comments and questions received from stakeholders.

The Final Draft has been updated to include:

- Edits to correct typos, formatting, and word choice to increase clarity and to align with all applicable regulations.

Overall members of the public and of the Mental Health and Substance Abuse Board expressed strong satisfaction with the Plan and the recommendations suggested.

Formal comments received during the public review process and/or public hearing:

1. Public: “Make sure that faith-based organizations are included when implementing the plan.”
2. Public: “I read the Early Intervention for Psychosis section. I like that there is a way to expand treatment for prodromal symptoms. I appreciate that.”
3. Public question: “Will the 3-Year Plan stay on the website following the 30-day posting?” Response from board member and staff: “Yes”
4. Board member: “ I think that the lack of pell-mell rush to overwhelm you with comments is that this process has been well exposed. People have had more than adequate time to participate. I am satisfied.”
5. Board member: “This was an excellent and daunting process. The plan covers every section you can think of.”
6. Board member: “The three-year plan as presented was well done and well thought out. I’m looking forward to it being implemented.”
7. Board member: “Kayce [Rane] has done an excellent job. She takes a lot of information and funnels it down.”
8. BHS staff: “I also want to acknowledge that there was a thoughtful discussion on how to fulfill the promise of MHSA by senior management.”

No substantive changes were recommended.

5. Adoption by the San Joaquin County Board of Supervisors

Adopted by the San Joaquin County Board of Supervisors, on September 9, 2014.

Section Two: MHSA Program Summary

I. 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, transition age youth, adults, and older adults. BHS has made significant changes to its PEI Plan; with nearly all program areas undergoing changes. The first year (Fiscal Year 2014/15) will be a transition period; PEI programs as described in this plan will be implemented starting in FY 15/16.

Moving forward, San Joaquin County's PEI projects include:

- Project 1: Community Trainings
- Project 2: Family Medicine Consultation
- Project 3: Trauma Services for Children and Adolescents
- Project 4: Early Interventions to Treat Psychosis
- Project 5: Skill Building for Parents and Guardians
- Project 6: TAY Mentoring
- Project 7: Juvenile Justice Project
- Project 8: Suicide Prevention
- Project 9: PEI Capacity Building

A. Changes to PEI Programming

In FY 2013/14 BHS funded four projects under the PEI strategies of *Reducing Disparities in Access* and *Connections for Seniors and Adults*. The four projects were Cultural Brokers, Senior Peer Counseling, Community Trainings, and Primary Care Medicine Consultation. Starting in June 2014, BHS will discontinue PEI funding for the Cultural Brokers and Senior Peer Counseling but similar services will be funded through the CSS Component Plan, See CSS Project 7 and 8 . The two other projects, Primary Care Medicine Consultation and Community Trainings will continue with slight modifications. See PEI Projects 1 and 2, below.

In prior years BHS funded the *School-based Mental Health Services* project. Project services will continue unchanged in 2014/15. Starting in FY 15/16, funding will be made available to schools and/or community based organizations to provide screenings and early interventions to reduce impacts of trauma in children and adolescents. See PEI Project 3, below.

In 2014/15 BHS will research the feasibility of developing a project implementing evidence based treatment practices for early interventions in psychosis. If an effective project is identified an additional project will be added by FY 2016/17. See PEI Project 4, below.

In 2013/14 BHS funded eleven programs under the *Empowering Youth and Families* strategy. The eleven programs provided skill building trainings to parents and guardians; mentoring and life skills support for high-risk adolescents and transitional age youth; and implemented universal screening and early intervention services within three county operated programs for at-risk youth. Activities continue, with modifications beginning in FY 15/16. See PEI Projects 5, 6, and 7 below.

Suicide Prevention programming will continue unchanged in 2014/15, but will be modified and expanded in 2015/16. In 2015/16 programming will include safeTALK, which trains youth ages 15 and over to recognize and identify individuals with thoughts of suicide, and connect them to mental health resources. Select teachers or other school based staff will be identified as "safe adults" and trained in the Question, Persuade, Refer (QPR) suicide prevention methodology in schools that implement a Yellow Ribbon Suicide Prevention program. See PEI Project 8, below.

Additionally, all PEI interventions will require evidence-based or promising practices; screenings and assessments must be conducted with validated tools; and all programs will be evaluated. Capacity building funds are available for programs to develop evidence based competencies and to strengthen organization and program capacity to provide high-quality mental health prevention, early intervention, and outreach and engagement services per the new PEI regulations. See PEI Project 9, below.

The following table describes each PEI project by the required MHSA strategy area defined for PEI.

PEI Projects by MHSA Strategy Areas		
	MHSA Strategy Areas	**Projects**
Early Intervention Programs	Outreach to Increase Recognition of Early Signs of Mental Illness	Project 1: Community Trainings Project 2: Family Medicine Consultation
	Program to Intervene Early in the Onset of a Mental Illness	Project 3: Trauma Services for Children and Adolescents Project 4: Early Interventions to Treat Psychosis
Prevention Programs	Program to Reduce Risks Related to Mental Illness	Project 5: Skill Building for Parents and Guardians Project 6: TAY Mentoring Project 7: Juvenile Justice Project
	Suicide Prevention Program	Project 8: Suicide Prevention
	Access to Services	Project 9: PEI Capacity Building

Early Intervention Program Projects

"Early Intervention Program" means treatment and other services and interventions to address and promote recovery and related functional outcomes for a mental illness early in its emergence, including applicable negative outcomes associated with mental illness. *as proposed, CA Code of Regulations §3710*

PEI Project 1: Community Trainings

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.

Project Goal: *To develop community members as effective partners in preventing the escalation of mental health crises and promoting behavioral health recovery.*

Project Components

Mental Health First Aid (MHFA) - Certified instructors will provide this evidence-based training to local trainers in San Joaquin County. All trainers will meet the certification standards of the national organization. Local MHFA trainers will then convene and facilitate MHFA classes throughout San Joaquin County, targeting community leaders and teachers in diverse geographic and cultural communities. MHFA teaches individuals, without educational or professional backgrounds in mental health, how to help individuals developing a mental illness or in crisis. Two eight-hour training modalities instruct participants to identify signs, symptoms, and risk factors of mental illness and addiction; navigate community resources; and help individuals in distress. For more information on evidence-based MHFA see: http://www.mentalhealthfirstaid.org/cs/ .

Funding for this project will be released through a Request for Proposals process.

NAMI Provider Education Program (PEP), In Our Own Voice (IOOV), and Peer-to-Peer (P2P) - Trained instructors will provide evidence-based classes to service providers, consumers and family members. 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 will be provided throughout the county (32 in English and 8 in Spanish). P2P are 10 2-hour sessions designed for adults living with mental illness. P2P provides critical information and strategies for living with mental illness. The 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. Two P2P classes will be taught in English and Spanish. The PEP helps people 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. For more information see: http://www.nami.org/template.cfm?section=Education_Training_and_Peer_Support_Center

PEI Project 2: Family Medicine Consultation

Community Need
New regulations require health insurers to provide coverage for mental health services. Family Medicine Practices in San Joaquin County need additional consultation and support on 1) how to screen and assess individuals for mental illnesses and 2) how to provide for or refer individuals with low- to moderately-severe mental illnesses to appropriate mental health treatment services to prevent illnesses from becoming severe and disabling.

Project Description
BHS will conduct a pilot project to provide consultation and support two or three family medicine practice clinics in San Joaquin County that serve Medi-Cal recipients.

Project Goal: *Primary care patients with behavioral health needs are identified early and receive services that prevent severe and persistent illness. Primary care providers increase their capacity to serve the behavioral healthcare needs of their patients.*

Project Components:

Screening: Age-appropriate, evidence-based, and validated screenings are designed to identify trauma and depression. Using screenings during annual health exams helps to identify emerging illnesses as early as possible, following onset of symptoms. Family Medicine practices will be encouraged to adopt mental health screening tools currently supported by BHS, such as:

- **UCLA PTSD Reaction Index** (Trauma in children and adolescents)
  http://www.istss.org/UCLAPosttraumaticStressDisorderReactionIndex.htm
- **Patient Health Questionnaire - PHQ-9** (Depression, Adults)
  http://www.phqscreeners.com/

Technical assistance for screenings will include: how to provide information to individuals and family members related to screening results; decision-making and authorization for further assessment and treatment; and coordination with specialty behavioral health services.

Evidence-Based Practice Consultation: BHS will provide ongoing coaching consultation to clinics interested in developing treatment capacity on providing evidence-based interventions within the clinical setting for individuals with mental health issues who would not otherwise meet the criteria for referral to the public mental health system of care. Trainings are available regionally in a range of cognitive behavioral evidence based interventions. Additionally, BHS will be convening trainings in some therapies for the local mental health workforce; Family Medicine practitioners will be notified of the trainings and invited to attend. (See WET plan).

Psychiatric Consultation: BHS will provide psychiatric consultation for medication management and treatment planning with primary care physicians and nurses to prevent serious and persistent illness among patients with complex mental health needs. Individual mental health services may be provided as clinically indicated.

Project continues in 2014/15; though modifications may be implemented if alternative funding is found.

PEI Project 3: Trauma Services for Children and Adolescents

Community Need
Children who experience trauma and abuse, and who do not receive early interventions, are at greater risk of developing serious mental illnesses later in life.

Project Description
For Children 6-12: In grammar schools that are implementing evidence-based Positive Behavioral Intervention Services (PBIS), the following will be implemented: 1) school personnel trained in recognizing and understanding trauma; 2) screenings administered to identify children suffering from the effects of traumatic incidents; 3) short term interventions provided to promote recovery and improve functional outcomes related to trauma; and 4) children who need it are linked to specialty mental health treatment.

For Adolescents: Selected schools or community based organizations in neighborhoods with high rates of violence will use screenings to identify adolescents suffering from the effects of trauma and abuse and provide *Seeking Safety for Adolescents* groups.

Project Goal: *Reduce risk of PTSD and other manifestations of trauma exposure, and improve access to treatment for those experiencing symptoms of trauma.*

Project Components:

Personnel Training in Trauma – School administrators, teachers, and program staff can help reduce the impact of trauma on children by recognizing trauma responses, accommodating and responding to traumatized students within the community or classroom setting, and referring children to outside professionals when necessary. An independent licensed clinician or community based provider will provide trainings at selected school or community sites using a standardized, evidence-based curriculum such as the National Child Traumatic Stress Network's Child Trauma Training Toolkit for Educators. For more information about the evidence-based toolkit see: http://www.nctsnet.org/products/child-welfare-trauma-training-toolkit-2008

Trauma Screenings - Children and youth exposed to traumatic situations will be identified and screened using a validated and evidence-based screening tool such as:

- *UCLA Trauma Screen and PTSD Reaction Index* - Children and youth with strong indications of trauma and risk for developing PTSD will be asked by school or program staff to complete the UCLA PTSD trauma screen to provide preliminary diagnostic information. Self-reported responses to the screening tool will be reviewed by a Licensed Professional of the Healing Arts (LPHA) to determine the need for further assessment and treatment. For more details about the evidence based Trauma Screen and PTSD Reaction Index see: http://www.nctsn.org/nctsn_assets/pdfs/mediasite/ptsd-training.pdf

Depending on their age and the result of screenings, children, youth, and families will be referred to the appropriate interventions below.

Short-term Trauma Interventions for Children - Evidence-based interventions will be provided, including, but not limited to:

- *Cognitive Behavioral Intervention for Trauma in Schools (CBITS).* CBITS is a school based program group and individual intervention designed to reduce symptoms of PTSD, depression and behavioral problems; improve peer and parent support; enhance coping for students exposed to traumatic life events, such as school and community violence, physical abuse, domestic violence, natural disasters. Target group is children ages 6-12 years old. Length of treatment is ten group sessions and one to three individual sessions. The intervention also includes two sessions with the parents and one with the teacher. For more details about the evidence-based CBITS program see: http://cbitsprogram.org

- *Seeking Safety for Adolescents* focuses on coping skills and psychoeducation and has been proved to be successful in helping adolescents with PTSD or trauma symptoms overcome patterns of using drugs or alcohol as a coping mechanism. The gender-specific group format addresses prosocial thinking, emotional regulation, positive behavioral choices, and personnel safety in their relationships. Twice weekly sessions are recommended over twelve weeks. BHS will offer Seeking Safety facilitator trainings through the Workforce Education and Training component (see WET Component Section, p. 82). For more details about the evidence-based Seeking Safety program see: http://www.seekingsafety.org

Link children and adolescents to specialty mental health treatment All individuals providing school or community-based trauma screenings and interventions must have appropriate training in the practice modality and an understanding of when and how to refer children, youth and parents/caregivers to specialty mental health services for treatment of SED and SMI. Referrals to BHS for further assessment and interventions for children with SMI/SED will be monitored and follow-up coaching will be provided when needed.

Funding for this project will be released through a Request for Proposals process, for funding in FY 2015/16.

PEI Project 4. Early Interventions to Treat Psychosis

Community Need: Schizophrenia is an illness that devastates individuals, their family and friends, and the larger community. The Center for Disease Control and Prevention has found that on average, schizophrenia sufferers die 25 years earlier, through suicide, misadventure, and the side effects of medication, than those in the general population. Individuals typically suffer from full-blown schizophrenia for almost three years before they are correctly diagnosed, and often alternate through repeated cycles of overmedication, treatment refusal, decompensation, and involuntary hospitalization. Standard treatments aim at symptom management and crisis intervention, not remission, rehabilitation, and recovery. Intervening early, either before symptoms affect functioning, and applying a combination of evidence-based treatments can result in long-term remission and recovery.

Project Description: The Early Interventions to Treat Psychosis (EITP) Project will provide an integrated set of promising practices that are research indicated to slow the progress of psychosis, early in its onset. EITP will offer a combination of outreach and engagement and evidence-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: www.prepwellness.org being piloted in select California Counties and www.schizophrenia.com/earlypsychosis.htm which is being piloted in various jurisdictions.

Project Goal: *To stably remit schizophrenia, restore cognitive, social and vocational functioning to normal levels, and return schizophrenia sufferers to a normal and productive life.*

Project Components

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 out of services once they are enrolled.

Assessment and Diagnosis – Trained clinicians will conduct a strength-based, recovery-oriented assessments using formal clinical assessment tools including, but not limited to, Structured Interview for Prodromal Symptoms (SIPS) or Structured Clinical Interview for Diagnosis (SCID) to determine appropriateness of services. Every 6 months, clinicians will follow up with a Quick Scale for Assessment of Positive and Negative Symptoms (QSAPS and QSANS) to inform treatment and determine exit readiness.

Cognitive Behavioral Therapy for Psychosis – CBT was originally developed to treat mood disorders, but in the 1990s, researchers began to study its application for psychotic conditions. Medication compliance alone can leave as many as 60% of psychotic patients with ongoing positive and negative symptoms. CBT, widely available in England and Australia, is now recognized as an effective additional treatment for residual symptoms. CBT teaches clients to understand and manage symptoms, avoid triggers, and develop a relapse prevention plan. For more information on CBT for Psychosis, see http://www.psychiatrictimes.com/schizophrenia/abcs-cognitive-behavioral-therapy-schizophrenia

Psychoeducational Multi-Family Groups – PMFG is an evidence-based treatment modality that focuses on informing consumers and their families about mental illness, developing coping skills, solving problems, creating social supports, and developing an alliance between consumers, practitioners, and their families or other support people. Practitioners invite five to six consumers and their families to participate in a psychoeducation group that typically meets every other week for at least 6 months. For more information on PMFG see: http://www.nrepp.samhsa.gov/viewintervention.aspx?id=120

Medication Management: According to the Schizophrenia Patient Outcomes Research Team (PORT) Study of nearly 1000 persons with schizophrenia, 80% had medication regimens that did not meet minimum standards. Many with schizophrenia are increasingly overmedicated, which leads to medication noncompliance, relapse, and hospitalization. Intensive medication management is required to help doctors, clients and family members in finding medication that provides symptom control with the fewest side effects.

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.

In 2014/15 BHS will research the feasibility of developing a project implementing evidence based treatment practices for early interventions in psychosis. If it is feasible to develop a project, funding will be released through a Request for Proposals process, for funding in FY 2015/16.

Prevention Program Projects

"Prevention Program" means a set of related activities to reduce risk factors for developing a potentially serious mental illness and to build protective factors. The goal of this program is to bring about mental health including reduction of applicable negative outcomes as a result of untreated mental illness for individuals and members of groups or populations whose risk of developing a serious mental illness is significantly higher than average and as applicable, their parents, caregivers, and other family members. *as proposed, CA Code of Regulations §3720*

PEI Project 5: Skill-Building for Parents and Guardians

Project Description
To reduce the risk of negative emotional impacts of abuse and trauma to children and youth, community-based organizations will facilitate evidence-based parenting groups in communities throughout San Joaquin County. Parenting 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
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/

Funding for this project will be released through a Request for Proposals process, for funding in FY 2015/16.

PEI Project 6: TAY Mentoring

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. Children, youth and young adults with these risk factors may not meet criteria for receiving specialty mental health services, yet in the absence of additional interventions are at a higher risk for developing mental illnesses.

Project Description

Public agencies serving at risk-youth or community-based organization(s) will provide intensive mentoring and support to transition-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 that are associated with adverse childhood experiences, severe trauma or ongoing stress, family or domestic violence, self-harm or suicidal behaviors.*

Project Components

Program Referrals: BHS will refer transitional-age youth with emotional/behavioral difficulties (EBD) and identified by BHS clinicians as needing additional mentoring and support to prevent the onset of serious mental illness. Youth will be referred from the Children's Mobile Crisis Support Team, the Juvenile Justice Center clinical team, the Children and Youth Services crisis team, and other selected programs. Other referral sources may include local police departments, the County Probation Department, and the City of Stockton's Ceasefire program.

Modest funding may be granted to selected public agencies working with very high-risk youth to support the referral process.

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 programs assist youth with emotional and/or behavioral difficulties in making a successful transition to adulthood. TIP mentoring
  - engages them in their own futures planning process;
  - provides them with developmentally-appropriate, non-stigmatizing, culturally-competent, and appealing services and supports; and
  - involves them 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

Funding for this project will be released through a Request for Proposals process, for funding in FY 2015/16.

PEI Project 7. Juvenile Justice Project

Community Need

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.

Project Description

The Juvenile Justice Project provides behavioral health screening, assessment, interventions, treatment and transition services to youth detained in San Joaquin County's Juvenile Justice Center.

Project Goal: *The goal of the Juvenile Justice project is to promptly identify behavioral health issues among juvenile justice involved youth, provide interim treatment, and ensure transition to ongoing services and supports. Untreated mental health conditions can be addressed including, trauma, depression and onset of a major mental illness. Fewer JJC youth will attempt or complete suicide.*

Project Components

***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 with an open behavioral health case or whose MAYSI-2 score indicate high to moderate behavioral health risk receive a comprehensive clinical assessment by BHS staff within 24 hours, including weekends. Youth with low to moderate indicators are assessed within 72 hours.

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.

This is a project of San Joaquin County Behavioral Health Services in partnership with San Joaquin County Probation Department.

PEI Project 8. Suicide Prevention

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
CalMHSA will implement a regional universal suicide prevention campaign. Public schools throughout the county will augment suicide prevention and anti-stigma messaging through evidence-based programs: *Yellow Ribbon*; *Question, Persuade, and Refer;* and *safeTALK.*

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 in the Community - CalMHSA provides local and regional suicide prevention strategies, including a public information campaign and training for community organizations suicide prevention. Funding is allocated to the CalMHSA suicide prevention program.

Suicide Prevention in Schools - High schools in high-violence neighborhoods will implement a whole-school approach to removing barriers for students to seek help in times of mental distress. Components of the universal approach include:

- *The Yellow Ribbon Campaign* develops universal awareness of suicide risk and a school-wide commitment to preventing suicides. For more information about the evidence-based Yellow Ribbon Campaign see: http://www.mhawisconsin.org/Data/Sites/1/media/gls/yellow_ribbon.pdf

- *Question, Persuade, Refer (QPR)* trains teachers and school personnel to engage and intervene with youth who are displaying or discussing suicidal or self-harming behaviors. For more information about the evidence-based QPR training see http://www.qprinstitute.com/index.html

- *safeTALK* trains youth ages 15 and over to recognize and identify individuals with thoughts of suicide, and connect them to mental health resources. The training teaches youth to be "alert helpers" who are better able to move beyond common tendencies to miss, dismiss, or avoid suicide; identify individuals with suicidal thoughts; and help connect a person with suicidal thoughts to suicide intervention responders. For more information on evidence-based safeTALK see: https://www.livingworks.net/programs/safetalk/

Funding for the Suicide Prevention in Schools project will be released through a Request for Proposals process, for funding in FY 2015/16.

PEI Project 9. PEI Capacity Building

Community Need
Programs providing mental health outreach and engagement, or prevention and early intervention services, or community trainings to promote mental health awareness amongst first responders will require equipment, training, and technical assistance resources to grow and strengthen as robust partners within the mental health system of care.

Project Description
BHS will provide one-time funding for capacity building projects to community-based organizations providing mental health services. BHS will fund one-time capacity building projects in four category areas: organizational development, training and technical assistance, fixed assets, and facility improvements. Organizations requesting capacity building funds must demonstrate their commitment to promoting behavioral health in San Joaquin County, their capacity to work within unserved and underserved communities, and how requested funding will improve timely access to mental health services to individuals at risk of developing or, with a serious mental illness, as defined in regulations.

Project Goal: *The project will improve access to services by strengthening the capacity of organizations to provide consistent, high-quality behavioral health services, including evidence-based practices.*

Project Components
BHS will provide mini-grants to selected organizations in the following funding categories:

Organizational Development: Funding will be provided for organizational development activities targeting the organization's board, senior leadership team, or fiscal or administrative systems. Potential areas of organizational development include:

- Non-profit Management Leadership Institute
- Board of Directors Training
- Grant Writing and Fund Development
- Financial or Accounting Systems
- Medi-Cal Provider Requirements
- Results Based Accountability

Training and Technical Assistance: Funding will be provided for direct service program staff to improve in mental health related competencies and for technical assistance in building program capacity. Potential areas of training and technical assistance include:

- Training in Evidence-based Practices
- Fidelity Management
- Program Evaluation
- Developing Policies and Procedures
- Mental Health Clinical Supervision
- Documentation Training for Mental Health Providers
- One-time Translation Services (to translate mental health program materials)

Tools, Equipment and Fixed Assets: Funding will be provided to organizations to purchase tools, equipment, or fixed assets that will enhance organizational capacity to provide mental health related services. Any fixed assets must be dedicated to the exclusive use of program staff to enhance direct services for mental health consumers or for individuals receiving prevention and early intervention or outreach and engagement services. Any client tracking software systems, case management software, and proprietary screening and assessment tools must align with BHS approved tools and/or standards. Potential tools, equipment, or fixed assets include:

- Client Tracking Software (approved/requested by BHS)
- Proprietary Mental Health Screening or Assessment Tools (approved/requested by BHS)
- Accounting or Fiscal Management Software
- Training Manuals
- Computing Equipment (e.g. computers, printers, etc.)
- Vehicles (for programs that provide client transport to mental health services)
- Program Outreach Materials (to improve access to services for consumers)
- Mental Health Stigma and Discrimination Reduction Campaign Materials

Facility Improvements: Funding will be provided to improve facilities to ensure spaces are welcoming to consumers and conducive to staff productivity.

- Minor Cosmetic Upgrades (e.g. paint, carpet, window coverings, etc.)
- Facility Repairs: to buildings that are owned or leased by the organization for a period of five or more years, to programs that provide crisis or long-term residential support services for mental health consumers
- Facility Repairs: to buildings that are owned or leased by the organization for a period of five or more years, in which at least 90% of programming activities support mental health consumer drop-in services

Organizations requesting capacity building funds must demonstrate how purchases will improve access to services for consumers of specialty mental health care services. Priority will be given to organizations that can demonstrate competencies in working with the vulnerable and unserved or underserved populations, described within this Plan. See page 43 for the definition of unserved and underserved individuals and pages 54 - 58 for a summary of existing disparities in access and the vulnerable populations requiring outreach and engagement services. Organizations must include justification for how purchases will provide a long-term impact and include performance measures for assessing the resulting increased access to services.

Funding for this project will be released through a Request for Proposals process, for immediate distribution. All purchases must be complete by May 31, 2015.

PEI Funding Summary

The amount of funding available for PEI projects is projected to fluctuate over the next several years.

Projected PEI Allocation		
2014-15	**2015-16**	**2016-17**
$ 6,167,292	$ 5,160,076	$ 5,160,424

PEI Project Summary		**2014/15 MHSA Allocation**	**Estimated number to Be Served**	**Estimated Cost per Person**
Early Intervention Projects				
1	Community Trainings	115,000	1500	$76
2	Family Medicine Consultation	166,609	175	$952
3	Trauma Services for Children and Adolescents	1,045,095	500	$2,000
4	Early Interventions to Treat Psychosis	600,000	60	$10,000
Prevention Projects				
5	Skill Building for Parents and Guardians	360,000	1500	$240
6	TAY Mentoring	700,000	450	$1,555
7	Juvenile Justice Center Interventions	894,946	1,548	$578
8	Suicide Prevention	481,241	6,000	$67
9	PEI Capacity Building	879,972	NA	NA
Subtotal Direct Project Costs		**5,242,863**		
Indirect Project Costs				
	PEI Program Evaluation	$99,999		
	Other Indirect Costs (Equipment, supplies etc.)	$38,000		
	Overhead	$786,430		
Subtotal Indirect Project Costs (15%)		**$924,429**		
Total Costs: Prevention and Early Intervention		**$6,167,292**		

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2014/15					
	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
PEI Programs - Early Intervention						
1. Community Trainings	$115,000	115,000	0	0	0	0
2. Family Medicine Consultation	229,156	166,609	55,797	0	0	6,750
3. Trauma Services	1,174,460	1,045,095	103,392	0	25,973	0
4. Early Interventions in the Treatment of Psychosis	600,000	600,000	0	0	0	0
PEI Programs - Prevention						
5. Skill Building for Parents	360,000	360,000	0	0	0	0
6. TAY Mentoring	700,000	700,000	0	0	0	0
7. JJC Interventions	1,057,784	894,946	159,838	0	0	3,000
8. Suicide Prevention	481,241	481,241	0	0	0	0
9. PEI Capacity Building	879,972	879,972	0	0	0	0
PEI Administration	924,429	924,429	0	0	0	0
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	$6,522,542	6,167,292	319,027	0	25,973	9,750

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2015/16					
	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
PEI Programs - Early Intervention						
1. Community Trainings	$165,000	165,000	0	0	0	0
2. Family Medicine Consultation	239,159	174,939	57,470	0	0	6,750
3. Trauma Services	1,181,875	1,050,000	105,500	0	26,375	0
4. Early Interventions in the Treatment of Psychosis	600,000	600,000	0	0	0	0
PEI Programs - Prevention						
5. Skill Building for Parents	360,000	360,000	0	0	0	0
6. TAY Mentoring	700,000	700,000	0	0	0	0
7. JJC Interventions	1,107,926	939,693	164,633	0	0	3,600
8. Suicide Prevention	400,000	400,000	0	0	0	0
PEI Administration	770,444	770,444	0	0	0	0
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	$5,524,404	5,160,076	327,603	0	26,375	10,350

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Prevention and Early Intervention (PEI) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2016/17					
	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
PEI Programs - Early Intervention						
1. Community Trainings	$120,000	120,000	0	0	0	0
2. Family Medicine Clinic	250,790	183,690	60,350	0	0	6,750
3. Trauma Services	1,181,875	1,050,000	105,500	0	26,375	0
4. Early Interventions in the Treatment of Psychosis	600,000	600,000	0	0	0	0
PEI Programs - Prevention						
5. Skill Building for Parents	360,000	360,000	0	0	0	0
6. TAY Mentoring	700,000	700,000	0	0	0	0
7. JJC Interventions	1,163,145	986,680	172,865	0	0	3,600
8. Suicide Prevention	400,000	400,000	0	0	0	0
PEI Administration	760,054	760,054	0	0	0	0
PEI Assigned Funds						
Total PEI Program Estimated Expenditures	$5,535,864	5,160,424	338,715	0	26,375	10,350

II. COMMUNITY SERVICES AND SUPPORTS

Overview

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 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.

Full Service Partnerships (FSP)

- Project 1: Children and Youth FSP
- Project 2: Transition-age Youth (TAY) FSP
- Project 3: Adult FSP
- Project 4: Older Adult FSP
- Project 5: Community Corrections FSP
- Project 6: Intensive FSP

Outreach and Engagement

- Project 7: Specialty Mental Health Engagement
- Project 8: FSP Engagement

General System Development

- Project 9: Wellness Centers
- Project 10: Mobile Crisis Support Team
- Project 11: Housing Empowerment Services
- Project 12: Employment Recovery Services
- Project 13: Community Behavioral Intervention Services
- Project 14: MHSA Housing
- Project 15: Crisis Response Team
- Project 16: Specialty Mental Health
- Project 17: MHSA Administration and Evaluation

Full Service Partnership Projects

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*

Over the past five years there has been one Full Service Partnership Program in San Joaquin County. With this Three Year Program and Expenditure Plan, BHS is outlining a plan to clarify and streamline full service partnership eligibility and discharge criteria, program services, and additional integrated services to continue to align with emerging best practices and the vision, direction, and regulations of the Mental Health Services Act. Full Service Partnership projects will remain largely unchanged during FY 2014/15 as BHS updates the policies and procedures, service contracts, and reporting and evaluation procedures necessary to update and enhance services. Starting in FY 2015/16, BHS will operate six distinct Full Service Partnership Programs (see CSS Projects 1-6, below). Changes to the FSP programs will include:

- Smaller caseloads, with clear eligibility and discharge criteria to determine enrollment.
- More focused outreach and engagement services, using a relationship-based care model.
- Increased access to individualized treatment services, including therapy.
- Discharge and transition procedures, including diverse services to sustain recovery.

The summary of the changes in FSP eligibility criteria and FSP component services are described below. The Implementation Plan to meet desired objectives is described in additional detail on page 105.

1. 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: Criminal Justice Involvement	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 will review and pilot level of care assessment tools during 2014/15. Use of the level of care assessment system will be implemented in 2015/16.	**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	**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. **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

And,

- Adults ages 18 and older, who meet all criteria for Full Service Partnership Program enrollment, and who are currently involved with the criminal justice system will be *prioritized* for enrollment.

2. FSP Components and Related Services

FSPs in San Joaquin County operate within a "full spectrum" of services and supports that are available throughout the mental health system of care. Services are provided in accordance to consumer and their family members' needs. Over the next three years, BHS will strengthen the FSP programs with a goal that all FSP Programs will include the following components by FY 16/17:

Referral and Engagement:

- *FSP Referrals:* All consumers referred to an FSP program are required to have an assessment for specialty mental health care services through San Joaquin County Behavioral Health Services. Assessments and referrals may be received through any of the BHS specialty mental health outpatient clinics or 24-hours services, including inpatient and residential services.
- *Orientation to FSP Services:* Within 14 calendar days of receiving a referral, 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.
- *FSP Engagement Services:* Individuals eligible for FSP services, and not receiving treatment services, may be referred for FSP engagement services. 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. (See page 58.)

Assessment and Service Planning:

- *FSP Treatment and Support Team:* Individuals enrolled in an FSP program will have an enhanced 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 Assessment and Enrollment:* Within 14 calendar days of the decision to enroll, the FSP treatment team will meet with the client to complete an initial orientation packet. 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 [1] to make recommendations for treatment and service interventions which are outlined in the *Client Treatment Plan*.
- *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 at least every twelve months.
- *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

[1] Level of care instrument will be selected during FY 2014/15 and implemented FY 2015/16.

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. Service Support 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.

Service Interventions and Monitoring:

- *Case Management:* FSP consumers are assigned a case manager to work with them during the period of enrollment in the FSP. Consumers will have intensive home or community-based case management. The frequency of contact will be directed by consumer needs and level of care.
- *Individual interventions:* FSP consumers will receive individualized interventions from a clinician. BHS clinicians are trained in several modalities. Consumers will work with clinicians that have training in the modality that best meets their treatment needs. Individual therapeutic approaches to support consumers may include:
    - Cognitive Behavior Therapies, including for psychosis
    - Trauma Focused Cognitive Behavioral Therapy
    - Parent Child Interactive Therapy
    - Therapeutic Behavioral Services
- *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 treatment services, including residential or outpatient treatment services. BHS and local community partners may offer a range of evidence-based treatment and support groups, 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 abuse treatment)
    - Cognitive Behavioral Interventions for Substance Abuse
    - Various peer and consumer-driven support groups
- *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.

- *Wraparound Supports:* Community Behavioral Intervention Services are available to adult and older adult FSP clients who are unable to stabilize within the treatment services and to prevent the development or escalation of a mental health crisis and to provide early interventions for problematic behaviors. Intensive Home Based Services and Care Coordination are available for children, youth, and their families for Katie A eligible Sub class members through FSP services.
- *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, beginning on p. 60, and include:
    - Wellness Centers
    - Mobile Crisis Support Team
    - Housing Empowerment Programming
    - Employment Recovery Services
    - Community-based Behavioral Interventions Services
- *Monitoring and Adapting Services and Supports:* A level of care assessment will be re-administered every six months, or per fidelity to the model, and will be used to inform and update the intervention recommendations described in a *Client Treatment Plan*.

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*: All 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 (see p. 58).

CSS Project 1: Children and Youth FSP

Project Description

The Children and Youth FSP provides intensive and comprehensive mental health services to unserved and underserved youth and families who have not yet received services necessary to address impairments and stabilize children and youth within their own environments. Full Service Partnership program interventions are targeted for children and youth who are juvenile justice involved and/or in foster care and meet the State of California definition of the Katie A. Subclass, specifically,

Katie A. Subclass Criteria

- Minors (children/youth up to age 21)
  - With an open child welfare services case
  - With full scope Medi-Cal (Title XIX) eligibility
  - Who meet medical necessity for Specialty Mental Health Services
  - Have either one of the following criteria(s):
    Currently in, or being considered for:
    - Wraparound, therapeutic foster care, specialized care rate due to behavioral health needs or other intensive EPSDT services (i.e. TBS, crisis stabilization / intervention)
    - Group Home (Level 10 or above), a psychiatric hospital or 24 hour mental health treatment facility (e.g., psychiatric inpatient hospital, community residential treatment facility); or has experienced three or more placements within 24 months due to behavioral health needs.

Target populations include:

- *Children and Youth* with serious emotional disturbances or serious mental illness, who fall into one of the following groups:
  - Children and Youth who meet the Katie A. Subclass definition (see above).
  - Children and Youth involved with the San Joaquin County Juvenile Justice system
  - Children and Youth who are identified at risk as a result of a serious mental health condition with recent crisis and or psychiatric hospitalization contacts.

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.

Target populations include:

- *(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.

- *Young adults 18-25,* with serious mental illness and co-occurring substance use disorders that have former juvenile justice system involvement. Services include a high-focus on doing "whatever-it takes" to stabilize and engage individuals into treatment services, including providing a range of readiness for recovery services such as extended engagement, housing supports, substance abuse treatment services, and benefit counseling prior to the formal "enrollment" into mental health treatment services.

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 involved with the criminal justice system, homeless, frequent users of crisis or emergency services, or are at-risk of placement in an institution. The foundation of San Joaquin County's Adult 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. The FSP programs have a high staff to consumer ratio, and a team approach that is predicated upon the partnership between the consumer, mental health clinical team, and family or peer partners in recovery.

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. 42*):
    - 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

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

- *African American consumers*
- *Latino/Hispanic consumers*
- *Lesbian, gay, bisexual and transgender consumers*
- *Muslim or Middle Eastern Consumers*
- *Native American consumers*
- *Southeast Asian consumers*

CSS Project 4: Older Adult FSP

Project Description

The Older Adult 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
  - On conservatorship

CSS Project 5: Community Corrections FSP

Project Description

The Community Corrections FSP 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. The program works in collaboration with the judicial system by providing 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. Treatment and case management services may begin 30 days prior to release from the County operated Jail, or as soon as possible on release, to prevent individuals with a diagnosed mental illness from being released without a treatment and support plan

Target 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.
- *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, including:
    - Mental Health Court (a.k.a. “Prop. 63 or MHSA Court”)
    - High Violence Court
    - AB109 Reentry Court
    - Felony Drug Court
    - Parolee Reentry Court
    - Veterans Court

CSS Project 6: Intensive Adult FSP

Project Description

The Intensive Adult FSP is a pilot project to serve adult consumers, with serious and persistent mental illnesses, that have co-occurring substance use disorders, are homeless, and have current or prior justice involvement. Consumers referred to the Intensive Adult FSP are at the greatest risk of institutionalization due to untreated mental illness. The Intensive Adult FSP provides the full spectrum of FSP services within a long-term supportive housing environment. The Intensive Adult FSP program operates on a long-term supportive housing model, recognizing that recovery from co-occurring mental health and substance use disorders requires a safe and stable living environment; consistent cognitive behavioral interventions; intensive, trauma-informed supportive services; and time to heal and recover.

This is a new program. Planning for this FSP will begin in FY 14/15. Funding for this project will be released through a Request for Proposals process for funding in FY15/16.

Target Population

- *Adults 18 and older,* with serious and persistent mental illness and co-occurring substance use disorders who are also homeless and who have had one or more arrests or incarcerations.

Outreach and Engagement Programs

The Outreach and Engagement Program area funds projects that will reduce disparities in access to mental health services for individuals that are unserved by the mental health care system or otherwise have unequal access to services.

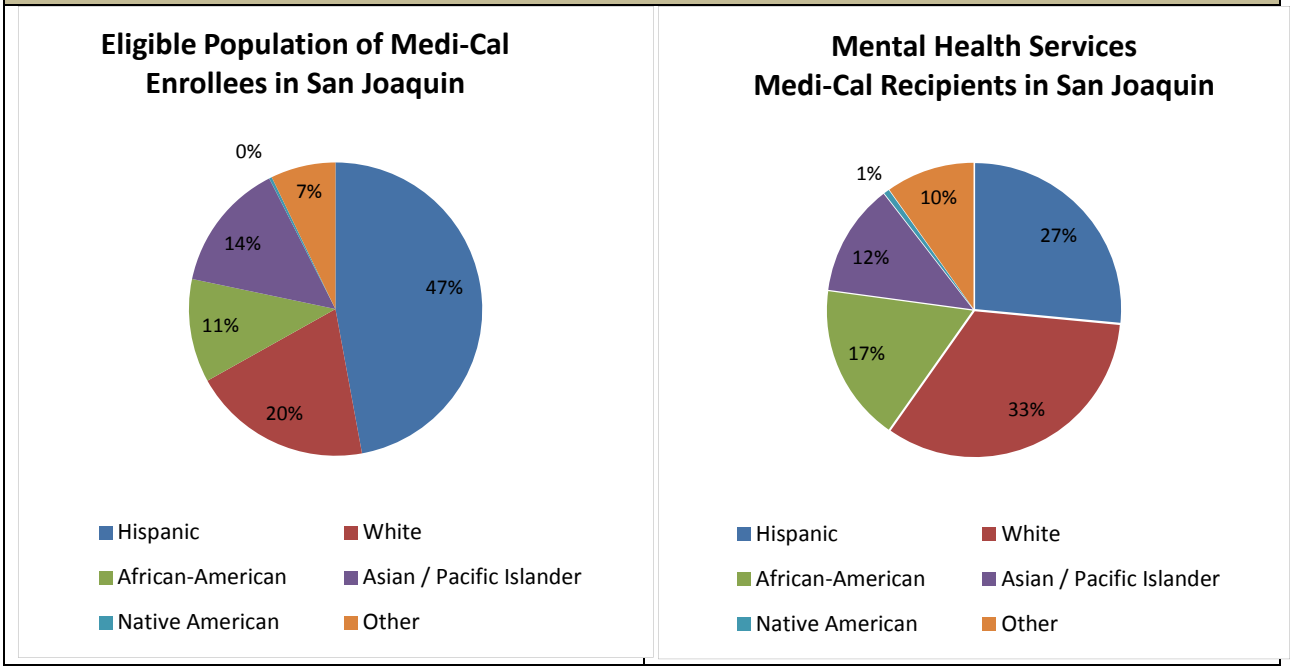
"Outreach and Engagement Service Category" means the service category of the Community Services and Supports component of the Three-Year Program and Expenditure Plan under which the County may fund activities to reach, identify, and engage unserved individuals and communities in the mental health system and reduce disparities identified by the County. *CA Code of Regulations § 3200.240*

Community Needs

BHS provides culturally and linguistically competent services designed to reach out to engage the diverse population of San Joaquin County. In general this works to engage and retain a consumer population that is reflective of the overall population of the County, however some disparities remain.

Disparity 1: The proportion of Hispanic individuals receiving specialty mental health services is low comparative to the number of Hispanics who are Medi-Cal beneficiaries. In San Joaquin County Hispanics account for 47% of all beneficiaries, but 27% of mental health recipients.

Medi-Cal Beneficiaries in San Joaquin County
Mental Health Services, Eligible vs. Recipients by Race/Ethnicity
2012



Disparity 2: African-American and Native American consumer utilization of 24-hour crisis services, and crisis residential services is disproportionate to their participation in specialty mental health services. This disproportionality indicates that many African-American and Native Americans are inappropriately served through crisis services and are not getting their treatment needs met in scheduled outpatient mental health services.

Disparity 3: Individuals with mental health issues have a disproportionate risk of being engaged by the criminal justice system. A recent study by the Department of Justice found that 64% of jail inmates have mental health issues and the California Department of Corrections and Rehabilitation estimates that 28% of inmates in California (a staggering 33,000 inmates) are mentally ill.

Disparity 4: Mental Health consumers for whom English is not their first language have uneven access to high-quality and culturally competent specialty mental health services. Translation services only partially address linguistic and cultural barriers between clinicians and consumers or their family members. Additional services are needed to ensure that consumers, for whom English is not their first language, have enough information and knowledge to make informed decisions about their recovery.

Disparity 5: Lesbian, gay, bisexual, or transgender (LGBT) individuals have mental illnesses at the same rate as non-LGBT individuals, but have a disproportionate risk of not receiving specialty mental health services due to (real or perceived) discrimination for their sexual orientation or gender identity. Emerging research suggests that LGBT individuals are also at a higher risk for depression, anxiety, and substance use disorders, compared to non-LGBT individuals, as a result of societal stigma, prejudice and discrimination. Left untreated, these mental health issues can escalate into serious illnesses.

Disparity 6: Over 20% of military veterans returned from overseas operations in Iraq and Afghanistan have post-traumatic stress disorder, according to a 2012 report by the Congressional Budget Office. Treatment services are available through the Veterans Administration, but stigma and discrimination pertaining to mental health services is high and access to screenings are limited in San Joaquin County. More outreach and engagement is needed to help veterans access available services.

Disparity 7: Specialty Mental Health Services are concentrated in the City of Stockton. Specialty mental health outpatient clinics operate in Lodi and Tracy for adults and in Manteca for children. Still gaps remain in access to care for individuals that live throughout the County.

Disparity 8: Mental illnesses occur at disproportionately high rates amongst individuals that have co-occurring mental health and developmental disabilities (DD). Emerging research suggests that the incidence of co-morbidity may be as high as 33% of the DD population. More screening services and specially trained outreach and engagement staff are needed to work with this vulnerable population.

CSS Project 7: Specialty Mental Health Engagement

Project Description

Specialty Mental Health Engagement services will reach 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. Specialty 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 health illnesses.
- *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.
- *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.
- *GLBT, Veterans, Individuals with DD, and Other Consumers of Unplanned Services,* including any individual who is a frequent crisis recipient, not well-engaged by the outpatient specialty mental health clinics, and not otherwise eligible for FSP program services (i.e. lower acuity or need).

Project Components

- *Conduct targeted outreach* to individuals referred by BHS outpatient clinics and 24-hour services staff to, provide additional information on available treatment services and the benefits of recovery supports.
  - Conduct outreach and engagement as requested by the consumer to family members to increase family/social support for participating in treatment services.

- Provide engagement and service linkages (including transportation) to encourage and sustain participation in treatment until a treatment team is established and a case manager is assigned.
- Ensure that consumers and family members develop a shared understanding of the range of available mental health treatment services, including community wellness services, crisis services, and treatment services for individuals with co-occurring disorders.

- *Provide Senior and Veteran Peer Counseling Services* for older adults and veterans living alone under isolated conditions who are suffering from depression, grief, loneliness, post-traumatic stress disorder, or who are experiencing a loss of mobility or independence.
  - 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 throughout the county.
  - Conduct two to four home visits to each participant on a monthly basis (seniors only).

- *Targeted Outreach will use a Relationship-Based Care Model* to support individuals who have difficulty with engagement and sustaining participation in mental health treatment. Core principles include:
  - Engagement. Use Motivational Interviewing techniques to engage consumers and establish foundation for participation. (see info at: www.motivationalinterviewing.org)
  - Trusting Relationship. Engagement workers, trained in Mental Health First Aid, ASIST suicide prevention, and local response procedures, will develop a stable and consistent relationship with the consumer. (see info at: www.nami.org/providereducation, www.mentalhealthfirstaid.org and www.livingworks.net)
  - Commitment to Recovery. Use the Wellness Recovery Action Plan (WRAP) process to help clients develop "future oriented" goals, including goals for recovery. (see info at: www.mentalhealthrecovery.com/wrap)

- *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:
  - Consumer outreach coordinator(s)
  - Patient rights advocacy
  - Family advocacy
  - Peer advocacy
  - Consumer Advisory Council

CSS Project 8: FSP Engagement

Project Description

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 services provide a warm link into FSP program services and warm hand-off to outpatient specialty mental health services upon discharge from an FSP.

FSP Engagement Teams are composed of "peer partners" to provide support services to consumers of mental health services within the first 90 days of their diagnosis and/or within the first 90 days of engagement/enrollment into a full service partnership program. Peer partners will be individuals who self-identify as a consumer, family member, or community member with experience in the recovery process. The Consumer Engagement Team program is intended to provide a caring peer or community member to support the individual in their first engagement with the mental health system of care.

Peer Partners will conduct non-urgent and non-clinical engagement activities intended to support individuals who are learning to navigate the mental health system of care and need additional peer support to prevent anxiety associated with navigating the service delivery system. Peer partners will also be assigned to all individuals *discharged from* a full service partnership to ensure that consumers are successfully engaged in on-going treatment services and WRAP plans continue to meet their recovery needs. Discharged FSP consumers may remain engaged for up to six months to ensure their continued stability in the community.

Target Population

- *All Individuals Eligible for FSP Programs.*
- *All Consumers Discharged from FSP Programs*

Project Components

- *Conduct targeted engagement* to FSP eligible individuals, referred by FSP clinical teams, to provide information on available treatment services and the benefits of recovery supports.
    - Conduct home or in-person visits with consumers to inform them of available treatment services and the benefits of recovery supports.
    - Conduct outreach and engagement as requested by the consumer to family members and/or other adults within the home to increase family/social support for participating in treatment services. Provide culturally and linguistically appropriate resources and information.
    - Ensure that consumers and family members develop a shared understanding of FSP program services, including MHSA housing, housing supports, employment and education services, 24/7 intervention services, community wellness services, crisis services, and services for individuals with co-occurring substance use disorders.

- *Provide FSP engagement services* to consumers in FSP programs to support and sustain them in planned treatment services.
    - Conduct in-person and telephone check-ins and appointment reminders.
    - Provide transportation to scheduled mental health appointments.
    - Encourage and support participation in treatment groups and socialization activities.
    - Assist consumers in developing their own Wellness Recovery Action Plan.
    - Conduct, as authorized, culturally and linguistically appropriate communication with family members to ensure family support and understanding of treatment services.

- *Provide FSP Discharge Support* to assist consumers in transitioning to more routine specialty or community-based mental health services for a period of up to six months.
    - Provide weekly in-person or telephone follow-up support services for a period of up to six months, or until stabilized in treatment (as determined by regular participation in scheduled appointments and recovery oriented activities) and satisfaction with new treatment services.
    - Help consumers periodically review and update their Wellness Recovery Action Plans.
    - Provide culturally and linguistically appropriate resources and information to help consumers and family members find additional supports within their communities.

- *FSP Engagement will use a Relationship-Based Care Model* to support individuals who have difficulty with engagement and sustaining participation in mental health treatment. Core principles include:
    - Engagement. Use *Motivational Interviewing* techniques to engage consumers and establish foundation for participation. (see info at: www.motivationalinterviewing.org)
    - Trusting Relationship. Engagement workers, trained in Mental Health First Aid, ASIST suicide prevention, and local response procedures, will develop a stable and consistent relationship with the consumer. (see info at: www.nami.org/providereducation, www.mentalhealthfirstaid.org and www.livingworks.net)
    - Commitment to Recovery. Use the *Wellness Recovery Action Plan (WRAP)* process to help clients develop "future oriented" goals, including goals for recovery. (see info at: www.mentalhealthrecovery.com/wrap)

General System Development Programs

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.

"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 seven 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. Projects funded include:

Project 9: Wellness Centers
Project 10: Mobile Crisis Support Team
Project 11: Housing Empowerment Services
Project 12: Employment Recovery Services
Project 13: Community Behavioral Intervention Services
Project 14: MHSA Housing
Project 15: Crisis Response Team
Project 16: Specialty Mental Health
Project 17: MHSA Administration and Evaluation

CSS Project 9: 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.

BHS currently provides funding for one Wellness Center in Stockton CA. Proposals for additional Wellness Centers may be solicited during FY 2016/17 for wellness center programming in additional communities.

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(s) 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.

CSS Project 10: 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.

BHS currently operates one MCST, but will be expanding operations to create two new teams stationed in alternate locations and extend the hours of operations of the teams to include evening and weekend hours.

Team:	Location:	Target Population:	Hours of Operation:
Children's Team	Mary Graham Children's Shelter	Children and youth and those receiving foster care services	Tues. – Sat. 10am – 7pm
Justice Team	Downtown Stockton	Justice Involved Offenders Forensic, mentally ill offenders	Tues. – Sat. 10am – 7pm
BHS Campus Team	Behavioral Health Services	Adults experiencing a crisis in the community or at hospitals	Mon. – Fri. 8am – 5pm Wed. – Sun. 3pm – 9pm

The new MCSTs will begin operations during FY 2014/15. Funding for this project is partially supported through the Mental Health Services Act and through the Investment in Mental Health Wellness Act.

CSS Project 11: 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 to attain and retain permanent housing. Supportive services empower consumers to live independently within their homes and communities.

Project Goal*: The goal of this project is to increase the numbers of mental health consumers who have stable, safe, and affordable permanent housing.*

The project is intended to result in:

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

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 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 info 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:

- *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.

- *Housing Coalition:* Establish and facilitate a coalition of housing experts, including housing providers, community planners, and others familiar with low-income housing, to provide networking, promote new housing opportunities for low-income mental health consumers, and to track the development of new housing projects. Maintain referral lists of landlords and property management firms with a history of providing housing to low income individuals and/or mental health consumers. Encourage and enlist other landlords and property managers to accept mental health consumers as tenants, especially those at risk for homelessness.
- *Housing Related Support Services:* Increase consumer's ability to choose, obtain and retain housing:
    - Help consumers search for suitable scattered site housing, complete housing applications and meet with landlords to discuss possible concerns.
    - 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.
    - Provide 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.
    - Provide assistance for consumers in moving their furniture and belongings into their new homes.
- *Financial Assistance for Consumers:* Provide financial assistance with rental deposits, initial month's rent, critical utility payments, essential furnishings, and property damage coverage in order to sustain and/or maintain stable housing in urgent situations.

CSS Project 12: 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 fund 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 Project 13: 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 Project 14: MHSA Housing

Project Description

The MHSA Housing program provides funding for the development and construction of permanent, affordable, and supportive housing for individuals with serious mental illnesses. It is a statewide program that operates in partnership with California Housing Finance Agency. To date San Joaquin County Behavioral Health Services has approved two projects for use of MHSA housing funds. Applications to the California Housing Finance Agency were approved in June 2014, though notifications of final approvals and financing are still pending.

Project Name	Target Population	Number of Units	Location	MHSA Funds
Zettie Miller's Haven	Adults with developmental disabilities, Adults with other disabilities, Adults and older adults with a serious mental illness who are enrolled in a MHSA program	Total units = 82 20 units will be set-aside for MHSA clients for 20 years	1545 Rosemarie Lane, Stockton, CA 95207	$3,327,000
Tienda Drive Senior Apartments	Very low and extremely low income seniors earning between 20% AMI and 55% AMI	Total units = 80 8 units will be set-aside for MHSA clients for 20 years	2245 Tienda Drive, Lodi, CA 95242	$1,434,726

Additional funding, allocated for MHSA Housing projects in San Joaquin County, is currently available through the California Housing Finance Agency. Should the above referenced projects be approved and constructed, there will still remain an additional, $1,577,774 available for permanent supportive low-income housing projects for mentally ill consumers. Interested housing developers are invited to review the funding criteria at: http://www.calhfa.ca.gov/multifamily/mhsa/.

CSS Project 15: Crisis Response Team

Project Description

Through MHSA funding, BHS has expanded and enhanced crisis response services. The Crisis Response Team provides a 24/7 crisis response for any individual experiencing a mental health emergency in San Joaquin County. Services include:

- Initial Crisis Intake and Assessment
- Psychiatric Interventions
- 24/7 Warm line
- Crisis Residential Housing Services
- Justice System Coordination
- Discharge Planning
- Post Crisis Clinic

CSS Project 16: Specialty Mental Health

Project Description

Specialty Mental Health 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 15,000.

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 4,000 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.

CSS Project 17: MHSA Administration and Program Evaluation

Project Description

The MHSA Administration and Program Evaluation team ensures that all MHSA funded programs and activities meet the vision, goals, and statutory mandates of the Mental Health Services Act. Specific duties and responsibilities of the team include:

- *Contract Monitoring and Performance Review:* Monitor all contracts to ensure that MHSA programs are implemented as planned and to fidelity and that program funds are appropriately serving the desired target population.
- *Technical Assistance:* Disseminate regional and statewide information on emerging practices, new regulations, and provide guidance on program implementation.
- *Training Coordination:* Ensure that mental health related trainings are offered to consumers, family members, clinicians, service providers, and community stakeholders as necessary to meet overall project goals and objectives.
- *Program Evaluation:* Evaluate how MHSA funding has been used and what outcomes have resulted from investments.
- *Continuous Quality Improvement:* Review findings and make recommendations to improve services and programs to maximize positive outcomes.
- *Strategic Planning:* Conduct community program planning in accordance with MHSA regulations to update, refine, and develop new MHSA programs reflective of current conditions and needs. Incorporate the vision, direction and objectives of MHSA into larger Behavioral Health Services and other local and County Strategic Plans.

CSS Funding Summary

The amount of funding available for CSS projects is projected to fluctuate over the next several years.

Projected CSS Allocation		
2014-15	**2015-16**	**2016-17**
$18,187,409	$18,263,321	$18,311,814

CSS Project Summary		Total 2014/15 Program Allocation (MHSA + other funds)	Estimated Number to Be Served	Estimated Cost per Person[2]
Full Service Partnership				
1	Children and Youth FSP	1,772,887	115	$15,734
2	Transitional Age Youth FSP	661,215	55	$12,367
3	Adult FSP	6,096,513	290	$21,263
4	Older Adult FSP	1,437,910	85	$16,906
5	Community Corrections FSP	959,409	40	$23,626
6	Intensive Adult FSP	(starts in FY 15/16)	12	$50,000
Outreach and Engagement				
7	Specialty Mental Health Engagement	1,760,819	1,051	$1,675
8	FSP Engagement	1,055,525	597	$1,768
General System Development				
9	Wellness Centers	412,000	450	$915
10	Mobile Crisis Support Team	697,809	1200	$582
11	Housing Empowerment Services	1,659,177	280	$5,925
12	Employment Recovery Services	309,161	50	$6,183
13	Community Behavioral Intervention Services	650,195	115	$5,654
14	MHSA Housing (see page 70)	-	-	-
15	Crisis Response Team	3,117,935	3,800	$820
16	Specialty Mental Health	3,013,326	4,000	$753
Subtotal Direct Project Costs				
Indirect Project Costs				
	CSS Administration	2,594,011	-	-
Total Costs: Community Services and Supports		**26,198,392**		

[2] FSP costs are based on 2016/17 estimated costs of FSP services, excluding housing costs.

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2014/15					
	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
Full Service Partnership						
1. Children and Youth FSP	$1,772,887	685,679	675,064	0	168,766	243,378
2. Transitional Age Youth FSP	661,215	406,051	184,627	0	46,157	24,380
3. Adult FSP	6,096,513	3,313,195	2,758,938	0	0	24,380
4. Older Adult FSP	1,437,910	1,111,308	311,302	0	0	15,300
5. Community Corrections FSP	959,409	764,645	193,424	0	0	1,340
6. Intensive Adult FSP	0	0	0	0	0	0
Outreach and Engagement						
7. Specialty Mental Health Engagement	1,760,819	1,760,819	0	0	0	0
8. FSP Engagement	1,055,525	1,055,525	0	0	0	0
2014/15 Program Expenditures are continued on the following page.						

	A Estimated Total Mental Health Expenditures	B Estimated CSS Funding	C Estimated Medi-Cal FFP	D Estimated 1991 Realignment	E Estimated Behavioral Health Subaccount	F Estimated Other Funding
General System Development						
9. Wellness Centers	412,000	412,000	0	0	0	0
10. Mobile Crisis Support Team	697,809	8,630	12,944	0	4,314	671,921
11. Housing Empowerment Services	1,659,177	1,659,177	0	0	0	0
12. Employment Recovery Services	309,161	309,161	00	0	0	0
13. Community Behavioral Intervention Services	650,195	404,215	245,880	0	0	100
14. MHSA Housing (see below)	-	-	-	-	-	-
15. Crisis Response Team	3,117,935	1,609,367	1,466,268	0	0	42,300
16. Specialty Mental Health	3,013,326	2,093,626	919,700	0	0	0
CSS Administration	2,594,511	2,594,011	0	0	0	500
CSS MHSA Housing Assigned Funds See page 70	0	0	0	0	0	0
Total CSS Program Estimated Expenditures	$26,198,392	18,187,409	6,768,147	0	219,237	1,023,599
FSP Programs as Percent of Total	75.6%					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2015/16					
	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
Full Service Partnership						
1. Children and Youth FSP	$1,781,500	690,000	677,500	0	170,500	243,500
2. Transitional Age Youth FSP	710,566	426,500	193,850	0	64,616	25,600
3. Adult FSP	5,227,400	2,841,000	2,365,500	0	0	20,900
4. Older Adult FSP	1,365,900	1,055,700	295,700	0	0	14,500
5. Community Corrections FSP	961,980	765,600	195,000	0	0	1,380
6. Intensive Adult FSP	600,000	600,000	0	0	0	0
Outreach and Engagement						
7. Specialty Mental Health Engagement	1,813,644	1,813,644	0	0	0	0
8. FSP Engagement	1,087,191	1,087,191	0	0	0	0
2015/16 Program Expenditures are continued on the following page.						

	A Estimated Total Mental Health Expenditures	B Estimated CSS Funding	C Estimated Medi-Cal FFP	D Estimated 1991 Realignment	E Estimated Behavioral Health Subaccount	F Estimated Other Funding
General System Development						
9. Wellness Centers	424,360	424,360	0	0	0	0
10. Mobile Crisis Support Team	654,802	22,214	125,300	0	41767	465,521
11. Housing Empowerment Services	1,660,000	1,660,000	0	0	0	0
12. Employment Recovery Services	310,601	310,601	0	0	0	0
13. Community Behavioral Intervention Services	669,766	416,341	253,250	0	0	175
14. MHSA Housing (see below)	-	-	-	-	-	-
15. Crisis Response Team	3,279,416	1,689,835	1,539,581	0	0	50,000
16. Specialty Mental Health	3,103,726	2,156,435	947,291	0	0	0
CSS Administration	2,303,900	2,303,900	0	0	0	0
CSS MHSA Housing Assigned Funds	0	0	0	0	0	0
Total CSS Program Estimated Expenditures	$25,354,752	18,263,321	6,592,972	0	276,883	841,576
FSP Programs as Percent of Total	73.3%					

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Community Services and Supports (CSS) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2016/17					
	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
Full Service Partnership						
1. Children and Youth FSP	$1,781,500	690,000	677,500	0	170,500	243,500
2. Transitional Age Youth FSP	744,643	447,800	203,543	0	68,000	25,300
3. Adult FSP	4,966,025	2,699,000	2,247,225	0	0	19,800
4. Older Adult FSP	1,297,630	1,002,915	280,915	0	0	13,800
5. Community Corrections FSP	961,380	765,000	195,000	0	0	1,380
6. Intensive Adults FSP	600,000	600,000	0	0	0	0
Outreach and Engagement						
7. Specialty Mental Health Engagement	1,868,053	1,868,053	0	0	0	0
8. FSP Engagement	1,119,800	1,119,800	0	0	0	0
2016/17 Program Expenditures are continued on the following page.						

	A Estimated Total Mental Health Expenditures	B Estimated CSS Funding	C Estimated Medi-Cal FFP	D Estimated 1991 Realignment	E Estimated Behavioral Health Subaccount	F Estimated Other Funding
General System Development						
9. Wellness Centers	438,000	438,000	0	0	0	0
10. Mobile Crisis Support Team	665,328	27,540	130,500	0	41,767	465,521
11. Housing Empowerment Services	1,720,000	1,720,000	0	0	0	0
12. Employment Recovery Services	315,000	315,000	0	0	0	0
13. Community Behavioral Intervention Services	689,881	428,831	260,850	0	0	200
14. MHSA Housing (see below)	-	-	-	-	-	-
15. Crisis Response Team	3,440,887	1,774,327	1,616,560	0	0	50,000
16. Specialty Mental Health	2,917,500	2,027,050	890,450	0	0	0
CSS Administration	2,388,498	2,388,498	0	0	0	0
CSS MHSA Housing Assigned Funds	0	0	0	0	0	0
Total CSS Program Estimated Expenditures	$25,914,125	18,311,814	6,502,543	0	280,267	819,501
FSP Programs as Percent of Total	72.8%					

III. WORKFORCE EDUCATION AND TRAINING

Overview

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.

The Workforce Education and Training Coordinator is a required program component of the MHSA WET Plan and instrumental in implementing the WET Plan as described below. The Workforce Education and Training Coordinator for San Joaquin County is:

Janelle Frederiksen,
Management Analyst II,
(209) 953-7558
jfrederiksen@sjcbhs.org

WET Project 1: Training and Technical Assistance

Community Workforce 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. The following trainings will be offered on an ongoing basis and available to BHS staff, volunteers and community partners:
    - *Motivational Interviewing*
    - *Mental Health First Aid*
    - *Wellness Recovery Action Plans*
    - *Crisis Intervention Training (for Law Enforcement)*

- *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 will be offered on an ongoing basis in the following treatment interventions:
    - *Seeking Safety*
    - *Cognitive Behavioral Therapies*
    - *Dialectical Behavioral Therapy*

- *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. Additional trainings include, but are not limited to:

- *Provider Education Training*
- *Trauma Informed Care*
- *Trainings to become support group facilitators*
- *Shaken Tree*

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 Project 2: Mental Health Career Pathways

Community Workforce Need

A stable and well-trained workforce is critical to the delivery of high quality mental health services. Findings from the Workforce Needs Assessment demonstrate that there is a shortage of mid-level clinicians (e.g. licensed Mental Health Clinician II employees) within the BHS workforce. Additional clinical supervision and support is necessary to help advance and promote entry level (non-licensed) clinicians.

Project Description

BHS will increase access to clinical supervision for new mental health clinicians. Clinical supervisors will provide supervision towards the hours required for licensure and will provide enhanced guidance on the core practice treatment modalities (e.g. cognitive behavioral therapy) to ensure that clinicians are delivering mental health treatment interventions with fidelity.

Project Components

- *Clinical Supervision.* Mental health clinical professionals are required to complete 3,200 hours of supervised work experience and 104 weeks of supervision once master's level course work has been satisfactorily completed to meet qualifications to take the Sate's licensing examination. BHS will contract with licensed mental health clinician(s) to serve as clinical supervisors and professional mentors for new mental health clinicians seeking to meet licensure qualifications. All clinical supervisors will have been licensed for at least two years, have a valid clinical license, and have completed 15-hours of supervisor training. Adding dedicated supervision services will create more career pathways for mental health interns and strengthen capacity in core competencies.

Project Objective

This project will increase the number of licensed mental health clinicians providing treatment interventions throughout BHS.

Additional Components

BHS continues to support the creation of a Peer Specialist Certification program within the State of California. The Department of Mental Health (DMH) and the California Office of Statewide Health Planning and Development (OSHPD) have prepared complimentary reports recommending the development of a Peer Specialist Certification Program and Career Pathway program. Should these recommendations be implemented, BHS will update the WET plan to create local career pathways for consumers and family members to obtain the Peer Specialist Certification and enter into the mental health profession. In lieu of the formal Peer Specialist Certificate, BHS will continue to promote training and employment supports for consumer and family member employees and volunteers as described elsewhere in this plan. (See page: 83)

WET Project 3: Residency and Internship Programs

Community Workforce Need

Findings from the Workforce Needs Assessment show continued shortages in the area of psychiatry, especially amongst board certified child and geriatric psychiatrists with experience in the public mental health care system. Additional programs are required to encourage psychiatrists to develop clinical competencies and a commitment to specialty mental health care services for SED/SMI individuals.

Project Description

Psychiatric residency programs are designed to provide comprehensive, hands-on, training and education in psychiatry for post-graduate psychiatrists. Statewide and MHSA funded residency programs through OSHPD are designed to ensure that more psychiatric residents receive training in the County public mental health system and in working with the populations prioritized by their community. Further, the psychiatric residents are encouraged to continue working in the California public mental health system after their rotations end.

Project Component

- *OSHPD Psychiatric Residency Program*. OSHPD is currently seeking solicitations from accredited psychiatric residency programs or fellowships within the State of California. These psychiatric programs will be required to place psychiatric residents and fellows in clinical settings within the public mental health system. In partnership with the selected accredited programs, BHS will support the placement and mentoring of psychiatric residents within county-operated programs and clinics in order to train the next generation of practitioners and to encourage employment in the public mental health care system.

Project Objective

This project will support the statewide objective of increasing the number of psychiatrists within the public mental health system.

WET Project 4: Financial Incentives Programs

Community Workforce Need

BHS is facing acute shortages of employees across all sectors of the mental health workforce. Shortages are most acute amongst psychiatrist, nurses, psychiatric technicians, and licensed clinical social workers. Financial incentive programs will be geared towards BHS employees within these classifications.

Project Description

The main purpose of this strategy is to ensure that there are sufficient qualified and culturally competent candidates to fill vacant positions within BHS. This strategy is designed to be flexible so that as an increasing number of candidates are recruited and trained for specific positions, financial incentives are redirected to other positions that have been identified as difficult to fill.

Individuals will be eligible to submit applications to BHS for financial incentives. The application will include an interview process that will, in part, assess the candidate's capacity to complete the educational programming and commitment to returning to the public mental health field in San Joaquin County. The number and amount of awards will vary annually according to demand for qualified staff and the strengths of the applications received. In some years no funding may be awarded and funding will "roll-over" for allocation in future years.

Project Components

The following financial incentives may be provided, depending on merit and/or need:

- Psychiatry Incentives
  BHS us facing an acute shortage of qualified psychiatrists and psychiatric nurse practitioners at all levels. The recent opening of the California Health Care Facility in Stockton for seriously ill inmates of California's Correctional System has further exacerbated the challenges in hiring qualified psychiatrists. Hiring incentives are standard practices for recruiting and retaining psychiatrists. Locally the California Health Care Facility and Kaiser Permanente offer hiring incentives to psychiatrists. Under this strategy BHS will explore the merit of providing hiring incentives to psychiatrists who agree to work with BHS for a specified period of time.

- Educational Incentives
  - *Stipends:* Stipends may be awarded to employees or to people not yet employed in public mental health. All recipients of stipends will sign a contract stating their intent to work for BHS or a contracting agency for a minimum of 2 years following graduation.
  - *Scholarships:* Scholarships will be awarded for specific educational costs such as tuition, textbooks, etc. Scholarships will be available to part-time and full-time regular employees.
  - *Loan Assumptions*: BHS will further explore the possibility of awarding loan assumptions to psychiatrists and psychiatric nurse practitioners employed by BHS.

All recipients of stipends, scholarships, loan assumptions, and other benefits will be contractually obligated to work for Behavioral Health Services or contracting community-based organizations, and with a minimum commitment of two years. Those who do not meet their obligations will be required to reimburse the County for the full amount of assistance, plus interest.

Project Objective

This project is intended to decrease identified workforce shortages and will make it more financially feasible for individuals to increase their level of educational attainment and stay employed within the County mental health care system.

WET Project 5: Workforce Staffing Support

Community Workforce Need

BHS is committed to ensuring that the WET plan meets the stated objectives described in each of the funded project areas, and to identifying additional goals and objectives as new challenges arise. The WET Coordinator will work with BHS management to continuously analyze the impact of WET-related activities, and each year the WET Coordinator will assist the MHSA Coordinator to complete all annual updates, s/he will also facilitate a comprehensive evaluation of WET activities, annually. Based on findings, BHS may make changes to the current plan and post such changes for public comment.

Project Description

BHS will fund a full-time WET Coordinator to manage MHSA-funded workforce development activities. The WET Coordinator will be supported by the Training Coordinator, who will help establish workforce development activities, and measurable objectives and data collection protocols for the tracking and management of such activities.

Project Components

- *Implement WET Plan Activities.*
  - Coordinate and manage staff trainings to ensure all staff receive trainings in core-competencies and that particular occupations and departments receive trainings in accordance with specific needs.
  - Develop relationships with partner organizations to ensure high-level support for staff participation in training activities and that such knowledge is incorporated into practice.
  - Provide information to all eligible staff about available financial incentives and for ensuring a fair and equitable system for reviewing and approving financial incentive awards.
  - Provide support and technical assistance in completing required WET reporting forms to the clinicians and psychiatrists overseeing clinical supervision and psychiatric residency programming.

- *Monitor and Track WET Expenditures.* The WET Coordinator will manage the WET budget and will make sure that funding is utilized according to the WET Plan and within the time periods specified. S/he will manage the distribution of financial incentives and payments to professional trainers and group facilitators.

- *Represent the Workforce Training and Development Needs of San Joaquin County.* The WET Coordinator will work with other County MHSA Coordinators, OSHPD and DMH to develop a single, unified MHSA plan that is consistent with County needs and local and state guiding principles.

Project Objectives

The WET Coordinator will ensure that the WET Plan is implemented as designed.

WET Funding Summary

The amount of funding available for WET projects is projected to fluctuate over the next several years.

Projected WET Allocation		
2014-15	**2015-16**	**2016-17**
$854,395	$619,152	$633,339

WET Project Summary		**2014/15 MHSA Allocation**	**Estimated Number to Be Trained**	**Estimated Cost per Person**
Workforce Education and Training				
1	Training and Technical Assistance	503,800	800	630
2	Mental Health Career Pathways	95,000	30	3,167
3	Residency and Internship Programs	0		
4	Financial Incentives Programs	50,000	NA	NA
5	Workforce Staffing and Support	94,152	NA	NA
Subtotal Direct Project Costs				
Indirect Project Costs				
	WET Administration	111,443		
Total Costs: Workforce Education and Training		**$854,395**		

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2014/15					
	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	$503,800	503,800	0	0	0	0
2. Mental Health Career Pathways Programs	95,000	95,000	0	0	0	0
3. Residency and internship Programs	0	0	0	0	0	0
4. Financial Incentive Programs	50,000	50,000	0	0	0	0
5. Workforce Staffing Support	94,152	94,152	0	0	0	0
WET Administration	111,443	111,443	0	0	0	0
Total WET Program Estimated Expenditures	$854,395	854,395	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2015/16					
	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	$211,413	211,413	0	0	0	0
2. Mental Health Career Pathways Programs	180,000	180,000	0	0	0	0
3. Residency and internship Programs	0	0	0	0	0	0
4. Financial Incentive Programs	50,000	50,000	0	0	0	0
5. Workforce Staffing Support	96,980	96,980	0	0	0	0
WET Administration	80,759	80,759	0	0	0	0
Total WET Program Estimated Expenditures	$619,152	619,152	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Workforce, Education and Training (WET) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2016/17					
	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 Mental Health Career Pathways	$219,870	219,870	0	0	0	0
2. Programs Residency and internship	180,000	180,000	0	0	0	0
3. Programs	0	0	0	0	0	0
4. Financial Incentive Programs	50,000	50,000	0	0	0	0
5. Workforce Staffing Support	100,860	100,860	0	0	0	0
WET Administration	82,609	82,609	0	0	0	0
Total WET Program Estimated Expenditures	$633,339	633,339	0	0	0	0

IV. INNOVATION

Overview

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. An Innovation project is defined as one that contributes to learning rather than having a primary focus on providing a service. It is an opportunity to "try out" new approaches that can inform current and future practices in communities.

INN Project 1: Adapting Functional Family Therapy

Project Description

BHS, in partnership with San Joaquin County Probation Department and two community-based organizations, is adapting the Functional Family Therapy Evidence Based Practice, to include the use of parent partners and peer mentors for both pre-engagement and post discharge. Interventions will be more inclusive of peer contributions and improve outcomes associated with retention and long-term benefits to the families. Additionally, this project will help promote interagency collaboration through the development of interagency operating procedures for referral, case management, and the coordination of additional resources amongst partner providers.

A crisis bed is currently funded for youth who are experiencing an immediate crisis episode within their home for whom a safe place to stay may avoid psychiatric hospitalization. The crisis bed is used primarily when there are conflicts within family that exacerbate the child/youth's mental health symptomology.

Preliminary findings are promising, and additional implementation is required to fully understand learning objectives. This project will continue through June 2017.

Further Innovation funding allocations remains to be determined.

INN Funding Summary

The amount of MHSA funding available for INN projects is projected to fluctuate over the next several years.

Projected INN Allocation		
2014-15	**2015-16**	**2016-17**
$1,951,640	$1,641,995	$955,755

INN Project Summary		2014/15 MHSA Allocation	Estimated Number to Be Served	Estimated Cost per Person
Innovation				
1	Adapting Functional Family Therapy	$1,401,337	56	$25,024
2	New INN project (to be determined)	342,716	NA	NA
3				
4				
5				
Subtotal Direct Project Costs				
Indirect Project Costs				
	INN Administration	207,587		
Subtotal Indirect Project Costs (15%)				
Total Costs: Innovation		**$1,951,640**		

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2014/15					
	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. Adapting Functional Family Therapy	$1,647,428	1,401,337	196,473	0	49,118	500
2. New Innovation Project (TBD)	342,716	342,716	0	0	0	0
3.						
4.						
5.						
INN Administration	207,587	207,587	0	0	0	0
Total INN Program Estimated Expenditures	$2,197,731	1,951,640	196,473	0	49,118	500

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2015/16					
	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. Adapting Functional Family Therapy	$1,141,300	970,800	136,000	0	34,000	500
2. New Innovation Project (TBD)	500,000	500,000	0	0	0	0
3.	0					
4.	0					
5.	0					
INN Administration	171,195	171,195	0	0	0	0
Total INN Program Estimated Expenditures	$1,812,495	1,641,995	136,000	0	34,000	500

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Innovations (INN) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2016/17					
	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. Adapting FFT	$449,568	388,320	46,598	0	14,150	500
2. New INN (TBD)	500,000	500,000	0	0	0	0
3.	0					
4.	0					
5.	0					
INN Administration	67,435	67,435	0	0	0	0
Total INN Program Estimated Expenditures	$1,017,003	955,755	46,598	0	14,150	500

V. CAPITAL FACILITIES AND TECHNOLOGICAL NEEDS

Overview

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 CFTN Plan in Spring 2013. The plan sets aside funding for future capital facilities planning and describes a major capacity building project to bring the county into compliance with state and federal mandates for electronic health records by January 2015.

CF Project 1: Provide Contingency Funds for Capital Facilities Project

Through construction funding approved under a grant from the California Health Facilities Financing Authority (CHFFA) under the California Mental Health Wellness Act of 2013, BHS will expand its current Crisis Stabilization Unit (CSU) to create three discrete clinical areas, each with a different level of care and target population. A shared nursing station will be built between the three clinical areas. As a result of this project:

- Access to services will be expanded to include children and youth.
- Services will be enhanced, to provide a separate treatment area for voluntary admissions.
- Service capacity will be doubled, from eight to sixteen individuals.

BHS was awarded $1,836,784 to enhance and expand the CSU to improve services for consumers and families. MHSA capital facilities component funds will be applied as a contingency for any design or construction cost overruns.

TN Project 2: Develop and Implement an Electronic Health Record (EHR) System

An EHR application is critical to fulfilling state and federal mandates and accomplishing MHSA goals of modernization and consumer and family empowerment. BHS is in the process of selecting an EHR application vendor and upgrading its network systems and hardware to accommodate technological improvements. Linked to the upgrades in the electronic health records is the capacity to share information between health providers. BHS, in participation with the Health Plan of San Joaquin, San Joaquin General Hospital, Community Medical Centers, and the Health Care Services Agency are jointly implementing a health information exchange to allow for the secure and confidential transmission of appropriate health information between medical providers.

CFTN Funding Summary

The amount of funding available for CFTN projects is projected to fluctuate over the next several years.

Projected CFTN Allocation		
2014-15	**2015-16**	**2016-17**
$3,676,492	$1,764,209	$1,104,206

CFTN Project Summary		**2014/15 MHSA Allocation**	**Estimated Number to Be Served**	**Estimated Cost per Person**
Capital Facilities and Technological Needs				
1	Contingency funds for CSU expansion	$500,000	NA	NA
2	Develop and Implement a E.H.R.	3,176,492	NA	NA
3				
4				
5				
Subtotal Direct Project Costs				
Indirect Project Costs				
	CFTN Administration	0		
Subtotal Indirect Project Costs (15%)				
Total Costs: Capital Facilities and Technological Needs		**$3,676,492**		

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2014/15					
	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. Contingency Funds for CSU Expansion	$500,000 0 0	500,000	0	0	0	0
CFTN Programs – Technological Needs Projects						
2. Develop and Implement of an E.H.R.	3,176,492 0 0	3,176,492	0	0	0	0
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	$3,676,492	3,676,492	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2015/16					
	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. Contingency Funds for CSU Expansion	$910,000 0 0	910,000	0	0	0	0
CFTN Programs – Technological Needs Projects						
2. Develop and Implement of an E.H.R.	854,209 0 0	854,209	0	0	0	0
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	$1,764,209	1,764,209	0	0	0	0

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Capital Facilities/Technological Needs (CFTN) Component Worksheet

County: San Joaquin Date: July 16, 2014

	Fiscal Year 2016/17					
	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. Contingency Funds for CSU Expansion	$1,104,206	1,104,206	0	0	0	0
	0					
	0					
CFTN Programs – Technological Needs Projects						
	0					
CFTN Administration	0					
Total CFTN Program Estimated Expenditures	$1,104,206	1,104,206	0	0	0	0

Section Three: Program Implementation and Evaluation

Consumer Art Credits:

Section One: Alicia Ortega

Section Two: Kristin Wall

Section Three: Leon Madrazo

PROGRAM IMPLEMENTATION

Over the next three years the greatest changes in MHSA funded programming activity will be evident in the full service partnership programs. Changes are in response to consumer and family member feedback that more intensive services should be developed and that the most intensive services should target those consumers that are consistently the hardest to successfully engage and retain in treatment.

In response to this feedback BHS intends to adjust the full service partnership model to provide more intensive services for consumers. The major shift will ultimately see FSP mental health staff assigned to smaller caseloads. Full service partnership programs will also benefit from more staff training in evidence based practices for working with acutely mentally ill clients; additional support from community partners to provide culturally and linguistically appropriate outreach and engagement services; and more services and supports within specialty mental health and crisis clinics to reduce the number of individuals with acute mental illnesses whose treatment needs escalate to the highest levels.

Project Goal: ***Full Service Partnership Programs stabilize consumers with the highest acuity of mental illnesses and place them on a pathway to wellness and recovery that they are able to manage and maintain through traditional, specialty mental health care services.***

Currently, BHS serves approximately 1,800 individuals within its full service partnership program. This number is significantly higher than in other, similar counties. The strategy of enlarging FSP program capacity was originally a temporary measure in response to the 2009/10 economic downturn, when funding for mental health services were reduced throughout California. As mental health funding has recovered from the economic downturn, BHS has more capacity to shift FSP programming back to the original vision and intention of the community. Further, while many of the FSP clients have significant treatment needs, others appear to have stabilized over time and are sustaining in their recovery with less intensive services. In order to provide FSP services for the most acutely ill, BHS will over the next few years examine all caseloads to ensure that FSP services are targeted to those that have the highest level of acuity. This means that some FSP clients will be transferred into specialty mental health care clinic services – a transition which will in practice result in few differences in services. The three-year plan to reduce case loads and intensify services within the FSP includes the following components:

1) *Clarify the FSP eligibility criteria*. As described in this Three Year Program and Expenditure Plan, all individuals enrolled within an FSP must meet the MHSA criteria for enrollment within an FSP. Additionally, BHS will prioritize FSP services for those individuals that are most acutely ill and secondly, currently involved with the justice system. (See page 42.)

2) *Review FSP caseloads.* Over the next three years, clinicians will be reviewing all FSP caseloads to determine which individuals have met their recovery goals and are ready to transition to other specialty mental health care services and/or community services and primary care. A range of "step-down" transition services are funded through this Plan. (See page 58.)

3) *Strengthen community-based mental health services.* Through the Affordable Care Act, more mental health services are now provided through primary care physicians. Some consumers may benefit from the capacity to access treatment services within their community and in the context of their primary care provider. BHS will provide psychiatric consultation to family medicine clinics and will help clinics increase their capacity to serve individuals with mental illnesses. (See page 25.)

4) *Expand the use of culturally and linguistically appropriate outreach and engagement.* BHS will expand the use and capacity of peer partners and recovery coaches in mental health services. Consumers at all levels of the service continuum will be engaged by a peer partner or recovery coach to help ensure understanding and commitment to treatment. Peer Partners will help support and sustain consumers in recovery by providing appointment reminders, assisting with transportation to appointments, and encouraging and supporting the creation of WRAP plans by the consumers to manage their own recovery goals. Culturally and linguistically appropriate outreach and engagement services will be available for any consumers receiving specialty mental health care services, full service partnership services, or seen by 24-hour crisis services for whom outreach and engagement is warranted. (See page 56.)

5) *Enhance the effectiveness of outreach and engagement services.* Within one year of plan implementation all program staff providing outreach and engagement services will be trained in the techniques necessary to adopt a relationship based care model. Specifically outreach and engagement staff will have training in motivational interviewing, WRAP planning, suicide prevention, and mental health first aid. (See page 83.)

6) *Reduce FSP case loads.* Over the next three years, through attrition, good care transition, and using the level of care assessment tools, BHS will reduce the average caseload per FSP clinician. Targeted program capacity for each FSP program area is described in the plan, however these numbers are target goals for 2016/17 and will be reviewed each year to determine true need and feasibility. (See FY 16/17 estimated FSP program capacity, page 74.)

7) *Adopt a Level of Care assessment tool.* BHS will research and select a level of care tool to determine the acuity of need for mental health consumers. Enrollment into and discharge from FSP services will be based in part on the findings from a level of care assessment tool. Only those individuals with a demonstrated acuity will be referred into or continue to receive services from an FSP. (See page 45.)

8) *Provide more intensive FSP services.* Over the next three years, and as case loads are reduced, clinicians will be able to provide more individualized and intensive mental health treatment services, including therapeutic services and clinical case management. (See page 45.)

FINANCIAL SUMMARY

FY 2014-15 Through FY 2016-17 Three-Year Mental Health Services Act Expenditure Plan
Funding Summary

County: San Joaquin Date: 7/16/14

	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 2014/15 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	22,541,876	10,062,148	2,514,897	2,271,982	6,544,907	
2. Estimated New FY2014/15 Funding	20,032,600	5,008,565	1,317,446			
3. Transfer in FY2014/15[a/]	0					
4. Access Local Prudent Reserve in FY2014/15						0
5. Estimated Available Funding for FY2014/15	42,574,476	15,070,713	3,832,343	2,271,982	6,544,907	
B. Estimated FY2014/15 MHSA Expenditures	18,187,409	6,167,292	1,951,640	854,395	3,676,492	
C. Estimated FY2015/16 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	24,387,067	8,903,421	1,880,703	1,417,587	2,868,415	
2. Estimated New FY2015/16 Funding	17,290,000	4,322,261	1,137,352			
3. Transfer in FY2015/16[a/]	0					
4. Access Local Prudent Reserve in FY2015/16						0
5. Estimated Available Funding for FY2015/16	41,677,067	13,225,682	3,018,055	1,417,587	2,868,415	

D. Estimated FY2015/16 Expenditures	18,263,321	5,160,076	1,641,995	619,152	1,764,209	
E. Estimated FY2016/17 Funding						
1. Estimated Unspent Funds from Prior Fiscal Years	23,413,746	8,065,606	1,376,060	798,435	1,104,206	
2. Estimated New FY2016/17 Funding	17,675,000	4,417,987	1,163,311			
3. Transfer in FY2016/17[a/]	0					
4. Access Local Prudent Reserve in FY2016/17						0
5. Estimated Available Funding for FY2016/17	41,088,746	12,483,593	2,539,371	798,435	1,104,206	
F. Estimated FY2016/17 Expenditures	18,311,814	5,160,424	955,755	633,339	1,104,206	
G. Estimated FY2016/17 Unspent Fund Balance	22,776,932	7,323,169	1,583,616	165,096	0	

H. Estimated Local Prudent Reserve Balance	
1. Estimated Local Prudent Reserve Balance on June 30, 2014	11,627,409
2. Contributions to the Local Prudent Reserve in FY 2014/15	0
3. Distributions from the Local Prudent Reserve in FY 2014/15	0
4. Estimated Local Prudent Reserve Balance on June 30, 2015	11,627,409
5. Contributions to the Local Prudent Reserve in FY 2015/16	0
6. Distributions from the Local Prudent Reserve in FY 2015/16	0
7. Estimated Local Prudent Reserve Balance on June 30, 2016	11,627,409
8. Contributions to the Local Prudent Reserve in FY 2016/17	0
9. Distributions from the Local Prudent Reserve in FY 2016/17	0
10. Estimated Local Prudent Reserve Balance on June 30, 2017	11,627,409

PROGRAM EVALUATION

PEI Evaluation Plan

The PEI evaluation intends to: 1) measure program performance and fidelity; 2) measure program impact on participants and systems; and 3) provide real-time, accurate data to inform ongoing program improvement.

Measure performance and fidelity

Prior to implementation or at the onset of a new fiscal year, the BHS evaluator will work with program staff to draft performance expectations, which will be included in formal scopes of work. Performance expectations may include description of 1) the services to be provided; 2) the number served, dosage and duration of service; 3) a demonstration of fidelity to evidence-based measures; and 4) the methods of collecting and reporting data.

On an annual basis, each program will report: 1) successes and challenges associated with service delivery; 2) program outputs (e.g., numbers served); and 3) demonstration of fidelity.

Each year, the evaluator will prepare a report describing the numbers of individuals and organizations trained; numbers of individuals and demographics of individuals served; numbers and types of referrals made and completed; successes and challenges in implementing programs according to plan, and program outcomes, if available.

Measure program impact on participants and system

At the beginning of each program year, the BHS evaluator will work with PEI program staff to develop outcome expectations based on: 1) literature on the evidence-based practice; 2) national standards; or 3) previous years' outcomes.[3] The BHS evaluator and PEI program staff will develop methods of assessing program impact, and methods of collecting and reporting data. During the year, the evaluator will work with program staff to ensure accurate and timely data collection. Each year, the evaluator will analyze and prepare a report demonstrating the effects of the program.

Provide real-time, accurate data to inform ongoing program improvement

As needed, the evaluator will convene meetings with PEI providers to identify and discuss program challenges and opportunities as they arise. Program staff will have an opportunity to dialogue and learn from one another. Each year, the evaluator will present output and outcome data to the PEI providers, and discuss strategies to improve programming. The "PEI Learning Community" will provide recommendations to BHS administrators to adjust program scopes of work for the following year based on evaluation findings.

[3] Outcome expectations will be described as: "*x% of participants will show improvements in y.*"

A. Evaluation Methods

Participant data tracking

The evaluator will develop a data system or modify existing data systems to track each program's outputs, and will train program staff to enter timely and accurate data. Data tracking may include paper intake or assessment forms, excel spreadsheets, or HIPAA compliant web-based databases. For each program or treatment modality, the administrative data tracking system will capture on a quarterly and annual basis:

- Number of individuals reached out to and methods of outreach
- Number of unduplicated individuals and family members served
- Demographics of individuals served
- Number of admissions
- Number of discharges
- Number of individuals completing program
- Duration of treatment
- Units of service received
- Missed and kept appointments
- Locations of services provided
- Number and types of referrals made and completed for persons with serious mental illness or emotional disturbances

Administration of evidence-based practice fidelity assessment tools

For each evidence-based practice, the evaluator will identify the appropriate fidelity measurement tools and train program staff, supervisors, and/or BHS administrators to conduct site visits and record scores, as required by the model. Examples of fidelity assessment tools include: TF-CBT Brief Practice Checklist and Seeking Safety Adherence Scale.

Pre, during and post assessments

The evaluator, in consultation with BHS administrators, will select validated assessment tools to measure participant outcomes. Tools will be selected based on evidence-based practice indicators, and if no measurement tools are provided, one will be selected by the evaluator based on the tool's use in measuring the intended outcomes. Program staff will administer validated assessment tools at intake and at regular intervals and/or program completion, depending upon fidelity recommendations. Program staff will enter data into the administrative tracking system to be analyzed by evaluation team. Assessment scores will be entered into a HIPAA-compliant tracking log or database using a de-identified client code so that the evaluator can determine each participant's changes in symptomology or functioning.

Satisfaction surveys

On an annual basis, for some PEI programs, staff will administer anonymous paper-based client and/or caregiver satisfaction surveys. Additionally, anonymous electronic surveys will be distributed to program staff to measure satisfaction as well as program strengths and challenges, and to identify ways in which the program has contributed to behavioral health workforce knowledge and system improvements.

Interviews with program manager and discussion group with program staff
In order to describe how the program was implemented and to identify opportunities for program improvement, the evaluator will conduct interviews with program managers and a discussion group with program staff at the completion of each 12-month service period.

Training
The evaluator will develop tools to track the number of individuals trained, the type and amount of training received, and the organizations that received training. The evaluator, in consultation with BHS administrators, will identify validated instruments for measuring trainee satisfaction and changes in knowledge and/or skills.

Reporting
On an annual basis, the evaluator, in partnership with BHS staff, will prepare a report describing the unduplicated number of individuals and family members served, including demographics, numbers and types of referrals and follow-through on referrals, duration of untreated mental illness, program successes and challenges. A three-year evaluation report will include answers to questions related to program impact and a description of evaluation methodology.

B. PEI Project Objectives

For each *early intervention* project BHS will evaluate the reduction of prolonged suffering that may result from untreated mental illness by measuring reduced symptoms and or improved recovery, including mental, emotional and related functioning.

For each *prevention* project BHS will measure a reduction of prolonged suffering that may result from untreated mental illness by measuring a reduction in the risk factors and/or increased protective factors that may lead to improved mental, emotional and relational functioning.

The sections below describe the outputs and outcomes expected as a result of each project, and the indicators or measures that will likely be tracked prior to, during and following implementation. In order to encourage continuous program improvement, new and modified objectives, indicators and measures may be considered as implementation progresses. All programs will also be monitored to ensure compliance with applicable BHS rules, and state and federal regulations and to ensure fidelity to evidence-based practice and to this plan.

1. Community Trainings

Project Goal: *To develop community members as effective partners in preventing the escalation of mental health crises and promoting behavioral health recovery.*

	Desired Outcomes	Measures
Process Outputs	A broad spectrum of community responders are trained to recognize and respond effectively to early signs of mental illness	Number, demographics, and affiliation (e.g., settings) of individuals who enroll in and complete each trainer course Number of trainings provided by each trainer Number, demographics, and affiliation of individuals who enroll in and complete each evidence-based training Degree of adherence to evidence-based training practices using observation checklists or other fidelity measures
Individual Outcomes	A broad spectrum of community responders are knowledgeable and capable to recognize and respond effectively to early signs of mental illness	Changes in knowledge, capacity, skill, and attitudes of trainees as measured by validated training assessment tools provided by EBP manual when possible
System Outcomes	Community responders respond effectively to early signs of mental illness, including for underserved populations	Number of referrals of individuals with potential SMI/SED referred to BHS by trained community responders, as measured by a post-training follow-up survey of a sample of trainees.

2. Family Medicine Consultation

Project Goal: *Primary care patients with behavioral health needs are identified early and receive services that prevent severe and persistent illness. Primary care providers increase their capacity to serve the behavioral healthcare needs of their patients.*

	Desired Outcomes	Measures
Process Outputs	Clinic staff will receive consultation and technical assistance from BHS staff	Number of hours and types of training, consultation, technical assistance, coaching provided by BHS staff
System Outcomes	Over time decrease in the proportion of family practice patients whose conditions receive consultation by BHS staff	Change in ratio of total number of family practice patients with mental health related conditions to number of family practice patients for whom BHS clinicians provide consultation
	Clinics provide greater variety of behavioral health services and units of service	Change in types of behavioral health services (e.g., screenings, EBPs, etc.) offered within the clinics Change in units of behavioral health services provided by clinics
	Increase in referrals from BHS to family practice clinics of consumers who have been stabilized in treatment Increase in proportion of referrals from family practice clinics of consumers who meet criteria of medical necessity for specialty MH care	Change in number of referrals from BHS to clinics Change in number of referrals from clinics to BHS

3. Trauma Services for Children and Youth

Project Goal: *Reduce risk of PTSD and other manifestations of trauma exposure, and improve access to treatment for those experiencing symptoms of trauma.*

	Desired Outcomes	Measures
Process Outputs	School personnel receive trauma training Children and adolescents, including underserved groups, receive screening All children and adolescents whose screening results indicate symptoms of trauma receive appropriate services and supports All interventions use EBPs with fidelity	Number of personnel receiving trauma training disaggregated by each school site Number and demographics of individuals receiving screenings by school or neighborhood Summary of screening scores and types of referrals provided as a result of scores Number and demographics of individuals enrolled in each EBP Total number of units/hours of service provided to individuals in for each EBP Number and demographics of individuals completing EBP Scores on self- and supervisor-administered fidelity checklists, such as Seeking Safety Adherence Scale
Individual Outcomes	Children and adolescents who receive services experience decrease in symptoms related to trauma exposure	Pre, during and post assessment scores using UCLA PTSD Symptom Checklist, or other validated outcome tools, as indicated for the specific EBP, disaggregated by demographics
System-Level Outcomes	Increase in knowledge and capacity of BHS and partner organization staff to identify trauma and treat PTSD symptoms Improve timely access to treatment for children and youth with SED/SMI	Validated training satisfaction surveys and/or tools for measuring knowledge/skill acquisition Number and demographics of children and youth with SED/SMI referred, including the type of treatment referred to Number and demographics of individuals who followed through with referral (participated at least once) Duration of untreated mental illness for referred individuals Duration of treatment of referred individuals

4. Early Interventions in Psychosis

Project Goal: *To stably remit schizophrenia, restore cognitive, social and vocational functioning to normal levels, and return schizophrenia sufferers to a normal and productive life.*

	Desired Outcomes	Measures
Process Outputs	A minimum of 60 clients will receive comprehensive EITP services annually.	Number and demographics of individuals screened and assessed for eligibility Number and demographics of individuals enrolled in program Number of units of service for each type of service provided for each enrolled individual Number and demographics of individuals who complete program Number and demographics of individuals who leave program before completion
Individual Outcome	Clients show reduction in acute care/crisis services over a three-year period	Number of admissions, patient days and treatment cost
Individual Outcome	Clients show short-term symptom reductions and long-term remission	Quarterly scores from QSAPS and QSANS or similar tools
Individual Outcome	75% of clients will be employed or in school by sixth month of treatment; this proportion will be maintained or exceeded every subsequent quarter during program participation	Number of participants employed or enrolled in school every quarter
Individual Outcome	90% of participants will be medication adherent in each quarter of program participation	Score on Medication Adherence Rating Scale (MARS) or similar tool
System-Level Outcomes	Cost per client of treatment, including cost of crisis hospitalizations, will be lower during participation in the program, and will remain lower after program termination. Improve timely access to treatment for transitional age youth with psychosis	Units of service and charges for all behavioral health care services provided to participants, pre, during and post participation Number and demographics of children and youth with SED/SMI referred, including the type of treatment referred to

5. Skill Building for Parents and Guardians

Project Goal: *To prevent and reduce risk factors for mental illness including but not limited trauma and abuse such as family conflict or domestic violence, and increase protective factors associated with social connectedness, parent and family resilience, and knowledge of child development.*

	Desired Outcomes	Measures
Process Outputs	Parents and guardians with children exhibiting social, emotional and behavioral issues will receive training Trainings will be offered throughout the County Trainings will be offered with fidelity to EBP models	Number and demographics of individuals enrolled in parenting classes Number and demographics of individuals completing program Locations where parenting classes are provided Fidelity checklists or observations by BHS manager
Outcomes	Parents and guardians will demonstrate improved skills, knowledge and confidence as a result of participating in parenting classes	Pre and post assessment scores using validated instruments endorsed by the evidence-based parenting class curriculum

6. TAY Mentoring

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

	Desired Outcomes	Measures
Process Outputs	TAYs with social and emotional difficulties receive services TAYs complete program Program is implemented with fidelity to selected model	Caseload size Number and demographics of youth referred to program Number and demographics of youth enrolled in program Number and type of units of service provided per individual Days between referral and intake Duration of active coaching Duration of maintenance coaching Number and demographics of youth completing program
Individual outcomes	Participants will increase protective factors and reduce risk factors along the following domains: ● Employment and career ● Educational opportunities ● Living situation ● Personal effectiveness and wellbeing ● Community life functioning	Scores from the Transition to Adulthood Program Information System (TAPIS) Progress Tracker - scores at baseline (90-days prior to intake) and (at 90 day interval) or participant tracking tools measuring • Increase school participation, attendance, achievement • Decrease Crime, law enforcement contact • Increase job training or skill building, or full or part-time employment • Increase in anger management and conflict resolution • Decrease in depression, anxiety, fear • Increase housing safety and stability
System outcomes	Improve timely access to treatment for TAYs with SED/SMI	Number and demographics of participants with SED/SMI referred for mental health treatment services

7. Juvenile Justice Project

Project Goal: *The goal of the Juvenile Justice project is to promptly identify behavioral health issues among juvenile justice involved youth, provide interim treatment, and ensure transition to ongoing services and supports.*

	Desired Outcomes	Measures
Screening Outputs	All youth detained at JCC BH screening	Number and demographics of youth detained Number and demographics of youth who are screened with MAYSI-2 or other appropriate tool
Assessment Outputs	Youth with open behavioral health files or with screening scores indicating BH risk receive comprehensive MH screening. Youth with behavioral health issues on the unit are referred for screening and assessment	Number and demographics of youth with open BH files Number and demographics of detained youth without BH files who received screening score indicating BH risk Number of additional youth identified by detention unit staff as needing MH assessment (due to disclosed suicidal ideation, threats or other BH crisis) Number and demographics of youth receiving comprehensive MH screenings
Crisis Intervention Outputs	Youth who are in crisis, disclose suicide ideation, or threaten suicide receive crisis intervention	Number and demographics of youth placed in a safety room for observation and crisis intervention services
Behavioral Health Interventions Outputs	Youth whose assessment indicates need are provided evidence-based and promising MH services, such as medication management, individual or group treatment, collateral, case management or rehabilitation.	Number and demographics of youth who receive each type of mental health service. Number of units of mental health service provided.
Individual Outcome	Youth released from custody to the community with identified SED receive BH services and supports following release or transfer	Number and demographics of youth who receive at least one follow up intervention or treatment following release from custody Number and demographics of youth diagnosed with SED who continue to receive treatment 3 months following release

8. Suicide Prevention

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

Component	Desired Outcomes	Measures
YR Outputs	12 schools participate in YR 35 school employees will be identified as "safe adults" and display Yellow Ribbon resource cards 600 students receive YR messaging 90 youth will be trained in YR per year	Number of schools participating in YR Number of adults and youth trained as YR trainers Number of children who receive YR messaging Number of youth trained in YR
QPR Outputs	15 school district personnel will be trained as QPR instructors 225 school personnel will be trained as QPR gatekeepers	Number of personnel trained as QPR instructors Number of district personnel trained as QPR gatekeepers Number of schools/districts with QPR gatekeepers
safeTALK Outputs	36 youth receive safeTALK training	Number of youth receiving safeTALK training
Individual Outcomes	Individuals receiving YR, QPR and safeTALK show: • Increased recognition of suicide risk and • Increased knowledge in responding to suicide risks	Scores of pre and post training surveys
Population Outcomes	Increase in students seeking help for mental health related concerns Decrease in incidents of self-harm, suicide attempts, and suicide.	Number of students who seek help through trained, school-based responders. Number of students within participating schools who are seen by emergency or crisis services for suicidal behaviors.
	Reductions of student reported: • Serious consideration of a suicide attempt and • Experiences of sadness and hopelessness leading to reduction of usual activities	Pre and post scores on CHKS for 9th and 11th graders at participating schools. 13/14, 5/16 school years
System Outcomes	Improve timely access to treatment for individuals at risk of suicide	Number and demographics of individuals at risk of suicide referred for mental health assessment and treatment

9. PEI Capacity Building

Project Goal: *The project will improve access to services by strengthening the capacity of organizations to provide consistent, high-quality behavioral health services, including evidence-based practices.*

Component	Desired Outcomes	Measures
System Outcomes	Programs complete purchase by May 31, 2015.	Funds expended as planned.
	Programs show demonstrated increase in capacity through purchase.	Narrative summary of how purchase has increased program capacity.
	Within one year of purchase organization will show an increase capacity for individuals at risk of developing, or, those with serious emotional illness, to the timely access to high-quality services	Program will meet stated objective to increase timely access in service

Appendix

1. Board of Supervisors Resolution
2. 2014 PEI Evaluation of the Empowering Youth and Families Project
3. Workforce Education and Training Assessment of Needs
4. Community Program Planning Process, Outreach Materials and Public Comments

This page deliberately left blank.

Please insert the Board of Supervisors Resolution here.

Evaluation of Empowering Youth and Families, an MHSA PEI Project

Table of Contents

BACKGROUND

In Fiscal Year 2012/13, San Joaquin County Behavioral Health Services (BHS) and contract providers delivered a variety of Prevention and Early Intervention (PEI) services and supports. PEI programming is made possible by MHSA funding, and PEI objectives and projects were developed through extensive stakeholder involvement in MHSA program planning. During the Community Program Planning (CPP) process that resulted in the PEI 3-Year Program and Expenditure Plan, stakeholders recommended evaluating the PEI programs that comprise the *Empowering Youth and Families Project*. These programs are delivered primarily in natural settings, and include:

Prevention Programs for High Risk Youth

1. City of Stockton: Operation Peacekeeper
2. City of Tracy: Community Youth Support Network
3. Women's Center

Screening and Early Intervention Programs

4. San Joaquin County Office of Education Partnership
5. San Joaquin County Foster Care Services Partnership
6. San Joaquin County Probation Partnership

Prevention Programs for Parents or Guardians

7. Child Abuse Prevention Council
8. El Concilio "Padres Para El Futuro"
9. Catholic Charities
10. Community Partnership for Families
11. Parents by Choice

While the San Joaquin County PEI Plan developed in 2009 provided program formats and potential program outcomes, it did not emphasize the use of evidence-based practices or pre- and post-measures. Therefore this evaluation was based on a review of contractually-required data collection reported to the County by each program.

EVALUATION OBJECTIVES

PEI program planning for Fiscal Year 2014/15 and beyond will focus on developing new programs and conforming existing programs, when possible, to new statewide regulations. To support program planning, BHS wishes to assess the performance of programming during Fiscal Year 2012/13 to better understand:

- What were the successful outcomes of PEI services and supports?
- What were the strengths of the service delivery models?
- What were the challenges of the service delivery models?
- What were some of the barriers to success?
- What are the recommendations for improving programming and outcomes?
- To what degree were the programs designed and implemented to achieve the original Empowering Youth and Families Project goals?
- What were some of the successes and challenges associated with reporting and evaluation, which can inform future PEI evaluation efforts?

Findings from this evaluation will be used to develop and improve PEI planning, implementation and evaluation efforts for Fiscal Year 2014/15 programming.

Evaluation Method

For this first PEI evaluation, BHS focused on data derived from program self-reporting, particularly the annual reports provided by program managers. The evaluator identified overall project goals and objectives and individual program goals and objectives from contractual agreements between BHS and service providers. A review of fourth quarter annual reports identified the extent to which programs met their objectives. Limitations to this method are clear; there was no external validation of data. However, the evaluation method intends to provide a baseline of understanding of program outputs, such as numbers served, and outcomes, such as proportion of those served avoiding criminal justice recidivism; and perhaps more importantly, provides an understanding of the challenges and opportunities for designing effective reporting, monitoring and evaluation tools for future PEI programming.

Report Structure

This report will include a brief discussion of the overall Empowering Youth and Families Project goals. The report will examine the degree to which the individual programs contribute to the broad goals described in the Three Year Program and Expenditure Plan. The report will include a brief discussion of opportunities for improving evaluation methods, data collection, monitoring, analysis and reporting.

Finally, for each PEI program this report will include the following:

- A program description, typically excerpted from FY 2012/13 contract language
- A simple program logic model describing intended inputs, activities, and expected outputs and outcomes.
- A brief description of program outputs and outcomes achieved, as reported by program staff
- An analysis of the degree to which outputs and outcomes achieved target objectives
- A discussion of facilitators and/or barriers to program success, as reported by program staff

PROGRESS MADE TOWARDS MEETING PEI 3-YEAR PROGRAM AND EXPENDITURE GOALS

The initial PEI Plan identified the following overarching goals for the Empowering Youth and Families Project:

1) Improve access to short-term mental health counseling and other early interventions supports for children and youth with juvenile justice involvement
2) Improve access to comprehensive case management and other early intervention supports for high-risk youth and Transition Age Youth (TAY).
3) Improve access to comprehensive community-based supports for TAY, TAY parents, and other high-risk parents

1. Improve access to short-term mental health counseling and other early interventions supports for children and youth with juvenile justice involvement

The Mentally Ill Offender Crime Reduction Program and Mental Health for Youth At Risk of Juvenile Justice Involvement demonstrated some success in improving access to mental health services for children and youth with or at-risk for juvenile justice involvement. For example, 1,232 detained youth (95.6%) received evidence-based mental health screenings upon entry into the JCC. Of those, 100% who showed concerning markers received a comprehensive mental health assessment and completed treatment provisional plans. Additionally, 100% of those assessed as needing psychiatric evaluations and substance abuse treatment received indicated services.

The Mental Health for Youth At-Risk of Juvenile Justice Involvement program also demonstrated that it provided mental health counseling and other early interventions. The program completed 129,600 minutes of Medi-Cal reimbursable mental health services including mentorship, intensive individual and family therapy and referrals.

2. Improve access to comprehensive case management and other early intervention supports for high-risk youth and TAYS

The Mental Health for Youth At Risk of Juvenile Justice Involvement showed strong outcomes associated with increasing school participation and attendance. Measures related to school attendance and participation are important indicators of increases in the types of protective factors that mitigate risks associated with serious emotional disturbances in children and potential escalation of serious mental illness..

The Foster Youth Services program improved access to case management as well as early intervention supports. Over five hundred (542) youth received screening, of which greater than 10% (74) received a comprehensive trauma screening and clinical assessment using UCLA's PTSD Index. All youth with significant findings were referred for additional services.

Other programs described as providing case management services to at-risk youth include Operation Peacekeepers and City of Tracy's Mayor's Community Youth Support Network, showing strong outcomes associated with mentoring, including new conflict resolution and anger management skills and reduced recidivism. The Women's Center Outreach and Intervention program demonstrated a caseload of over 30 youth with "underlying and unresolved mental health issues" who received case management. Additionally, the program reported that 82% of participants reported improvements in symptoms of fear, anxiety, anger and depression.

3. Improve access to comprehensive community-based supports for TAYS, TAY parents, and other high-risk parents

Over 4,000 at-risk children, youth, and their families received a range of prevention and early intervention services. While this figure represents a small portion of the overall need within the County, it does begin the significant work needed to provide mental health prevention and early intervention services within community-based settings. Overall contracted program partners have built local agency capacity to address mental health issues. Anecdotally, project managers report that their outreach efforts have increased their awareness on the importance of addressing stigma and discrimination towards the mentally ill and have heightened their commitment to reducing other barriers and misperceptions that prevent individuals from seeking timely mental health supports and interventions.

Organization	Target	Totals served
City of Stockton: Operation Peacekeeper	High-risk youth	199
City of Tracy: Community Youth Support Network	High-risk youth	407
Women's Center	High-risk youth	375
San Joaquin County Office of Education Partnership	Youth at County-operated ONE Schools	307
San Joaquin County Foster Care Services Partnership	Children and Youth referred for a Family Dependency Court Proceeding	542
San Joaquin County Probation Partnership	Youth booked into the Juvenile Justice Center	1,232
Child Abuse Prevention Council	Parents or Guardians	161
El Concilio "Padres Para El Futuro"	Parents or Guardians	153
Catholic Charities	Parents or Guardians	131
Community Partnership for Families	Parents or Guardians	454
Parents by Choice	Parents or Guardians	153
Total: Children, Youth, and Families Served		**4,114**

EVALUATION FINDINGS AND RECOMMENDATIONS

This evaluation represents San Joaquin County's initial step towards quality evaluation of PEI programs. A great deal was learned from the evaluation process that will inform future efforts. Specific recommendations for future evaluations are:

- Performance objectives should be clear and measurable, differentiating between those which measures are process-oriented – those that the program has direct control over – and which are outcome oriented – those that should be achieved if the program adheres to evidence-based, promising, or community-based practice standards. The evaluator recommends establishing specific performance standards for outputs (i.e., expectations of numbers served) which programs have direct control over, and directional standards for client or system-level outcomes (i.e., reduction in prolonged suffering, improvements in protective factors, etc.).

- Develop system-level and program-level capacity for collecting accurate data. BHS can help programs collect and report client-level, rather than aggregate data by developing simple HIPAA-compatible excel spreadsheets or databases to track each participants' engagement and pre- post- scores. The evaluator can work directly with program staff to accurately report data in a timely manner. The evaluator can also work with program staff to develop effective ways of capturing program successes and challenges, and other qualitative data that help explain quantitative outputs and outcomes.

- To the extent possible, PEI contracts should specify the exact measures, methods and tools that will be used in the evaluation, but should also include a description of the evaluation process and the expectation that program staff will work with the evaluator to improve evaluation processes. At the same time, the programs should be assured that the evaluator will provide timely analyses of data.

Evaluation of Empowering Youth and Families, an MHSA PEI Project

Welcome

APPENDIX

Prevention Programs for High Risk Youth

1. City of Stockton: Operation Peacekeeper
2. City of Tracy: Community Youth Support Network
3. Women's Center

Screening and Early Intervention Programs

4. San Joaquin County Office of Education Partnership
5. San Joaquin County Foster Care Services Partnership

Prevention Programs for Parents or Guardians

7. Child Abuse Prevention Council
8. El Concilio "Padres Para El Futuro"
9. Catholic Charities
10. Community Partnership for Families
11. Parents by Choice

6. San Joaquin County Probation Partnership

INDIVIDUAL PROGRAM ASSESSMENTS

BHS provided funding and / or program staff to eleven different organizations to implement the Empowering Youth and Families Project. Desired outcomes for each strategy area are listed below. Individual program summaries, strategic goals, and related outcomes are described below.

Strategies	Activities	Desired Outcomes
Prevention Programs for High Risk Youth	• Individualized mentoring • Wraparound support and case management • Skill-building classes • Positive recreation and socialization Experiences	• Increase protective factors ▪ Increased skills ▪ Increased school /program Participation ▪ Sustain in mentoring or program activities • Reduce violence, truancy, and justice involvement
Screening and Early Intervention Programs	• Universal and targeted screening • Use of evidence based screening tools • Brief and targeted early interventions • Referrals for mental health services	• Increase proportion of at-risk youth screened using evidence based tools • Increase efficacy of referrals for additional services
Prevention Programs for Parents or Guardians	• Parenting classes • Social-support programs • Leadership activities • Identify /strengthen family protective factors	• Parents and guardians will have an increased understanding of child / youth development • Parents and guardians will have better parenting skills including ability to manage family conflict / anger • Parents and guardians will have increased stability, decreased anxiety, and improved confidence in their parenting skills

1. Prevention Program for High Risk Youth: City of Stockton Operation Peacekeepers

Program description:

Operation Peacekeepers provides comprehensive outreach (relationship-building), engagement (field trips, activities, recreation), and mentoring (case management and support services) to youth, ages 16 to 24, who are experiencing or are at risk of homelessness, witnessing or experiencing or exhibiting violence, unplanned parenting, substance abuse, or gang involvement.

Participants are expected to learn positive ways to interact with peers and other adults, to control anger or disruptive behavior, and to develop positive interest and expectations for the future.

Operation Peacekeepers will provide case management and gender-specific support groups to participating youth to promote frank discussions and constructive dialogue about major issues and provide opportunities to learn new skills and approaches to resolving conflict.

The overall goal of the program will be to help give high-risk youth the supports and skills needed to reduce harmful or risky behaviors related to substance use, acceptance of violence, possible gang involvement, expectation of failure, and development or exacerbation of mental health issues.[4]

[4] Excerpted from program contractual agreement, scope of work, exhibit A

Operation Peacekeepers Program Logic Model

Inputs	Activities	Target Outputs	Target Outcomes
MHSA PEI funding	Outreach	250 high-risk youth participate in program activities (62.5/quarter)	80% of participants will not be arrested during participation in program
Culturally competent staff	Engagement	75% participate in mentoring	80% of participants will reduce school truancy rate during participation in program
Staff with lived experience	Mentoring	50% participate in classes or outings	75% of participants will learn new skills and approaches to resolving conflicts and achieving goals
Staff with training and education	Case management		
	Gender-specific support groups		

Program Highlights

Staff reported that in addition to mentoring, outreach, and violence prevention activities, Operation Peacekeepers facilitated Peacekeeper Advisory Group meetings with government agencies, community-based organizations, faith-based organizations, and members of the public to discuss youth violence and strategize ways to reduce the impact of violence. They facilitated CORE meetings with probation, law enforcement, and school personnel to discuss trends and events involving gang violence. Peacekeepers are active participants in the City of Stockton's operation Ceasefire Project to end gang violence, participating at Ceasefire "Call-ins" and conducting home visits to identified gang-involved youth looking for support and assistance in developing positive life pathways. Through MHSA funding Peacekeepers bring a trauma-informed approach to mentoring and family engagement work and use mentoring as an opportunity to encourage participation in additional behavioral health related supports and services.

Outputs and Outcomes

Target Outcomes	Q1	Q2	Q3	Q4	Overall
Outputs					
250 high-risk youth participate in program activities (62.5/quarter)	53	54	51	41	199
75% participate in mentoring	100%	85%	88%	98%	92%
50% participate in classes or outings	62%	111%	63%	54%	74%
Outcomes					
80% of participants will not be arrested during participation in program	89%	96%	86%	93%	91%
80% of participants will reduce school truancy rate during participation in program	74%	78%	76%	63%	73%
75% of participants will learn new skills and approaches to resolving conflicts and achieving goals	77%	78%	88%	98%	92%

Summary of Findings

Gang-involved youth require intensive mentoring and support to develop the protective factors required to develop in positive directions. Of the nearly 200 youth who participated in Stockton Peacekeeper mentoring and other support services, over 90% of them remained engaged i in the mentoring process and avoid further arrests. Additionally, school truancy rates decreased amongst nearly three-quarters of participants and 92% increased their anger management and conflict resolution skills.

2. Prevention Program for High Risk Youth: City of Tracy Mayor's Community Youth Support Network

Program description:

The City of Tracy Mayor's Community Youth Support Network (MCYSN) will provide comprehensive outreach, engagement, and mentoring to youth aged 16 to 24 years experiencing or at risk of violence, unplanned parenting, gang involvement, substance abuse and/or mental health issues.

Participants are expected to learn positive ways to interact with peers and other adults, to control anger or disruptive behavior, and to develop positive interest and expectations for the future. Participants will receive mentoring as well as opportunities to learn new skills and approaches for resolving conflicts.

The overall goal of the project will be to provide high-risk youth the supports and skills needed to reduce harmful or risky behaviors related to risk of homelessness, acceptance of violence, unplanned parenting, gang involvement, substance abuse and development or exacerbation of mental health issues.[5]

[5] Excerpted from program contractual agreement, scope of work, exhibit A

City of Tracy, Community Youth Support Network:
Comprehensive Youth Outreach and Early Intervention Logic Model

Inputs	Activities	Target Outputs	Target Outcomes
MHSA PEI funding	Develop network of community service providers	250 high-risk youth participate in program activities (62.5/quarter)	80% of participants will not be arrested during participation in program
City of Tracy coordination	Specific Services TBD	75% participate in mentoring	75% of participants will learn new skills and approaches to resolving conflicts and achieving goals
		75% participate in activities designed to engage youth	

Program Highlights

Smart Girls Program, administered by Boys and Girls Club of Tracy, addressed coping skills, dating violence, and self esteem. 182 youth graduated. Youth engaged in field trips to Santa Cruz Beach Boardwalk, Olive Garden Restaurants, Yosemite, and Mercer Caverns.

Peacemakers Program provided mentoring and intervention services on campus. In the 12/13 Fiscal Year, 59% of participants improved in one or more core classes; suspensions had been reduced; and youth development assets increased by 25%. Peacemakers implemented after school tutoring 2 afternoons per week as a result of the demand for one-on-one academic support.

Build Your Teen Tool Box provided psycho-educational support groups, resulting in an 87% youth-reported increase in self-esteem and 75% improvement in the ability to build and maintain relationships. Monolingual Spanish-speaking youth participated with the help of bilingual peer interpreters. Staff reported that non-English speakers participated in all activities without feeling left out and enjoyed making new friends. Participants reported appreciating de-stress techniques and meditation skill building.

Outputs and Outcomes

Target Outcomes	Q1 & Q2	Q3	Q4	Overall
Outputs				
250 high-risk youth participate in program activities	259	133	15	162%
75% participate in mentoring	100%	100%	100%	100%
50% participate in activities	100%	100%	100%	100%
Outcomes				
80% of participants will not be arrested during participation in program	100%	100%	100%	100%
75% of participants will learn new skills and approaches to resolving conflicts and achieving goals	97%	94%	91%	94%

Summary of Findings

In general, program participants in the Community Youth Support Network achieved targeted goals. However the strategy of providing services to school-age children and youth within schools and clubs resulted in fewer referrals during the final quarter of the year. Program staff explained that they were reluctant to engage new participants during the final quarter, and most outreach and enrollment during the first two quarters. Additional consideration may be needed as to how to sustain program involvement and identify at-risk youth during the fourth quarter.

3. Prevention Program for High Risk Youth: Women's Center Youth and Family Services

Program Description

As a community partner, Women's Center Youth & Family Services will provide Comprehensive Youth Outreach and Early Intervention services on behalf of Behavioral Health Services (BHS) by providing outreach, engagement and mentoring services in a culturally competent manner for San Joaquin County youth and young adults ages 16-24 who are identified with underlying and unresolved mental health issues.

Outreach: Contractor will provide comprehensive outreach to youth and young adults, and organizations that serve these clients and the community that embraces them as a whole. Outreach services will include community based outreach and education, access and transportation services, individual assessments, prevention and education activities, information and referrals, crisis intervention and follow-up support.

Engagement: Contractor will provide recreation opportunities and classes that will help build interest among youth and young adults in participating in program activities that will strengthen the relationship between participants and program staff. Contractor will provide opportunities for participants to engage in positive activities under the supervision of a caring adult.

Mentoring: Contractor will provide extensive mentoring services for at-risk youth and young adults throughout San Joaquin County. Services provided are based on the Transition to Independence Model (TIP), an evidence-supported practice based on six published studies that demonstrate improvement in real-life outcomes for youth and young adults with emotional/behavioral difficulties. The Contractor will help prepare youth and young adults for their movement into adult roles through an individualized process, engaging them in their own futures planning process, as well as providing developmentally appropriate services and supports.

Cultural Competency: Contractor will provide services to youth, young adults, and their families in a culturally competent manner. Upon request, Contractor will provide evidence of cultural sensitivity training to their staff members

The overall goal of the program is to provide community outreach and case management to at-risk youth and young adults ages 16-24. The project is intended to provide early interventions for youth and adults for whom a purely prevention approach is no longer appropriate and for whom full scale mental health treatments are not clinically necessary. It serves to "fill in the gaps" of the existing mental health service delivery system by providing low level interventions for youth and adults with mild to moderate mental health issues. [6]

[6] Excerpted from program contractual agreement, scope of work, exhibit A

Women's Center Logic Model

Inputs	Activities	Objectives	Target Outputs	Target Outcomes
MHSA PEI funding	Outreach Engagement - recreation and classes Mentoring - Using Transition to Independence (TIP) model.	Increase service provision to at-risk youth and young adults through outreach and community awareness activities	Outreach occurs in 25 locations and seven cities 230 youth served in FY 12/13 60% of youth referred to appropriate community resources	
		Increase interest among youth and young adults in participating in program activities that strengthen the relationship between participants and program staff	Program maintains caseload of 30 participants 60% of participants attend one non-recreational class 30% of participants referred to mentoring program	
		Reduce the likelihood of risky behaviors and mental health impact (fear, anxiety, anger and depression) through mentoring services	30 Mentoring participants receive case management 60% of participants attend support group	60% of participants report feeling less fear, anxiety, anger, depression

		Increase school participation and engagement		15% of un-enrolled participants enroll in education program 60% of participants in an education program will show an increase in a class grade by at least one level
		Increase the ability for at-risk youth and young adults to obtain and retain gainful employment		60% of participants engage in one employment skill activity 50% of participants report an increase in confidence that he/she has the skills to obtain employment 15% of participants obtain part or full time employment.

Program Highlights

All contacts received mentoring referrals. Many active clients participated in non-recreational classes. The most popular class was “Right Choices,” which focused on problem solving and decision making skills. Another class, “Making Relationships Work,” educated youth on healthy relationships. Other activities included digital photography and music mixing. Youth participated in recreational activities including movie days, BBQs, and tours of museums, including the Exploratorium in San Francisco. The program continued to foster relationships with a variety of community partners, including Office of Education, Probation, Human Service Agency, and Behavioral Health, and participated in Ceasefire “call-ins” at Stockton Police Department and Peacekeeper meetings.

Outputs and Outcomes

Target Outcomes	Q1	Q2	Q3	Q4	Overall
Outputs					
Outreach occurs in 25 locations and seven cities	50	33	34	31	148
230 youth served in FY 12/13(<60/quarter)	87	61	113	114	375
60% of youth referred to appropriate community resources	100%	100%	100%	100%	100%
Program maintains caseload of 30 participants (per quarter)	31	34	36	35	34
60% of participants attend one non-recreational class	81%	62%	61%	63%	66%
30% of participants referred to mentoring program	100%	100%	100%	100%	100%
30 Mentoring participants receive case management (30 individuals receive mentoring services)	25	33	36	35	129
60% of participants attend support group	81%	62%	100%	100%	86%
Outcomes					
60% of participants report feeling less fear, anxiety, anger, depression	90%	82%	67%	96%	82%
15% of un-enrolled participants enroll in education program (Unique individuals who enrolled in an educational program)	16%	59%	64%	43%	46%
60% of participants in an education program will show an increase in a class grade by at least one level	20%	5%	17%	73%	27%
60% of participants engage in one employment skill activity	65%	56%	75%	66%	65%
50% of participants report an increase in confidence that he/she has the skills to obtain employment	95%	44%	64%	96%	72%
15% of participants obtain part or full time employment.	10%	29%	22%	40%	26%

Summary of Findings

Overall the Women's center provided services to 375 transitional age youth, 60% more than target objectives. All youth served were provided with resources to additional community resource and a third received intensive mentoring services.

4. Screening and Early Intervention Program: San Joaquin County Office of Education Partnership:

Program description

San Joaquin County Office of Education will provide services to address the needs of youth involved in the juvenile justice system and youth at risk of juvenile justice attending the County Operated Schools Program (COSP) and San Joaquin County school districts. Best practices approaches will serve as common threads to counseling and therapy services while crafting individual case plans to meet the unique needs of at-risk and juvenile justice involved students. A two-tiered approach will be used to support students. Probation Assistants and school counselors will work collectively to identify students and serve as a nexus for support and encouragement. Using the Asset Development model, they will serve as positive, caring adult role models; the number one predictor of positive student/school connectedness. Students with more intensive mental health needs will be bridged through counselors, probation assistants, teachers or school nurses to licensed clinicians who will provide therapeutic services.

Licensed Clinicians (Licensed Clinical Social Workers and/or Licensed Marriage and Family Therapists) from external counseling agencies or through independent contracts will bed to provide more intensive individual and family therapy services. If non-licensed clinicians are used, the Office of Education will appoint a Licensed Clinician as the Head of Services, who will supervise and oversee the work of the non-licensed clinicians. All non-licensed clinicians must possess waivers from the California Board of Behavioral Sciences.

Licensed Clinicians will work with probation assistants, teacher, school counselors, school nurse and project director to provide students who need more intensive services. Students who demonstrate greater mental health needs beyond the capacity of the aforementioned services, i.e., substance abuse or suicidal behavior, will be referred to appropriate settings where their needs may be addressed.

The overall goals of the project are:

1) *Increase probation completion rates by students who are concurrently enrolled in COSP or neighboring school districts, receiving counseling services through this program, and are involved in the Juvenile justice system*
2) *Increase school attendance of at risk students who are receiving counseling and/or therapy.*
3) *Reduce recidivism rates of students who are concurrently enrolled in COSP or neighboring school districts and are involved in the Juvenile Justice system and participating in therapy or counseling program.*

4) *Increase school participation as measured by homework completion, classroom involvement and other school based activities as reported by teachers, counselors or licensed clinicians.*[7]

Mental Health for Youth At Risk of Juvenile Justice Involvement Logic Model

Inputs	Activities	Target Outputs	Target Outcomes
MHSA PEI funding	Identification of students attending County-operated schools who are at-risk or juvenile justice involved.	129,600 in Medi-Cal reimbursable mental health services	25% of students receiving counseling or therapy services will have an increase in school attendance.
Licensed Clinicians	Provision of intensive individual and family therapy services.		25% of students receiving counseling or therapy services will have an increase in school participation.
Probation Assistants	Referrals to other intensive services as needed.		

Program Highlights

Staff report that they have significantly increased reimbursable services this year. Meetings between County Office of Education and Behavioral Health Services have resulted in fewer case notes, treatment plans and assessments requiring revision.

[7] Excerpted from program contractual agreement, scope of work, exhibit A

Outputs and Outcomes

Target Outcomes	Q1	Q2	Q3	Q4	Overall
Outputs					
129,600 minutes of Medi-Cal reimbursable services	30,013	45,495	49,703	48,734	173,945
Outcomes					
25% of students receiving counseling or therapeutic services will have increase in school attendance	83% (71/86)	85% (84/99)	79% (83/105)	81% (95/117)	82% (333/407)
25% of students receiving counseling or therapeutic services will have an increase in school participation (n = number of responses not number of students)	87% (75/86)	74% (61/82)	80% (64/80)	73% (43/59)	79% (243/307)

Program Findings

This program was originally intended to serve children/youth on active probation supervision. Due to changes in Probation practices, to reflect evidence-based guidelines on using assessments to determine need for active probation, far fewer youth in San Joaquin County are now receiving the same type of "formal" supervision as was indicated at program development. Instead this program shifted the population focus to youth, identified by schools or probation assistants, as being at-risk of further law-enforcement contact and in need of mental health support services. Over time this unique partnership has resulted in over 300 at-risk children and youth receiving counseling and therapeutic services with approximately 80% of participants showing positive outcomes regarding school attendance and participation – a success rate significantly higher than originally anticipated, and closely linked to the protective factors that mitigate mental health related concerns.

5. Screening and Early Intervention Program:

San Joaquin County Behavioral Foster Care Partnership

Program Description

Foster Youth Services begin with a screening by Child Welfare Social Workers of all children and youth newly detained in the family dependency court system. The Child Welfare Social Workers use a brief screening tool to identify risk factors and triage immediate needs, and refer identified children to a BHS clinician for a comprehensive assessment. The assessment includes gathering a complete developmental and trauma history of each child or youth and the administration of the UCLA PTSD Index. The PTSD Index determines the severity of PTSD symptoms and the significance of individual criteria, as identified in the DSM-IV-TR. Youth with clinically significant scores on the PTSD Index are referred to Trauma Focused Cognitive Behavioral Therapy (TF-CBT) or other mental health services (e.g., individual therapy, rehabilitative services, and case management).

Foster Youth Services Logic Model

Inputs	Activities	Target Outputs	Target Outcomes
MHSA PEI funding	Triage and referral for assessment by child welfare social worker	# of foster youth triaged	
Child Welfare Social Workers	Comprehensive assessment by BHS clinician	# of youth who receive comprehensive assessment	
BHS Clinical Staff	Development of treatment recommendations and referrals	# of youth who receive direct mental health services as identified through assessment	
	Trauma-focused cognitive behavioral therapy		
	Other behavioral health services, including individual therapy, rehabilitative services and case management		

Outputs and Outcomes

Target Outcomes	Q1	Q2	Q3	Q4	Overall
Outputs					
# of foster youth triaged	111	137	156	138	542
# of youth who receive comprehensive assessment	10	14	39	11	74
# of youth who receive direct mental health services as identified through assessment	n/a	n/a	n/a	n/a	150

Program Findings

This program was launched in 2014 in a response to the State of California Katie A Initiative. Overall the program has resulted in closer ties between BHS and Foster Care services with nearly all foster care youth triaged for mental health services. Of the 542 youth receiving triage services, 74 received a comprehensive assessment for a serious emotional disturbance or serious mental illness from a BHS clinician stationed within the Foster Care Services unit and 150 received mental health services as a result of triage and assessment activities.

6. Screening and Early Intervention Program: San Joaquin County Probation Partnership

Program Description

BHS provides early intervention services to youth placed at the Juvenile Justice Center (detention center). A team of Clinicians (4 FTE), Mental Health Specialists (2 FTE), Licensed Psychiatric Technician (1 FTE), Supervisor (1 FTE) and Psychiatrist (8 hours per week) deliver a broad array of mental health services including screening, assessment, individual and group treatment, rehabilitation services, crisis intervention, psychiatric evaluation, and medication management.

All youth are screened for mental health and substance use issues at the time of detention using MAYSI-2, a self-administered computerized screening tool. Those with high-risk scores receive a mental health assessment and possible psychiatric referral. These minors get recorded in triage book. If somatic complaints are scored within the Warning Range, the mental health clinicians refers the minor to the Juvenile Hall health Clinic for further evaluation. A minor who scores high for Suicide Ideation is considered in crisis and treated under the procedures of the BHS CYS JJC Suicide Prevention. Minors who score in the Caution or Warning Range for substance abuse are referred to the CYS substance abuse counselor. Upon proper notice of a minor's release from Juvenile Hall, the clinician may make a referral to CYS Outpatient Services for continuity of services.

In addition, the program offers evidence-based Aggression Replacement Training and Cognitive Behavioral Therapy groups.

Mentally Ill Offender Crime Reduction Program Logic Model

Inputs	Activities	Target Outputs	Target Outcomes
MHSA PEI funding	Screening upon detention at Juvenile Justice Center using MAYSI-2	100% of youth booked at JCC will receive MAYSI-2 screening	N/A
4 FTE Clinicians	Clinical assessment for those with high-risk scores	100% of youth who receive MAYSI-2 screening indicating concerning markers will receive an assessment and be recorded in triage book	
2 FTE Mental Health Specialists	Psychiatric evaluation and crisis intervention	100% of youth who are recorded into triage book will have a provisional treatment plan	
1 FTE Licensed Psych Tech	Medication management	100% of youth identified during the assessment needing a psychiatric evaluation received a psychiatric evaluation	
1 FTE supervisor	Individual and group treatment using ART and CBT	100% of youth identified during the assessment needing SAS get referred to CYS substance abuse counselor	
.2 FTE Psychiatrist	Rehabilitation services		
Evidence Based treatment models: ART & CBT	Referrals, including substance abuse treatment, health clinic, etc.		
	Referral to Outpatient Services, as appropriate, upon release		

Program Highlights

- The Mentally Ill Offender Crime Reduction Team (BHS CYS JCC) is housed at the Juvenile Justice Center. BHS CYS JCC provides services during business hours, after hours and weekends.
- Collaboration on the use of the safety room occurred among BHS CYS JJC, JJC Detention, and SJC Correctional Health staff to ensure youth with suicidal ideation get appropriate evaluation and monitoring referrals.
- BHS CYS JJC collaborated with BHS CYS Crisis Team, BHS Crisis Team (after hour) and JJC Detention staff to develop a crisis policy that ensures that minors who are evaluated by the Crisis Team do not have to return to the safety room.
- BHS CYS JJC psychiatric staff collaborated with the SJC Correctional Health staff to develop procedures for monitoring the side effects of psychotropic drugs.
- BHS CYS JJS collaborated with SJC Correctional Health staff to develop and implement after hours and weekend psychiatric medications procedures and 24/7 psychiatrist on-call coverage.
- Suicide prevention planning has been effective in preventing suicides, as evidenced by the reduction in safety room placements, number of hours the minors stayed in the safety room, and no completed suicides during the fiscal year.
- Detained minors reporting suicide ideation, plans, means and intention are monitored closely, and BHS CYS staff prepare the crisis management plans to manage suicidal gestures and behaviors, and assist the custody staff.

Outputs and Outcomes

Target Outcomes	Q1	Q2	Q3	Q4	Overall
Outputs					
100% of youth booked at JJC will receive MAYSI-2 screening.*	316	263	341	312	95.6% 1232/1289
100% of youth who receive a MAYSI-2 screening indicating concerning markers will receive an assessment and be recorded in triage book.	100% 154/154	100% 144/144	100% 146/146	100% 170/170	100% 614/614
100% of youth who are recorded into triage book will have a provisional treatment plan.	100% 154/154	100% 144/144	100% 146/146	100% 170/170	100% 614/614
100% of youth identified during the assessment as needing a psychiatric evaluation received a psychiatric evaluation.	100% 31/31	100% 17/17	100% 29/29	100% 27/27	100% 104/104
100% of youth identified during the assessment as needing SAS get referred to CYS substance abuse counselor.	100% 18/18	100% 12/12	100% 20/20	100% 19/19	100% 69/69
Outcomes					
n/a	n/a	n/a	n/a	n/a	n/a

* Note: Not all youth complete the full booking process. Those that are booked and released without being admitted to the Juvenile Justice Center will not receive a screening.

Program Findings

Nearly all youth booked into JCC receiving a screening (95.6%), however staff report that they are developing a plan with Probation to ensure that 100% of youth are being screened. Additional BHS and Probation are also jointly exploring additional screening tools including trauma screening and a girl's health screening. All youth who screen positively receive a longer mental health assessment and, depending on findings by the clinician, are linked to additional community-based or mental health programming upon release.

While screening is one avenue for identifying youth mental health concerns, much of how screenings are scored is based on youth self-report and there are significant limitations in relying on screening alone. BHS is working with the detention and mental health staff to develop better trainings to identify and refer youth for assessment outside of the booking process. Additionally BHS is implementing new practices to treat youth with PTSD related to exposure to trauma and are exploring opportunities for evidence-based programming within JJC.

7. Prevention Programs for Parents and Guardians: Child Abuse Prevention Council "Parent Cafés":

Program Description

The Child Abuse Prevention Council (CAPC) will implement a strategy called "Parent Cafés" designed to assist high-risk parents in improving functioning and reducing anxiety, anger, and depression. This [is a] culturally sensitive approach to mental health prevention for children and youth that focuses on stabilizing families.

Parent Cafés will incorporate the research-based 'Strengthening Families" approach to building protective factors in families through an innovative method of parent support groups that explore questions and create solutions tailored to individual neighborhoods. The Parent Cafés are designed to facilitate conversations among parents about keeping their families strong.

Parent Cafes will work with families to build six protective factors: 1) parental resilience; 2) social connections; 3) knowledge of parenting and youth protective factors; 4) concrete support in times of need; 5) children's social and emotional development; and 6) healthy parent-child relationships.

This strategy is also a mechanism for the emergence and training of neighborhood and/or parent leaders who can continue the Parent Café after the CAPC has laid the groundwork.

Each Parent Café will consist of an average of 30 weekly sessions lasting approximately two hours in length. Each session will focus on exploring one or more protective factors. Services will be provided at locations including schools, community centers and churches. Childcare will be made available on an as needed basis. Program staff who speak the languages of the identified participating community will be available to assist with translation services as needed.

The overall goal of this agreement is to improve functioning and reduce anxiety, anger and depression among high-risk parents.[8]

[8] Excerpted from program contractual agreement, scope of work, exhibit A

Child Abuse Prevention Council "Parent Cafés" Logic Model

Inputs	Activities	Target Outputs	Target Outcomes
MHSA PEI funding	Parent support groups (e.g., Parent Cafés)	15 Parent Cafés in high-risk communities	80% of parent participants report increased ability to manage conflict and appropriately handle anger
Evidence-based "Strengthening Families" approach	30 weekly sessions lasting two hours, each focusing on one or more protective factor	150 participating high-risk youth and adults	80% of parent participants report increased knowledge of parenting and youth protective factors
	Translation services, as needed	150 Resource sheets created for each Café cohort based on identified needs of participants	
	Childcare, as needed		

Program Highlights

During the summer, Parent Cafés transitioned from being predominantly school-based to predominantly held in community centers, shelters, and parks. Cafés were held in Stockton, Lodi, Manteca, and Tracy. CAPC conducted extensive outreach to ensure summer participation. Curriculum was modified to better assist the needs of these parents.

Outputs and Outcomes

Target Outcomes	Q1	Q2	Q3	Q4	Overall
Outputs					
15 Parent Cafés in high-risk communities	8	0	8	5	21
150 participating high-risk youth and adults	165	259	421	226	1071
Discharged during quarter	16	14	245	176	451
Completed program during quarter	16	14	67	64	161
150 Resource Sheets created for each Café	n/a	n/a	n/a	n/a	172
Outcomes					
80% report increased ability to manage conflict and appropriately handle anger	100%	100%	85%	89%	89%
80% report increased knowledge of parenting and youth protective factors	100%	100%	85%	89%	89%

Program Findings

In the initial program design, CAPC proposed hosting 15 parent cafes, targeting approximately 10 high-risk youth and young adult within each café group. These numbers were exceeded due to demand. Twenty-one parent cafés were convened with over 1,000 participants informed of and touched by parent café convenings. Of the individuals that participated intensively, nearly 90% reported strong outcomes as a result; increasing their ability to manage conflicts and having a better understanding of youth protective factors and the skills necessary to be better parents.

8. Prevention Programs for Parents and Guardians: El Concilio "Padres Para El Futuro"

Program Description

El Concilio will provide "Padres Para El Futuro," a comprehensive family support program for mono-lingual Spanish speaking or bi-lingual transitional age young adults, ages 18-25 living within the City of Manteca.

The program will offer a safe environment for Latino transitional age young parents to identify trauma and its consequences and to protect the participants and their families from further trauma. The program is designed to work with young Latino parents to reduce stress, teach coping skills and life skills, and to improve self-esteem and well-being.

The program will conduct outreach at the 16 elementary schools within the City of Manteca and will target parents of elementary English Learners. A special focus will be on outreach to the eight feeder schools to Manteca High School. The program will specifically address the cultural, ethnic and linguistic needs of the Latino students within Manteca High School.

The program will provide participants with Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT), an evidence-based practice demonstrated to reduce behavioral problems, and to decrease symptoms of depression in children, young adults and adults.

The program will coordinate monthly "Family Fun Nights" at rotating sites, which will consist of activities designed to foster positive relationships between parents and children such as art, active recreational activities and movie nights that promote the Latino culture.

The program will link participants to available community resources and provide comprehensive support services for the participating parents and families. Community resources and Support services for parents and families will include the following:

1. *Case management and family counseling*
2. *Anger management, support groups and coping skills*
3. *Parenting classes, child development classes, and supports for parents with developmentally challenged children*
4. *Job readiness, job training and other employment related classes,*
5. *GED preparation, English as a second language, citizenship classes and other educational classes*
6. *Mentoring*
7. *Parent/child activities, including active3 recreational activities.*

The overall goal of the program will be to provide a safe environment for Latino transitional age young parents to identify trauma and its consequences and to protect the participants and their families from further trauma.[9]

El Concilio "Padres Para El Futuro" Logic Model

Inputs	Activities	Target Outputs	Target Outcomes
MHSA PEI funding	Outreach at 16 elementary schools, and 8 feeder schools to Manteca High School	135 Spanish-speaking parents, 18-25 receive outreach at 16 elementary schools	75% of participating parents report reduced behavioral problems, including use of violence
Evidence-based "Trauma-Focused Cognitive Behavioral Therapy" (TF-CBT) approach	Trauma-Focused Cognitive Behavioral Therapy	135 Spanish-speaking TAY parents receive TF-CBT	75% of participating parents report reduced incidences of depression, anger, fear and/or anxiety
	"Family Fun Nights"	50% of participating parents and families receive comprehensive support services	
	Linkages to community resources		
	Comprehensive support services including case management, anger mgmt., support groups, parenting classes, job training, educational classes, mentoring		

[9] Excerpted from program contractual agreement, scope of work, exhibit A

Program Highlights

During the fourth quarter, the program sponsored monthly Family Fun Nights, which included refreshments, a short discussion of the importance of making time for the family, and participatory games to promote positive family interactions and positive feelings towards the Latino culture. During the quarter, El Concilio received a grant from Comcast Foundation to provide computer classes and education about the role of technology in children's and family life.

Outputs and Outcomes

Target Outcomes	Q1	Q2	Q3	Q4	Overall
Outputs					
135 parents, 18-25, receive outreach	44	75	5	23	147
135 parents, 18-25, receive TF-CBT	28	39	18	14	99
50% of participating parents and families receive comprehensive support services	22	19	55	65	161
Outcomes					
75% of participating parents report reduced behavioral problems, including use of violence	28	39	55	14	136
75% of participating parents report reduced incidences of depression, anger, fear and/or anxiety	28	39	55	14	136

Program Findings

This program was originally designed for Spanish-speaking parents. Over time, and in response to local needs, the program direction shifted to allow access to programming for local parents and families who could most benefit from services, regardless of the primary language. BHS and the program are discussing the challenges in reaching out to monolingual Spanish-speaking families and new outreach efforts include a plan to reach out to school counselors, Planned Parenthood, Manteca Library, WIC and CalWORKS offices, and to other high schools in Manteca, Lathrop, French Camp, and East Union, and Head Starts in Manteca, French Camp, and Lathrop.

9. Prevention Programs for Parents and Guardians: Catholic Charities Parent Support:

Program Description

Catholic Charities will implement the Nurturing Parenting Program (NPP), an evidence-based parenting program for high-risk parents age 18 and over, in geographically and culturally diverse parishes of San Joaquin County.

The NPP curriculum is a family centered initiative designed to build nurturing parenting skills as an alternative to abusive and neglectful parenting and child-rearing practices. The program is designed to respond to the needs of the following populations:

- *Families in need of treatment for child abuse and/or neglect*
- *Families that are considered high risk for child abuse and/or neglect*
- *Families seeking to improve their parenting skills*

The ten-week program will be made available free of cost to the target population through the Catholic Charities' existing network of parishes across San Joaquin County beginning with sites in the cities of Lodi Stockton, and Tracy.

Through case management, the Catholic Charities' Parents Support Project will provide the participants access to community resources to address their basic needs and for other stress factors affecting the family.[10]

[10] Excerpted from program contractual agreement, scope of work, exhibit A

Catholic Charities' Parent Support Program Logic Model

Inputs	Activities	Target Outputs	Target Outcomes
MHSA PEI funding	Outreach and engagement	Six 10-week programs over the course of 15 months	80% of parent participants demonstrate significant improvements in parenting skills
	10-week Nurturing Parenting Program	25 participants per program = 150 participants complete program over 15 months	80% of parent participants report improved anger management and conflict mgmt. skills
	Case management		80% of parent participants report improvements in their child's school behavior
			80% of parent participants will report no or reduced levels of their children's involvement with law enforcement

Program Highlights

Staff reported that NPP was offered in Stockton, Lodi, and Lathrop, and that case management and other unspecified services were provided in Stockton and Lodi. In the fourth quarter, 20 participants received assessments for basic family needs, including prenatal care, health services, senior services, counseling services, nutrition services, Immigration and legal Services, and social justice services. In the first half of 2013, the program made 62 referrals to community providers.

Outputs and Outcomes

Target Outcomes	Q1	Q2	Q3	Q4	Overall
Outputs					
125 high-risk parents complete Nurturing Parenting Program within 12 months	28	22	26	55	131
Outcomes					
80% of parent participants demonstrate significant improvements in parenting skills	93%	100%	96%	91%	94%
80% of parent participants report improved anger management and conflict mgmt. skills	93%	100%	96%	91%	94%
80% of parent participants report improvements in their child's school behavior	93%	100%	96%	91%	94%
80% of parent participants will report no or reduced levels of their children's involvement with law enforcement	93%	100%	96%	91%	94%

Program Findings

Staff reported that they are currently providing services at maximum capacity, and that there is an increasing interest amongst the (mostly Latino) parishioners in the Nurturing Parenting Program. Barriers associated with access to services, especially related to reliable transportation continues to affect participation. Inclement weather tended to affected participation rates, as many parents opted against walking or waiting in the rain for public transportation; underscoring the need for complex approaches when working within this community. Additionally, many Hispanic families return to their countries of origin during the winter, further reducing participation.

Further highlights, include reports that NPP has become so successful within their parishes that one Stockton parish plans to implement NPP as part of their Religious Education Program in Fiscal Year 2013/14. According to staff, the Parent Support Program has fulfilled a great need in the community, and is being received with “open arms”.

10. Prevention Programs for Parents and Guardians: Community Partnership for Families (CPF)

Program description

The Community Partnership for Families will implement a Comprehensive Family Support Program using an evidence-based strengthening approach and three-tier family support model to reduce harmful behavioral patterns and improve the well being of youth and families.

CPF will implement a program of outreach and relationship-building for parents ages 18 and over with mild to moderate mental health issues who would benefit from stress reduction, life and occupational skills, and supports that improve self-esteem and well-being. Services will be provided through CPF's Family Resource Centers.

The target population for the program is ethnically, linguistically and culturally diverse parents ages 18 and over with mild to moderate mental health issues and risks—and their families. The geographic target area consists of high need communities in Stockton, Lodi, Tracy, Escalon, Farmington, Manteca, Linden, Lathrop, French Camp, Acampo, and Mountain House.

CPF's case management process is a three-tier family support model used to assist and support parents in their role as caregivers. The three-tier family support model involves: 1) stabilization to support urgent, yet basic needs; 2) engagement through case management, enrichment classes, support group-s and recreation; and 3) involvement in a variety of uplifting community-oriented group activities e.g., volunteering, discussion forums, community organizing, and recreational events with positive themes such as promoting health, fitness, cultural diversity, etc.

The overall goal of this agreement is to reduce harmful behavioral patterns and improve the well-being of youth and families.[11]

[11] Excerpted from program contractual agreement, scope of work, exhibit A

Community Partnership for Families: Comprehensive Family Support Program Logic Model

Inputs	Activities	Target Outputs	Target Outcomes
MHSA PEI funding	Outreach	Outreach to 400 high-risk parents	
Evidence-based family strengthening approach and three-tier family support model	Tier I: Stabilization	120 families stabilized through Tier I of Family Support Model	80% report that basic needs have been met and that they experience reduced anxiety
	Tier II: Case management	32 families will be provided wraparound case management through Tier II of Family Support Model	80% of Tier II families will move from crises to stabilization in six months
	Tier III: Community involvement	16 families will actively participate in Tier III Involvement by learning about mental health issues and becoming involved in positive activities	

Program Highlights

Program staff report that there are ongoing barriers and challenges for clients who seek a broad range of public services and supports, often related to access and navigating eligibility requirements. CPF case managers help clients by helping them through the process of finding and accessing services such as counseling, legal assistance, financial benefits counseling, and other public programs like CalFresh.

Outputs and Outcomes

Target Outcomes	Q1	Q2	Q3	Q4	Overall
Outputs					
Outreach to 400 high-risk parents (100 per quarter)	159	93	70	132	454
120 families stabilized through Tier I (30 per quarter)	58	57	28	96	229
32 families will be provided wraparound case management through Tier II (8 per quarter)	31	12	17	32	92
16 families will actively participate in Tier III Community Involvement (4 per quarter)	5	16	11	21	53
Outcomes					
80% report that basic needs have been met and that they experience reduced anxiety	48%	42%	82%	14%	38%
80% of Tier II families will move from crises to stabilization in six months	48%	17%	6%	13%	20%

Program Findings

CPF successfully met participation objectives; however, client outcomes did not achieve target expectations. Participation outcomes were much higher than anticipated, suggesting that case managers were spread too thin or may have had caseloads that were too large.

Upon internal program review, staff recognized that they needed to provide a deeper level of intervention to support client follow-through, and are therefore attempting to implement more formal coaching/system navigation support.

11. Prevention Programs for Parents and Guardians: Parents by Choice: Positive Parenting Program

Program Description

Parents by Choice will implement a program of parent education and support which will target parents of at-risk families to provide skills and information designed to reduce stress and build family stability.

Parents by Choice will use the evidence-based practice: "Positive Parenting Program" or "Triple P," a parent and family support strategy whose goals are to prevent behavioral, emotional and developmental problems in children by enhancing the knowledge, skills and confidence of parents.

Parents by Choice will use the interventions outlined in Level 4 of the Triple P training program, in which parents are taught in a group format and are given the combination of information and active skills training and support. Group- Triple P is an 8-hour program, delivered in four, 2-hour groups meetings, and ideally conducted in groups of 8-12 parents.

Participation in groups will be voluntary, but referrals will be sought from schools, child welfare professionals, and the community at large.

Group sessions will be held at school sites where possible, and community centers or churches when school sites are unavailable. Multiple group sessions will be held simultaneously at different locations during the 15 month program period. Services will be provided in at least three areas of the county: North Stockton, South Stockton and Manteca/Lathrop.

Group sessions will be offered in both English and Spanish. Services will be offered at no charge to the participants.

The overall goals of this agreement are to build family relationships and to give parents the skills they need to deal with current and future problematic behavior.[12]

[12] Excerpted from program contractual agreement, scope of work, exhibit A

Parents by Choice: Comprehensive Family Support Program Logic Model

Inputs	Activities	Target Outputs	Target Outcomes
MHSA PEI funding	Seek referrals from schools, child welfare professionals and community at large	150 participants complete program over 15 months (120 per 12 month = 30 per quarter)	80% of parent participants report experiencing reduced family stress and increased family stability
Evidence-based "Positive Parenting Program": Level 4	Triple P - Level 4 Interventions: 8-hour group instruction		80% of parent participants report improvements in their child's school behavior
			80% of parent participants will report no or reduced levels of their children's involvement with law enforcement

Program Highlights

Program: In the 4th quarter, 30 individuals participated in 4 different Triple-P groups. Staff described this as a "slow" quarter, but even so, they were still able to exceed their annual target of participants. Staff reported that they reduced attendance barriers and dropout rates by providing free workbooks, dinner and childcare, and that they achieved greater retention than the national average. They also staggered group scheduling to allow participation soon after initial inquiry. Participants reported "strong feelings about the support they gain and friendships."

Staff training: Two new staff received Triple-P training in Los Angeles; one newly trained staff member is bilingual in English and Spanish, which will allow monolingual Spanish-speaking classes.

Outreach: Outreach included door-to-door program promotion in targeted neighborhoods. Staff gave presentations to a variety of community organizations and agencies and promoted services in the Stockton Record.

Partnerships: Dr. Scott Jenson from University of the Pacific, Department of Psychology, has helped the program develop spreadsheets to input assessment data.

Outputs and Outcomes

Target Outcomes	Q1	Q2	Q3	Q4	Overall
Outputs					
120 high-risk parents complete Positive Parenting Program Level 4 Interventions	41	40	42	30	153
Outcomes					
80% of parent participants report experiencing reduced family stress and increased family stability	n/a	n/a	n/a	n/a	n/a
80% of parent participants report improvements in their child's school behavior	90%	93%	95%	93%	93%
80% of parent participants will report no or reduced levels of their children's involvement with law enforcement	90%	93%	95%	93%	93%

Program Findings

Over the past year over 150 parents and families participated in the Positive Parenting Program. Overall participants reported a high satisfaction with the program, with nearly all participants reporting improvements in their own parenting skills, anger management and conflict resolution skills, and an overall improvement in their child's behavior. Additionally, over 90% of program participants reported decreased levels of law enforcement contact with their child.

California's Public Mental/Behavioral Health Workforce Needs Assessment
Due July 28, 2013

The Office of Statewide Health Planning and Development (OSHPD) is developing the next Mental Health Workforce Education and Training (WET) Five-Year Plan 2014-2019. To develop a comprehensive plan that meets local and regional needs, OSHPD is requesting information from counties that identifies their mental/behavioral health workforce needs. This need assessment will help inform the next WET Five-Year Plan and its funding priorities. Please fill out the following needs assessment for your County by July 28, 2013 and submit to OSHPD.MHSAWET@oshpd.ca.gov . If you have any questions on how to fill out the form please contact Sergio Aguilar at (916) 326-3699 or Sergio.Aguilar@oshpd.ca.gov

Survey completed by (name, title or position):	Frances Hutchins, Deputy Director, Administration/MHSA Coordinator		
Contact Information (email and phone number):	fhutchins@sjcbhs.org (209) 468-3698	*County*:	San Joaquin

GENERAL
Existing and Future Mental/Behavioral Health Workforce Shortages (Provide the top 7 mental/behavioral health workforce shortages in your county in order starting with highest need by using sample occupational categories outlined in Appendix 1 below): 1. Psychiatrist, Child/Adolescent 2. Psychiatrist, Geriatric 3. Psychiatrist 4. Psychiatric Mental Health Nurse Practitioner 5. Licensed Psychiatric Technician 6. Licensed Clinical Social Worker 7. Clinical Nurse Specialist
Mental/Behavioral Health Workforce Demands Met (Does your county have occupational categories that are declining in need and/or demand? Provide the top 5 mental/behavioral health workforce occupational categories in your county that are declining in needs starting with the least need by using sample occupational categories outlined in Appendix 1 below): 1. None

2.
3.
4.
5.

Mental/Behavioral Health Workforce Hard-to-Fill Hard-to-Retain Positions (Provide the top 7 mental/behavioral health workforce hard-to-fill, hard-to-retain positions in your county in order starting with highest need)

1. Psychiatrist, Child/Adolescent
2. Psychiatrist, Geriatric
3. Psychiatrist
4. Psychiatric Mental Health Nurse Practitioner
5. Licensed Psychiatric Technician
6. Licensed Clinical Social Worker
7. Clinical Nurse Specialist

Mental/Behavioral Health Workforce Diversity (Provide the top 7 mental/behavioral health workforce diversity needs in your county in order starting with highest need using sample categories outlined in Appendix 1 below):

1. LGBT
2. Transitional Age Youth
3. Mental Health Consumers
4. Latino
5. Asian
6. African-American
7. Family Members

Language Proficiency (Provide the top 7 mental/behavioral health workforce language proficiency needs in your county in order starting with highest need using sample languages outlined in Appendix 1 below):

1. Spanish
2. Cambodian
3. Vietnamese
4. American Sign Language

5. Hmong
6. Tagalog
7. Farsi

Consumer and/or Family Member Designated Positions: (Provide a description of currently designated positions and specific roles for consumer and/or family member positions, if any. Provide a description of future roles consumers and/or family members could have in your county, if any.):

1. Consumer Outreach Worker
2. Consumer Outreach Coordinator

STATEWIDE WET PROGRAMS

Stipends (Provide the top 5 mental/behavioral health workforce occupational categories that should have a statewide WET stipend program in order starting with highest need by using sample occupational categories outlined in Appendix 1 below):

1. Psychiatrist, Child/Adolescent
2. Psychiatrist, Geriatric
3. Psychiatrist
4. Psychiatric Mental Health Nurse Practitioner
5. Licensed Psychiatric Technician

Stipends (Provide a description of your counties use of and recommendations to enhance this program)
Stipends are part of our WET plan, however, they have not been implemented.

Mental Health Loan Assumption (MHLAP) (Provide the top 5 mental/behavioral health workforce occupational categories that should be eligible for MHLAP in order starting with highest need by using sample occupational categories outlined in Appendix 1 below):

1. Psychiatrist, Child/Adolescent
2. Psychiatrist, Geriatric
3. Psychiatrist
4. Psychiatric Mental Health Nurse Practitioner
5. Licensed Psychiatric Technician

MHLAP (Provide a description of your counties use of and recommendations to enhance this program)

Our county has opened up this opportunity to consumer designated positions

Residency Program for Physician Assistants (Provide a description of your counties use of and recommendations to enhance this program)

Not applicable.

Psychiatric Residency Program (Provide a description of your counties use of and recommendations to enhance this program)

Not applicable.

Working Well Together (Provide a description of your counties use of and recommendations to enhance this program)

Our county has been actively participating in the Working Well Together Peer Specialist Certification campaign

Regional Partnerships (Provide a description of your counties use of and recommendations to enhance this program)

We have used our Regional Partnership for a variety of trainings including Mental Health First Aid Train the Trainers, SBIRT and Motivational Interviewing, Educate, Equip and Support, Leadership Training Series provided by UC Davis Extension Center, Online Psychosocial Rehabilitation Program offered by two community colleges in our region, Seeking Safety, AMSR (Assessing and Managing Suicide Risk), Older Adult trainings. San Joaquin County was the host for the TAY Un-Convention- a one-time event used to introduce our under-served transition aged youth to resources in our communities and to determine their needs while providing them an opportunity to network.

Statewide WET Programs (What other mental health workforce development programs should be included in the statewide WET Program?)
More focus on the integration of primary care and behavioral health.

Statewide WET Programs (Other comments not referenced above)

None.

OTHER

Other miscellaneous: (Prove a description of any other critical mental/behavioral health workforce needs not identified in the sections above including but not limited to supervisor needs, succession planning needs, needs for individuals with lived experience):

Appendix 1- Definitions

Mental/Behavioral Health Workforce Occupational Categories: *Unlicensed Mental Health Professional:* Benefits/Eligibility Specialist; Case Manager/Service Coordinator; Designated Consumer and/or Family Member Position, Direct Service Provider (e.g. peer specialist, peer navigators, community support workers; Designated Consumer and/or Family Member Position, Training and Education (e.g. speakers bureaus, recovery educators, peer provider training staff); Designated Consumer and/or Family Member Position, Administrative/ Policy and Planning (e.g. consumer relations managers, clerical, IT support); Designated Consumer and/or Family Member Position, Advocacy (e.g. peer advocates, patient rights advocates, community organizers,); Employment Service Staff (e.g., vocational rehabilitation specialist); Housing Support Services Staff; Mental Health Rehabilitation Specialist; Promotora; Substance Abuse Counselor (alcohol and other drug abuse counselor); Other Non-Licensed Mental Health Staff Not listed above; *Licensed Mental Health Professional:* Clinical Nurse Specialist; Clinical Psychologist; Licensed Clinical Psychologist; Licensed Clinical Social Worker; Licensed Professional Clinical Counselors; Licensed Psychiatric Technician; Marriage and Family Therapist; Occupational Therapist; Physician Assistant; Psychologist; Psychiatrist; Psychiatrist, Child/Adolescent; Psychiatrist, Geriatric; Psychiatric Mental Health Nurse Practitioner; School Psychologist.

Diversity*:* Includes dimensions of race/ethnicity, gender, sexual orientation, socio-economic status, age, physical and/or mental abilities, and/or other pertinent characteristics.

Language**:** English; Spanish; Vietnamese; Chinese; Cantonese; Mandarin; Tagalog; Korean; Cambodian; Russian; Armenian; Khmer; Farsi; Arabic; Hmong; and Sign Language.

Appendix 2 – Direct Services Positions

BHS Workforce Needs Assessment	
Mental Health Staff (licensed) (109)	
Chief Mental Health Clinicians	15
Clinical Social Workers	8
Mental Health Clinician II	21
Mental Health Clinician III	22
Psychiatrists (full and part time)	21
Staff Nurse (III- V)	22
Mental Health Staff (unlicensed) (243)	
Mental Health Clinician I	64
Mental Health Interpreter	8
Mental Health Outreach Workers and Trainees	24
Mental Health Specialist (I, II, and III)	76
Psychiatric Technician / Senior Psych Techs	65
Chief Psychiatric Technician	6
Pharmacy Staff (23)	
Pharmacist	11
Pharmacy Technician	8
Other Pharmacy Staff	4

Based on Filled Positions, September 2013.

San Joaquin County Behavioral Health Services

Transforming Mental Health Services

Mental Health Services Act
3-Year Program and Expenditure Plan

In November 2004 voters passed Proposition 63, the Mental Health Services Act (MHSA), intended to transform public mental health care for children, youth, adults and seniors.

San Joaquin County Behavioral Health Services is preparing a Three-Year Program and Expenditure Plan (Plan) for the use of MHSA funds to support community based mental health services. Funding is distributed in five services areas: 1) Community Services and Supports, 2) Workforce Education and Training, 3) Prevention and Early Intervention, 4) Innovation and 5) Facilities and Technology. The Three-Year Plan presents an opportunity to reflect upon how well mental health services are currently delivered in the community and to develop recommendations for ongoing improvements.

We are counting on your voice to help guide us!

Community discussions are being held throughout San Joaquin County as a component of the MHSA planning process. Please come hear about how MHSA currently contributes to mental health services and share your experiences and recommendations for strengthening services. A public meeting will also be held at San Joaquin County Behavioral Health Services at 6:00pm on April 16th, 2014 to present the DRAFT Three-Year Program and Expenditure Plan.

(The same discussion will be held at each meeting.)

Tuesday, March 4, 2014	Wednesday March 12, 2014	Thursday March 13, 2014	Thursday, March 13, 2014
3:00 pm – 5:00 pm	1:00 pm – 3:00 pm	1:30 pm – 3:30 pm	6:00 pm – 8:00 pm
Tracy Library	**SJC Behavioral Health Services**	**Lodi Library**	**Central United Methodist Church**
20 E. Eaton Ave. Community Room Tracy, CA 95376	1212 N. California St. Conference Room B Stockton, CA 95202	201 W. Locust St. Community Room Lodi, CA 95240	3700 Pacific Ave. Fireside Room Stockton, CA

Please Post this Flyer in your Lobby for Public Review

If you require special accommodations to attend (interpreters, accessible seating, sign language or documents in alternate formats) please call us at 209-468-8871.

San Joaquin County Behavioral Health Services
MHSA Planning Process

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: _____

Public Comments received during the Posting Period
July 16, 2014 – August 20, 2014

- CF/TN - Try and spend the least amount in 14/15 budget for EHR. Allow the pot that left over from 14/15 and 15/16 to not be spent until 16/17 budget. I feel that there may be some unexpected shifts in technology sector. Which leads me to believe you should have the most money in 16/17 and in case of political problem; you are prepared for the shifted and have the funds to cover unknown problems and politics in technology.

- CSS – Integration with substance abuse program as a continuum of care.

- I would like the program in Manteca – comprehensive family support program/services by El Concilio to continue (it is serving many families). I think it is important we have trainings like MH First Aid, NAMI, WRAP be done in Spanish to better education the Spanish speaking community. CBOs like El Concilio, Mary Magdalene, and APSARA should be the ones outreaching to their respected communities since they have already established trust in those communities. CBOs like El Concilio should be provided with economical support to become providers to serve those who may not meet SJCBHS guidelines.

- Inn – Specific funding to CBOs to advertise on TV – Univision/Telemundo and radio Spanish speaking like 100.9 and 97.1. I heard about a relationship based model – many CBOs like El Concilio, Mary Magdalene, and APSARA have these relationships with their respected community.

- Will the Crisis Response Team consist of or hire culturally appropriate staff to be on that team that will represent the SJ community?

- VIVO has experience of on-the-job training, VIVO want to assist (FSP clients) practice within his/her skill then assist (FSP clients) look for job, a place for illness person or family members to stay in a short time – respite care. Computer systems for activities, materials in various languages

- Capacity building!

- Some program are planned some have started. So how can we refer a person to the various programs? Do they have to be an open client?

- WET – Online training and on-site training related to SUD very beneficial to enhance the education/knowledge level of employees

- CSS – Greater benefit for consumers that have COD if MH and SUD were located in the same building.

- CSS – Location of SUD services at 1212 N. California
- CSS - TAY specific Wellness Center needed
- CSS - Are there any thoughts on modifying the criteria for recovery coaches for children's FSP? Possibly making the role more relevant to children (i.e. someone with "lived experience" who may be younger person, a teen or child could relate to)
- CSS – Integration substance abuse programs
- One strategy that I have is regarding serving the Spanish speaking – I recommend advertising on the Spanish Radio (100.9), also through El Concilio
- WET – Continuing education training related to Substance use disorders
- CSS – expanding wellness center services is a great idea!

Before the Board of Supervisors
County of San Joaquin, State of California

B- 14-511

MOTION: **Vogel/Villapudua/4-0; Ruhstaller - Absent**

Approval of 2014-2017 Mental Health Services Act
Three-Year Program and Expenditure Plan Totaling $84.5 Million

THIS BOARD OF SUPERVISORS does hereby approve the 2014-2017 Mental Health Services Act Three-Year Program and Expenditure Plan.

I HEREBY CERTIFY that the above order was passed and adopted on 9/9/2014 by the following vote of the Board of Supervisors, to wit:

AYES: **Villapudua, Bestolarides, Vogel, Elliott**

NOES: **None**

ABSENT: **Ruhstaller**

ABSTAIN: **None**

Clerk of the Board of Supervisors
County of San Joaquin
State of California

By: _____
Clerk